Information Processing and Motivation in Eating Disorders

by

Emma Harrold

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Volume One

Department of Psychology
School of Human Sciences
University of Surrey

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I would like to acknowledge my clinical supervisors. Each supervisor has made a positive contribution to my personal and professional development in the course of training.

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INTRODUCTION – VOLUME ONE

Overview

This portfolio comprises three volumes. These contain a collection of work, a sample of the work completed during my training on the PsychD. Clinical Psychology training course at the University of Surrey. The work presented in the portfolio demonstrates the different clients groups, the presenting problems and the psychological approaches covered. The order of the work is maintained in the order it was carried out to convey the development of my knowledge base, clinical skills and competency over the training period.

Volume One comprises the academic dossier, clinical dossier and research dossier. The academic dossier presents four essays representing the core client groups. The clinical dossier consists of summaries for each placement undertaken and summaries for each case report. The research dossier contains the Service Related Research Project from Year One, Qualitative Research Project from Year Two and Major Research Project from Year Three.

Volume Two is the part one of the clinical dossier. The dossier contains a full case report from each core placement.

Volume Three is part two of the clinical dossier. For each placement the documents presented include: placement contract, evaluation forms, summary of clinical activity, logbook of clinical experience and samples of correspondence.

The clinical dossier contains confidential clinical material, for this reason it is held in the Clinical Psychology Department, at the University of Surrey.
Overview

Essays from the four core client groups are contained in the academic dossier. The core client groups are as follows:

1. Adult mental health;
2. People with learning disabilities;
3. Children, adolescents and families;
4. Older adults.

These essays critically evaluate psychological theories, models and treatment approaches to issues occurring throughout life span and applied in the contexts of clinical practice.
Compare and contrast the evidence base for two different theoretical models of Eating Disorders. What implications does this have for the delivery and provision of clinical services for people with Eating Disorders?

January 2002

Year 1
Introduction

This essay will present and evaluate the evidence for two psychotherapeutic theoretical models commonly used as a basis for the treatment of patients with eating disorders. The eating disorders referred to in this discussion will be bulimia nervosa and anorexia nervosa. These two disorders are chosen as there is considerable evidence for the efficacy of treatments. The two psychotherapeutic models for which evidence will be presented are Cognitive Behavioural Therapy (CBT) and Interpersonal Therapy (IPT). The evidence base drawn upon will refer to a variety of information sources including: quasi investigations of the associations between factors involved in the disorders, randomised controlled trials and the evidence-based treatment guidelines current at the time of writing this essay. The essay concludes with a discussion of the implications for provision and delivery of psychological treatment services.

Characteristics and prevalence of bulimia nervosa and anorexia nervosa

Bulimia nervosa is prevalent among young adult females in the population at a rate of between 1% and 3%, it is reported with greater frequency among women than men (Roth & Fonagy, 1996). Bulimia nervosa is characterized by recurring episodes of binge eating and vomiting, patients also exhibit dietary restraint. The characteristic concerns of patients with this disorder, as with anorexia nervosa, are persisting beliefs relating to body shape and weight. Anorexia nervosa is most common among adolescent and young adult females, with conservative estimates of prevalence of between 0.5% and 1% in the population, estimates for prevalence among the male population are wider ranging (Roth & Fonagy, 1996). Anorexia nervosa is characterized by maintenance of low body weight, persistent beliefs relating to body shape and concerns about weight. The DSM-VI (APA, 1994) diagnostic criteria for both of these disorders are given in appendix one and two for information. It should be noted that in addition to anorexia nervosa and bulimia nervosa, the range of eating disorders given in the common diagnostic systems (e.g. DSM-IV) includes eating disorders not otherwise specified and binge eating disorder.

Both bulimia nervosa and anorexia nervosa are associated with secondary psychopathology including low self-esteem, poor social skills, external locus of control and lack of autonomy. These eating disorders are also commonly associated with indicators of poor psychological
adjustment including anxiety, depression and poor social functioning. The levels of co-morbid psychiatric disturbance in a cohort of sufferers of bulimia nervosa reported in a study by Agras, Walsh, Fairburn, Wilson and Kraemer (2000) are given here as an illustration. Among this population, lifetime major depression was recorded among 117 cases (53%), current depression among 48 cases (22%), personality disorder was recorded among 81 cases (37%) and lifetime substance dependence among 51 (23%) of cases.

The need for a treatment for these disorders is demonstrated by the debilitating effects of their symptoms, noted above, it is also demonstrated by the prognosis of patients with this disorder. For patients with chronic bulimia nervosa, prognosis may be poor due to the severe medical complications that are the consequences of the behaviours and symptoms of the disorder, such as potassium imbalance and dehydration as a result of persistent vomiting (Roth & Fonagy, 1996; Bell, Clare & Thorn, 2001). The long-term prognosis for patients with anorexia nervosa is also poor, with reports of mortality rates ranging between 4.4% and 15% (Roth & Fonagy, 1996).

**Evidence for psychotherapeutic treatments for bulimia nervosa and anorexia nervosa**

An indication of the effectiveness of psychological therapies for bulimia nervosa compared to treatment with medication and to waiting list controls is provided in systematic reviews by Hay and Bacaltchuk (2001) and Bacaltchuk, Hay and Trefiglio (2001). Hay and Bacaltchuk (2001) observe that, CBT is superior to waiting list controls but is not significantly different to the effect of other psychotherapies. Bacaltchuk, et al. (2001) report that remission and drop out rates are higher for antidepressant compared with psychological therapy interventions. They also find that for combination approaches compared with psychological interventions, remission rates were similar, but drop out rates were higher. These authors observe that psychological therapies seem to be more acceptable to patients, but that there are an insufficient number of randomized controlled trials for conclusive evidence on the superiority of particular treatment approaches. Cognitive behavioural therapy and interpersonal psychotherapy for eating disorders are described below.
Cognitive behavioural therapy model for bulimia nervosa and anorexia nervosa

The cognitive behavioural therapeutic (CBT) approach is based on Beck, Rush, Shaw and Emery's (1979) original work on the cognitive model for depression. In terms of bulimia nervosa and anorexia nervosa the central premise of the CBT formulation is that the condition is maintained by cognitions relating to body weight and eating behaviour and that secondary to this are factors such as low self esteem. The cognitions relating to these factors serve as biases to the processing of information and this becomes automatic. In bulimia nervosa, behaviours of binging and purging are in reciprocal relationship with these cognitive biases. These behaviours are triggered by, and also serve to maintain and reinforce cognitive biases. For example, an experience of binging may be interpreted by the individual as failure and as a result the person may perform purging behaviours and these may in turn contribute to negative self-evaluations. Perfectionism and dichotomous thinking ('all or nothing' thoughts) are noted as common types of cognitive bias and logical error contributing to the maintenance of bulimia nervosa (Fairburn, 1997a). An example of a cognitive model to explain the maintenance of bulimia nervosa is given in appendix three.

In a recently published CBT model for anorexia nervosa, the underlying cognitive premise or core belief held by the patient, in its simplified form, is that self-control and self-worth are determined and indicated principally by bodily appearance in terms of weight and body shape and by eating behaviour (Fairburn, Shafran & Cooper, 1999). There is substantial evidence for the efficacy of the cognitive behavioural approach for the treatment of bulimia nervosa and anorexia nervosa. This is compared with the evidence for the IPT approach below. The following section discusses the evidence for certain features of the CBT model.

The CBT programme takes a three-stage approach focusing on education and eating behaviour first, then on cognitive techniques including cognitive restructuring and finally, on consolidation and relapse prevention (Fairburn, 1997a). A key feature of the CBT model for eating disorders is its focus on maintaining factors (Fairburn, 1997a; Wilson, 1999). The current conception of maintaining factors is derived from evidence from quasi investigations of the association between factors. Examples of maintaining factors include: negative and positive cognitions (Godley, Tchanturia, MacLeod & Schmidt, 2001), cognitive and somatic symptoms of depression (Troop, Serpell & Treasure, 2001), negative emotions (Meyer, Leung, Feary & Mann, 2001) and mood (Waters, Hill & Waller, 2001).
The role of positive as well as negative cognitions in the maintenance of eating disorders has been demonstrated, for example in a study of future directed thinking by Godley, Tchanturia, MacLeod and Schmidt (2001). This study found more negative future directed cognitions among patients with anorexia nervosa than in controls, although no specific negative cognitions related to personal health and social outcome. Bulimia nervosa patients held more negative cognitions relating to personal health outcomes and social outcomes, more general worry and hopelessness than controls. Patients with both types of disorder held fewer, positive future cognitions than the controls. The authors found evidence, providing detail on the mediating role of motivation affecting therapeutic intervention outcomes, this issue is incorporated in therapeutic approaches and is discussed in detail below.

Troop, Serpell and Treasure (2001) found that 73% (n=151) of patients reported symptoms equivalent to levels of moderate or severe depression. In this study dietary restriction and bulimia (e.g. cognitive and behavioural symptoms of eating disorders) were found to predict cognitive symptoms of depression (e.g. pessimism, guilt and self-criticism), but not somatic or affective symptoms of depression (e.g. irritability and work difficulty). They concluded that depressive symptoms appeared to be part of eating disorder symptomatology, and that it was specifically the cognitive rather than somatic/affective elements of depressive symptoms that were related. The authors noted that this study would be substantiated with the addition of objective measures. The role of specific core beliefs and the moderating effect of levels of negative emotions, symptoms of borderline personality, were observed both among a non-clinical sample by Meyer, Leung, Feary and Mann (2001) and among patients undergoing group CBT by Leung, Waller and Thomas (2000a).

An explanatory model for the specific relationship between emotion, cognitions and certain bulimic behaviours was examined by Waters, Hill and Waller (2001). In a prospective study of food cravings they proposed an emotional blocking model to explain binge-eating behaviour. Waters, et al. (2001) identify elevated levels of tension, low mood and low hunger as associated with binge-eating in response to food cravings. This conceptualization incorporates cognitive and contextual factors, explaining food cravings as a classical conditioning state. An alternative explanatory model is the starvation or dietary restraint model (Cooper & Fairburn, 1986) where binge-eating is explained as an element of a cycle of starvation – food craving – binging.

The CBT approach, recent to the time of writing this essay, has been adapted to focus on core beliefs held by patients with the use of schema-focused techniques. As noted above, the role
of core beliefs in the outcome of a twelve-session trial of group CBT for bulimia nervosa is explored by Leung, et al. (2000a). With one exception, poorer pre-treatment core beliefs were associated with lower gains post-treatment. They suggest that schema focused techniques might be incorporated particularly for those patients with greatest psychopathology pre-treatment. The exception was that poorer social deprivation beliefs were associated with greater gains post-treatment. The authors speculate that for this sub-group, the experience of group support itself challenged the social deprivation belief and that as a result these individuals experienced greater gains from the treatment. They conclude that specific core beliefs (e.g. defectiveness/shame, functional independence/incompetence) might be addressed in CBT for bulimia in the future. In a separate study, Leung, Thomas and Waller (2000b) suggest that core beliefs originating from parental bonding behaviour, may be used as a focus of schema change in therapy for eating disorders. They report that among patients suffering from anorexia nervosa, low levels of parental care are predictive of unhealthy core beliefs. Their study provides preliminary evidence for the association of these specific core beliefs with disorder symptomatology, although the design of their study may be criticized for its reliance on a single source for the retrospective report of patient’s perceptions.

There is evidence that CBT improves levels on markers of psychological adjustment including self-esteem, social functioning and depression among patients with bulimia nervosa (Wilson, 1999). CBT is shown to improve binge-eating behaviours, purging and restrictive dieting, yet there are fewer reports on the reduction of core beliefs regarding shape and weight. It is noted that, in contrast, these elements are emphasized as central to the CBT model (Fairburn, 1997a, Wilson, 1999) and future developments in CBT may focus specifically on these core beliefs. Certainly the preliminary research discussed above has attempted to identify these core beliefs and to describe their development and their role.

Interpersonal therapy model for bulimia nervosa and anorexia nervosa

Interpersonal psychotherapy (IPT) originated as a treatment for depressive illness (Klerman, Weissman, Rounsaville & Chevron, 1984). Under the original formulation, the two goals of interpersonal psychotherapy are a reduction in depressive symptoms and addressing interpersonal problems associated with the cause of the illness. IPT is categorized as an explorative psychotherapy (Klerman, et al., 1984). In IPT the unit of observation and focus of treatment is the patient’s interactions with their primary social group (e.g. significant
relationships, family, work and neighbourhood). The model emphasizes interpersonal problems including anxiety, in particular in relation to roles, conflict, rejection, and associated emotions and the function of these on attachment, self-esteem and purpose.

The action of these phenomena occur at multiple points in the model. The relationship between psychopathology and interpersonal relationships is viewed as two-way, although interpersonal relationships including social support and life events are also viewed in the model as antecedent to psychological disturbance. Interpersonal relationships are also viewed as predisposing factors in the explanatory model, particularly in terms of the role of childhood experiences in later psychological adjustment. In the case of eating disorders, schema based studies of the role of parental bonding behaviour find some preliminary evidence for an association with eating disorder symptomatology (Leung, et al., 2000b). Interpersonal relationships are also regarded as having an effect on the maintenance and exacerbation of the condition (Klerman, et al., 1984). There is also evidence for the contribution of specific social cognitions to the maintenance of eating disorders. Godley et al. (2001) found social cognitions of negative future outcomes to be associated with outcomes in eating disorders.

Applied to eating disorders, the IPT explanatory therapeutic model emphasizes the interpersonal problems that under-pin and maintain the condition and the associated problems of regulating affect (Apple, 1999). IPT has been evaluated for both bulimia nervosa and anorexia nervosa. The primary therapeutic goals are essentially problem focused. The four key interpersonal problem areas relate to role in terms of: transition, disputes, grief and skill deficits (Apple, 1999). An example formulation might be that a client, as a result of new life circumstances or life developments in terms of independence, may experience problems. These problems may be explained by the individual's expectations of roles in relationships and their perception of their requirements for closeness and/or distance in relationships. Therapeutic work might focus on adjusting boundaries, monitoring and reflection on outcome. There is a secondary purpose in IPT of 'enabling the sufferer to modulate emotional states' (Apple 1999). The rationale for this focus is that certain attitudes and expectations of the patient may lead to conflict avoidance, which may serve to perpetuate the experience of related affect. IPT was initially selected for use in eating disorders as a standardized psychological treatment in a controlled trial to enable comparison and investigation of the therapeutic properties of CBT for treating bulimia nervosa (Fairburn, et al., 1991; Fairburn, Jones, Peveler, Hope & O'Connor, 1993).
Comparison of CBT and IPT approaches
The CBT approach to eating disorders focuses on illness related thoughts and behaviours (e.g. symptoms) whereas IPT focuses on interpersonal relationships, and symptoms of the illness are regarded as a distraction from the aim of IPT therapy (Apple, 1999). In terms of principles of the therapeutic approach, IPT and CBT have in common that there is a shared responsibility for raising topics, both therapist and patient are active in the process. For example, in IPT the therapist acts as advocate rather than taking a neutral stance, certain techniques are employed by the therapist including active support and guidance.

Neither IPT nor CBT therapy has a focus on the therapeutic relationship, this is in contrast to the traditions of psychodynamic psychotherapy. IPT views the relationship and interactions between therapist and patient as real rather than as an artefact and focus of therapy, although these may be treated as analogous to external interpersonal problems as part of therapy (Klerman, et al., 1984) and recognized in therapy to avoid them becoming an obstacle to the therapeutic task itself (Apple, 1999). Apple (1999) gives the example of a case where a client's fear of overwhelming others by expressing her feelings was identified at the outset by the client and therapist as a potential obstacle to the therapeutic project. With both CBT and IPT therapeutic approaches the responsibility for change is with the patient. Neither approach has a focus on role transition, for example from adolescence to adulthood, although IPT incorporates life chart techniques. Considering the evidence on prevalence of eating disorders among young adults and the characteristic problems of these clients, techniques focusing on role transition may be a useful adjunct to therapy in the future.

The operationalization of these approaches utilizes a variety of specific techniques. In IPT, in order to enable exploration of interpersonal issues, specific techniques such as decision-making analysis are employed (Klerman, et al., 1984). CBT employs specific, systematic techniques to change thoughts and beliefs, such as cognitive restructuring. Client homework is also employed in CBT. IPT does not employ these specific techniques, however Apple (1999) notes that certain IPT techniques may result in similar changes. He observes that the adapted form of IPT used by Fairburn, et al. (1993) does refer to the therapist making a ‘non-specific recommendation for change’ in the time between sessions.

In general, both approaches also employ common psychotherapeutic techniques of open-ended questioning, problem solving and role-play (Apple, 1999). The form of IPT adapted for clinical research trials has excluded problem solving and role-play techniques in order to
ensure that it is distinct from CBT (Fairburn, et al., 1993). Similarly the content of IPT has been controlled for research purposes, in particular, concerns over eating and client’s shape and weight are excluded, as these are a focus of the CBT approach (Fairburn, et al., 1993). A method that is unusual to IPT is the use of a life chart as a tool to aid identification of associations between eating problems, interpersonal relationships, life events and levels of psychological adjustment at different periods in the patient’s life. Both CBT and IPT interventions are time limited, although intervention for IPT is long-term relative to interventions for other conditions (24-36 weeks) (Apple, 1999).

The typical problems that are encountered in IPT, are described by Klerman, et al. (1984). These share some similarities with problems that are the particular focus of certain CBT techniques. These problems include: attitudes toward undergoing treatment, normalization, avoidance and maintaining factors. Klerman, et al. (1984) describe common problems requiring normalization such as focusing on prevalence of illness, characteristic symptoms, coping strategies and potential for recovery. Avoidance and maintaining factors such as styles of communication and relationships with family or in the work environment are often a focus of later therapeutic sessions in IPT (Klerman, et al., 1984). As noted above, maintaining factors are a main focus of the CBT approach.

Comparison of clinical trials evidence for CBT and IPT

Several studies have compared the efficacy of psychological treatments for bulimia nervosa, in particular CBT and IPT. As noted above, treatment manuals are available for both CBT and IPT for eating disorders. Studies employing these standardized procedures have reported on changes over the course of treatment (Jones, Peveler, Hope, & Fairburn, 1993) and outcome and long-term effects (e.g. Fairburn, et al., 1993; Fairburn, et al., 1995; Agras, et al., 2000). Both CBT and IPT have been found to be effective for treating bulimia nervosa (Fairburn, 1997a).

Fairburn, et al. (1993) report that both CBT and IPT show better outcome than behavioural therapy at end of therapy and significantly better long-term effects than behavioural therapy at 12 months follow-up. In this study, there was a significant improvement for both treatments in self-esteem, improvement in social functioning and also a reduction in general psychiatric symptoms. Both treatments also resulted in a reduction in frequency of bulimic behaviours of overeating and purging, reduction in dietary restraint, improved attitudes towards shape and
weight and global eating attitudes, with a significant effect at 12 months. An important finding was of the temporal differences in the effects of the treatments. Patients undergoing IPT showed a trend of continuing improvement over the whole study period and favourable, although not significantly different end-point outcome in terms of bulimic episodes at 12 months follow-up. Fairburn, et al. (1993) highlighted a need for an understanding of the mechanisms that maintain eating disorders on the grounds that the disorder can be successfully treated via the treatment of its secondary effects with IPT.

Agras, Walsh, Fairburn, Wilson and Kraemer (2000) in the United States collaborated closely with Fairburn and colleagues to replicate this study. They found that, in support of Fairburn et al., (1993) CBT is clinically and statistically more effective at end of treatment than IPT in terms of recovery, remission and reduction of eating attitudes and behaviours. Among those who completed treatment, they found significantly more CBT patients recovered compared with IPT patients. However, the significant difference between the effects of these two interventions disappeared at 8 and 12-month follow-up, with the exception of primary eating disorder behaviours, where CBT remained more effective. The outcome measures reported at each stage of follow-up, suggest that improvement of IPT patients on eating attitudes and behaviours and also on social adjustment and self-esteem ratings is gradual, compared with the CBT intervention group who display maintenance or minor reduction in effects at follow up (Agras, et al., 2000). At 6-year follow up the differential effects of CBT and IPT are maintained (Fairburn, et al., 1995). A follow up to this replica study (Agras, et al., 2000) would provide useful additional information on the long-term impact of IPT as a treatment. A possible explanation is that the improvements in the IPT group occur as their improved interpersonal functioning takes effect in various areas of the client’s life.

Agras, et al. (2000) interpret their findings as reflecting the shared mechanisms of CBT and IPT over time, in effecting psychological components of concern over weight and shape, self-esteem and interpersonal functioning. They confirm that CBT in addition, is effective in impacting on eating attitudes and behaviours that are a target of the CBT intervention. In their interpretation, Fairburn, et al. (1993) and Fairburn (1997b) emphasize the indirect action of IPT impacting over time on the interpersonal consequences of the eating disorder. They also suggest that the effects of CBT on general psychiatric symptoms and social functioning are secondary effects of the action of CBT on eating attitudes and behaviours.

An explanation for the mechanism by which IPT impacts on the patient is that it is effective via an increased sense of self-efficacy, increased self-esteem, diverted attention of concerns,
increased social contact and reduced impact of social stressors (Fairburn, 1997b). Longitudinal follow-up information and more detailed assessments of psychological functioning both pre-treatment and at follow-up would provide detail on specific combinations of techniques and appropriate referral of cases to these treatments.

In addition, Fairburn, et al. (1993) also observe that, as with CBT, some immediate effect is seen in IPT patients, that is not explained by the indirect action of improved interpersonal relationships over time. Jones, et al. (1993) reporting on the comparative trial by Fairburn, et al. (1993) aimed to address this question. They were inconclusive as to the specific action of IPT. They conclude that in general ‘non-specific’ psychological properties are common across these psychological treatments (i.e. CBT, IPT and behavioural therapy) for bulimia nervosa and that they impact in the early stages of treatment. These properties include; the characteristics of the therapeutic alliance (e.g. being accepted by the therapist), an individualized and coherent explanation for the problem and a convincing treatment approach. Jones, et al. (1993) speculate that patients suffering from bulimia nervosa may share certain characteristics that make them particularly susceptible to these effects. For example, those patients who have hidden their bulimic behaviour and have felt ashamed, may show improvement in the early stages of treatment as a result of being accepted by their therapist and by beginning an open discussion about their problem.

Anorexia nervosa has been the subject of research on systematic treatments only relatively recently. Reasons given for the lack of outcome studies on CBT for anorexia nervosa include: the low incidence of the disorder, the particular cognitive characteristics of patients resulting in problems specifically with engagement in treatment and trials and absence of a comprehensive treatment manual (Fairburn, 1997a; Roth & Fonagy, 1996).

Several studies have focused on factors with a role in modifying therapeutic outcome for eating disorders. Treasure, et al., (1999) report evidence to suggest that choice of treatment should be informed by level of patient engagement in therapy at initial treatment. They also suggest that patients may benefit from motivation techniques. Although the actual efficacy of motivational techniques in altering the level of engagement among patients is yet to be established they did find that in the first phase of intervention, motivational therapy results in a reduction of symptoms of binge-eating, vomiting and laxative use, equivalent to CBT. Wolk and Devlin (2001) report on the stages of change theory applied to an analysis of eating disorder patients referred randomly to a psychotherapeutic intervention either CBT or IPT. They found an association of these factors in response to treatment with IPT but not CBT.
among patients with bulimia nervosa. Unfortunately this paper does not refer to the study by Treasure, et al. (1999). Towell, Woodford, Reid and Rooney (2001) found that compliance at admission but not length of illness was associated with treatment outcome. They also use the stages of change model to explain that this specific patient group may have been at 'an earlier stage of the (change) model'. Godley, et al. (2001) suggested that motivational approaches may also be used to address the positive and negative thoughts that the authors identify as being characteristic of eating disorders.

The published clinical guidelines suggest that, in the case of bulimia nervosa, the most evidence for the relative effectiveness of psychotherapeutic interventions is for the effectiveness of CBT, although controlled trials also show IPT to be useful (Roth & Fonagy, 1996; A.P.A., 2000; Bell, et al., 2001). The A.P.A (2000) recommendations also suggest that there is evidence for a combination of therapy with medication for control of co-morbid depression and symptoms of binging and purging. The A.P.A (2000) guidelines recommend that behavioural techniques may be helpful in addressing bulimic symptoms of binge eating and vomiting through exposure and response prevention. Relapse prevention is indicated as a required part of the treatment programme (A.P.A., 2000), this should take into consideration evidence for the longer-term action of certain psychotherapies for bulimia nervosa, in particular IPT. The treatment of anorexia nervosa recommended in clinical guidelines is for nutritional rehabilitation and controlled weight gain combined with psychotherapy (A.P.A., 2000). The focus of psychotherapeutic treatment for anorexia nervosa is given as 'psychodynamic conflict, cognitive development, psychological defences, complexity of family relationships and other psychiatric disorders'. The A.P.A (2000) guidelines state that 'no clear evidence exists' for the relative effectiveness of one form of psychotherapy for this disorder.

Implications for delivery and provision of clinical services

The evidence discussed above provides the detail available on two psychotherapeutic models for eating disorders, including reference to the efficacy of treatments based on these models. There is increasing evidence to support these models of the complex mechanisms that comprise eating disorders. In comparison to this, the development of services is in relatively early stages, for example, Wilson (1999) observes that CBT for bulimia nervosa is relatively rarely used in the US despite its established efficacy. Similarly, service guidelines for eating
disorders incorporating psychotherapeutic treatments are being developed in the UK (Bell, et al., 2001).

The specialized nature and long duration of treatment programmes for eating disorders and the long-term natural history of the various conditions, may be used as arguments in favor of care provision via a centralized specialized service rather than via local generic services (Bell, et al., 2001). Furthermore, a specialized service may more efficiently meet the requirement for a multidisciplinary team approach to address the range of care needs for this client group. The training of primary care staff has also been recommended in order to enhance service provision for eating disorders. However, the deskilling of staff in generic services is seen as a possible consequence of provision of services via specialized teams (Bell, et al., 2001).

Whilst treatment is generally carried out by specialized services, other methods for delivering CBT approaches are being developed and documented. Tuschen-Caffier, Pook and Frank (2001) report on the evaluation of CBT for bulimia nervosa following a manual among an unselected out patient service population. This study finds evidence that the therapy is effective outside the research setting and is 'highly acceptable to patients', exhibited by a low drop out rate in this study. Similarly, a self-help manual form of CBT is found to be effective for a subset of bulimia nervosa and binge-eating disorder patients, guided self-help and short CBT approaches have also been developed (Wilson, 1999; Fairburn, 1997a).

The above discussion of CBT and IPT also gives evidence to suggest that follow-up and relapse prevention should be a focus of the planning and delivery of services for eating disorders.

Several studies suggest that compliance and engagement in therapy for eating disorders hold potential for improving treatment success (Treasure, et al., 1999; Godley, et al., 2001; Towell, et al., 2001; Wolk & Devlin, 2001). These features of the therapeutic intervention may prove to be generic to the success of eating disorders treatment and therefore may require attention in psychotherapeutic intervention informed by cognitive behavioural or interpersonal therapy models.
References


Appendix 1. A definition of bulimia nervosa


307.51 BULIMIA NERVOSA (BN)
A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both the following.

i. Eating in a discrete period of time (e.g. within any two hour period) an amount of food that is definitely larger than most people would eat during a similar period of time in similar circumstances.

ii. A sense of lack of control over eating during the episode.

B. Recurrent inappropriate compensatory behaviours in order to prevent weight gain such as self-induced vomiting, misuse of laxatives, diuretics and excessive exercise.

C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for three months.

D. Self-evaluation is unduly influenced by body weight and shape.

E. The disturbance does not occur exclusively during episodes of AN.

i. Purging type - the person regularly engages in self-induced vomiting or the misuse of laxatives and diuretics.

ii. Non-purging type - the person uses other compensatory behaviours such as fasting or excessive exercise, but does not regularly engage in self-induced vomiting or the misuse of laxatives or diuretics.
Appendix 2. A definition of anorexia nervosa


307.1 ANOREXIA NERVOSA (AN)

A. Refusal to maintain body weight at or above a minimally normal weight for age and height* (e.g. weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self evaluation or denial of the seriousness of current low body weight.

D. In post menarcheal women, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles.

i. Restricting type - during the episode of AN the person does not regularly engage in bingeing and purging behaviour.

ii. Binge eating/purging subtype - during the episode of AN, the person regularly engages in bingeing and purging behaviour

* Body Mass Index (BMI) = \[
\frac{\text{weight (kg)}}{\text{height (m}^2)}\]

(A healthy BMI range is 20-25. BMI 17.5 kg/ m² is the threshold for AN. A BMI of 13.5 kg/ m² is at a critical level of weight loss at which admission to hospital should be considered. Reference: WHO 1993. The ICD-10 classification of mental health and behavioural disorders, diagnostic criteria for research, Geneva, WHO.)
Appendix 3. A cognitive model for the maintenance of bulimia nervosa

- Negative self-evaluation

- Characteristic extreme concerns about shape and weight

- Perfectionism and dichotomous thinking

- Intense and rigid dieting

- Perfectionism and dichotomous thinking

- Binge eating

- Negative affect

- Self-induced vomiting/laxative misuse

Figure 1. Cognitive model of Bulimia Nervosa from Fairburn (1997a).
Critically review the current status of the assessment and treatment of dementia in adults with learning disabilities

July 2002

Year 1
Background

A striking feature of the current literature on learning disability and dementia is its recent proliferation. This can be regarded as a response to the health need identified in the increasing number of people with learning disabilities living into old age, with a proportion going on to develop dementia. The essay will describe the assessment and treatment methods for dementia in people with learning disabilities, with an emphasis on developments in psychological approaches and with reference to the challenges of working to this goal.

The work of the Disability Movement and the policy debate as to the effect of institutional care on the individual underpin the current trends in care and the development of assessment procedures for people with learning disabilities. In particular, there has been attention to issues such as ‘social role valorization’ (Wolfensberger, 1983), a perspective that recognizes the rich life experience and the roles in society that individuals with learning disabilities may attain. This is a development from ‘normalisation theory’, a theory that explains the effects of labelling and negative images resulting in the devaluing of people with disabilities. Recent assessment and treatment approaches have aimed to utilize these perspectives. For example, new approaches to address ‘challenging behaviour’ view the presenting difficulty as challenge to all, rather than solely as a problem residing in the person (Woods, 1995).

The literature on psychotherapeutic work with people with learning disabilities provides an emotional and human perspective to this context. The distinction between concepts of primary and secondary handicap in people with learning disabilities (Stokes & Sinason, 1992) has provided an understanding of the lives of people with a learning disability. The secondary handicap may be a defence against further trauma. In another way, secondary losses for a person with a learning disability might include a loss of sense of dignity, loss of potential for status among peers and siblings and loss of the possibility of fulfilling a range of roles in adult life. Sinason (1992) describes the loss reaction to handicap and the person’s reaction to loss as a result of dementia. This suggests that to a person with a learning disability the symptoms of dementia may be seen as a double blow.
Dementia

Dementia ‘symptoms’
Dementia is a condition that is most commonly associated with old age. People with symptoms of dementia show multiple cognitive deficits, including memory impairment, these deficits are due to neurophysiological changes in the brain (DSM IV; American Psychiatric Association, 1994; Woods & Roth, 1996). As a result the individual shows a decline in social and occupational functioning. People with dementia can experience a wide range of difficulties. They may become unable to engage in their preferred activities. They may lose their daily living skills, communication skills and the ability to recognize individuals who are familiar to them. They may experience mood changes, such as increased levels of agitation and may display behaviours that challenge others, such as wandering or walking about and engagement in inappropriate sexual behaviour (Kerr, 1997). The prognosis of the dementias is poor, although in the early stages deterioration can be imperceptible for several years (Woods & Roth, 1996). Finally, the debate as to whether the pattern of decline that is labelled ‘dementia’ is due to the normal aging process or to a disease process is addressed by diagnostic systems, these are referred to below.

Dementia classification and diagnosis
A classification system of ‘the dementias’ that is commonly used gives three main types, these are defined by the area of the brain that is affected. ‘Alzheimer’s disease’ is the most common form of dementia. The main physiological change in this form of dementia is atrophy (i.e. wasting) of the cerebral cortex (Davidson & Neale, 2001). This involves the death of cells in the brain that secrete the neurotransmitter acetylcholine. In its early stages, the main problems experienced by persons with this disease are in terms of concentration and memory for new information. Physical problems occur only at the late stages of the disease when the motor and sensory areas of the cortex are affected. ‘Frontal-temporal dementia’ is a form of dementia where cognitive impairment is accompanied by behavioural and personality changes as a result of the area of the brain affected. ‘Frontal-subcortical dementia’ is a form of dementia where the person suffers from cognitive impairment accompanied by involvement of the area of the brain controlling motor function. Subtypes of frontal-subcortical dementia include: Parkinson’s disease, Huntington’s chorea and Vascular dementia.
Diagnostic systems for dementia are included in the ICD-10 (World Health Organization, 1992) and DSM-IV (American Psychiatric Association, 1994), these give the most strict criteria for a diagnosis of dementia. The DSM-IV criteria include a category for ‘Age-Related Cognitive Decline’ (ARCD), this is defined as specific cognitive deficiencies occurring at insufficient levels to meet criteria for dementia. Assessment of dementia requires information from a battery of cognitive and functional assessment tools (see section on Assessment). The process of obtaining a differential diagnosis of dementia can involve multiple health professionals and is demanding on resources. For example the diagnosis of Alzheimer’s disease combines information from CT scans, neuropsychological testing batteries, pathology tests (including blood profiles), lumbar spinal fluid testing and magnetic resonance imaging. A direct test of neuro thread proteins in cerebro-spinal fluid is currently available but as yet is not used in diagnosing dementia in people with Down’s syndrome (Percy, in Janicki & Dalton, 1999).

In order to meet a diagnosis of dementia using the DSM-IV (APA, 1994) deterioration is required in one test of memory and one test of cognitive ability, occurring in a context of change in the individual’s level of everyday functioning. Among people with learning disabilities the challenges of diagnosing dementia include those presented by overlap of symptoms, co-incidence of depression with dementia or depression as a ‘prodromal syndrome’, eventually developing into dementia (Burt, in Janicki & Dalton, 1999). The assessment of dementia requires that changes that are ascribed to dementia are distinguished from changes that are normally associated with aging and from changes in behaviour that may have another cause.

**Epidemiology**

The prevalence of ‘the dementias’ in the general population (UK) ranges between 5% for those over 65 years and 20% for those over 80 years (Woods & Roth, 1996). Among people with learning disability there is only preliminary evidence on the prevalence and incidence of ‘the dementias’. A study by Holland, Hon, Huppert and Stevens (2000) reported on a cohort study of sixty-eight people with Down’s syndrome, with mean age of 42.3 years (SD = 8.3 years). At 18 month follow-up and using the DSM-IV criteria, the prevalence of dementia was 8.8% and the dementia incidence rate was 4.6%. There is a reported increasing incidence of dementia among people with learning disabilities and projections of this pattern continuing.

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1 ‘Prodromal syndrome’ is defined as ‘premonitory symptoms of disease’ by Janicki and Dalton (1999)
Life expectancy of people with learning disabilities has increased dramatically in the past century, at present 80% of people with Down’s syndrome survive into their fifth decade. There is evidence that currently the aging of people with mild learning disabilities is similar to the general population (Patja, Livanainen, Wesala, Oksanen & Ruoppila, 2000). Only recently has a national register been established with the aim of determining the projected provision requirements for older people with learning disabilities.

**Etiology**

The current evidence on risk factors for dementia in people with learning disabilities mostly relates to genetic causation. The possibility of a genetic link is indicated by the high incidence of the disease among people with Down’s syndrome. This observation has also fuelled research into the genetic causes of Alzheimer’s in general (Davison & Neale, 2001). Down’s syndrome (or trisomy 21) is caused by a chromosomal abnormality. People with Down’s syndrome generally have moderate to severe learning disabilities, in addition to this they have a number of distinctive physical signs (e.g. short and stocky stature and oval, upwards slanting eyes) (Davidson & Neale, 2001).

For the general population there is strong evidence for genetic causes for both early onset and for involvement in late onset in Alzheimer’s disease (Davidson & Neale, 2001). The role of environmental factors in the onset of dementia in the general population has also been demonstrated, for example, as a result of head injury. There is some evidence to suggest that there are protective factors, these include aspirin, nicotine and a previously high level of cognitive ability (Davidson & Neale, 2001). There is preliminary evidence to suggest that life events coincide with onset of decline in functioning leading to dementia. One explanation offered is that, rather than having a causal role, stressful life events highlight deficits in cognitive resources that would usually go unnoticed. For each of the factors noted above there is accumulating evidence to suggest their role in the causation of dementia in people with Down’s syndrome.
Assessment

Current status of dementia assessment in people with learning disabilities

At present the assessment and diagnosis of dementia in people with learning disabilities is haphazard. At the stage of referral for assessment, it is unclear as to the extent that requirements of funding, placements, staff or the needs of the person experiencing changes result in a referral of assessment for diagnosis of dementia. In an example given in a published case-study of a client with a learning disability, changes in the person’s daily living skills were the trigger for requesting an assessment for dementia (Hammond & Benedetti, in Janicki & Dalton, 1999). The report described how staff had initially attempted to challenge the client to maintain her living skills, thinking that the change that they observed was due to normal aging. Similarly, changes observed in a client may be perceived by staff initially as transitory changes, thus delaying the assessment of the problem. Certainly demands on scarce resources are implicated in the current rate of assessments for dementia in the older people. It is noted that compared to other age groups, older people in the general population do not receive equitable psychological services (Roth & Woods, 1996). However, diagnostic skills, referral patterns and therapists’ attitudes are all considered to be factors contributing to the slow development of assessment services.

Assessment tools for dementia in people with learning disabilities

The problem of a lack of tests that are specifically designed for assessing dementia in people with learning disabilities is highlighted in reviews of assessment issues in the literature (e.g. Oliver, in Janicki & Dalton, 1999). Testing for memory deficits is the given exception, as adapted tests are available (Oliver, 1999). An evaluation of the strategies used for assessment of dementia in persons with learning disabilities by Oliver (1999) is illustrated in table 1. These strategies include the use of assessment tools developed to assess dementia among people with a learning disability. They also rely on information from generic tools for the assessment of learning disabilities and dementia. With respect to ethical issues in general, standard practices that consider the views of the person are an important aspect of the assessment process from the outset. It should be recognized that the assessment procedure can be lengthy and intrusive. The person may have an increased awareness of the decline highlighted by the assessment for example, through cognitive testing. This should be recognized with the individual and support offered to the individual should they wish.
Table 1. A summary evaluation of the strategies that may be adopted for the assessment of dementia in persons with intellectual disabilities. Reproduced from Oliver in Janicki and Dalton (1999).

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Reliability and Validity</th>
<th>Resources</th>
<th>Ethical Issues</th>
<th>Quality of Life Issues</th>
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<tbody>
<tr>
<td>Prospective</td>
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<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
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<tr>
<td>Retrospective</td>
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<td>Substantial</td>
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<th>Reliability and Validity</th>
<th>Resources</th>
<th>Ethical Issues</th>
<th>Quality of Life Issues</th>
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<tr>
<td>Informant based</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
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<tr>
<td>Direct</td>
<td>High</td>
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<tr>
<th>Specificity of Assessment to Learning Disability and Dementia</th>
<th>Reliability and Validity</th>
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<tbody>
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</tr>
<tr>
<td>Dementia only</td>
<td>Low</td>
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<tr>
<td>Learning Disability only</td>
<td>Low</td>
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<tr>
<td>Learning Disability and Dementia</td>
<td>High</td>
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Baseline assessment of functioning using standardized procedures, including cognitive testing, is recommended in the assessment of dementia in people with Down’s syndrome. A baseline is necessary in order to determine the extent of decline (Aylward, Burt, Thorpe, Lai & Dalton, 1997). A comprehensive assessment of cognitive functioning, including memory functioning, is required in order to encompass differences between the modalities of cognitive functioning (e.g. memory and verbal reasoning). A battery of psychometric tests that are used for dementia in the general population are employed including assessments of cognitive functioning measured using IQ (intelligence quotient) for example with the Wechsler Adult Intelligence Scale - III (Wechsler, 1998) and additional tasks to assess aspects of memory. This is supplemented with tests specific to dementia in people with intellectual disabilities such as the Dyspraxia Scale for Adults with Down Syndrome (Dalton, 1996). The problems with using the standardized assessments of dementia with people with learning disabilities are that: they assume a baseline of functioning within the ‘normal’ IQ range, they require availability of staff with long term knowledge of the person and that decline is often
incorrectly attributed to the person’s learning disability (Whitehouse, Chamberlain & Tunna, 2000).

In the absence of pre-morbid measures of ability, the knowledge of multiple informants, both family and professional carers is a necessary element of dementia assessment in this population, these include assessments of adaptive behaviour. Assessments of adaptive behaviour based on informant interviews can be used in this context to indicate the manifestation of cognitive impairment in the person’s life. For example, deficits of abstract reasoning may be indicated by a difficulty with ability to organize and plan one’s activities. Another example is that deficits of motor abilities may be indicated by inability to dress and feed oneself. Informant based interviews can provide a range of information on current status of daily living skills (including physical abilities), social functioning and adaptive behaviour in the individual. Examples of these interviews are the Vineland Adaptive Behaviour Scales (Sparrow, Balla & Chicchetti, 1984) and the Hampshire Assessment for Living with Others (HALO) (Shackleton-Bailey & Pidcock, 1983). The HALO includes dimensions relating to self, community living, relationships and behaviour. With the use of these inventories apparently paradoxical combinations of behaviours may be highlighted. In turn these may be understood with an analysis of the different functions of distinct areas of the brain that have been affected by the disease in combination with information on environmental factors (Kerr, 1997). The assessment process presents many challenges; behavioural change may be difficult to determine for professionals unfamiliar with this client group. There are several causes of this difficulty. Behavioural abnormality is common among people with intellectual disability, it may be a result of the environment and express unmet need, but it may also predate the onset of dementia and therefore is not clinically significant in the diagnosis (Burt and Aylward, in Janicki & Dalton, 1999). In addition to the onset of dementia, age, severity of intellectual disability and co-morbidity are associated with a decline in adaptive behaviour (Prasher, in Janicki & Dalton, 1999).

The informant interviews specifically designed to assess dementia in people with learning disabilities include: the Dementia Questionnaire for Mentally Retarded Persons (Evenhuis, et al., 1990) and the Dementia Scale for Down Syndrome (DSDS; Gedye, 1995). The Dementia Questionnaire for Mentally Retarded Persons (Evenhuis, et al., 1990) was adapted for people with Down’s syndrome by Prasher (1997). The DSDS compared with clinical diagnosis for Alzheimer’s dementia shows sensitivity of 58% and specificity of 96%, maintained at eighteen month follow-up, with the highest correlation for mid and late stage dementia (Huxley, Prasher & Haque, 2000).
An assessment battery that includes the ICD-10 (WHO, 1992) and DSM-IV (APA, 1994) has been recommended by a working party on the diagnosis of dementia in people with learning disabilities (Burt & Aylward, 2000). There is a current debate on the degree of decline in functioning required in this population in order to be clinically significant (Burt & Aylward, 2000). The PAS-ADD an informant based psychiatric assessment tool is also used (Moss, 1994). More appropriate to this population is the Cambridge Examination for Mental Disorders of the Elderly (CAMDEX; Roth et al., 1986). The CAMDEX considers the areas of functioning that decline with dementia: memory, aphasia, apraxia, functional skills and personality (Holland, Hon, Huppert & Stevens, 2000). It provides useful information as part of the assessment, although the reliability of the informant version as a diagnostic tool for dementia is yet to be established (Holland, et al., 2000). There is preliminary evidence from assessments using CAMDEX that find reports of early changes in behaviour or personality (Holland, et al., 2000). They explain this as being a result of cognitive decline, for example in memory and orientation. The model that they propose suggests that overall functional decline is a result of neuropathological and functional changes resulting from dementia and changes due to age-related cognitive decline (Holland, et al., 2000).

The assessment of dementia in the person with learning disabilities is supplemented by informal information from sources including assessments, reports and medical records (e.g. epilepsy, hypothyroidism and sensory impairments). Routine information on the person’s life and psychiatric history is also essential. Finally, the progressive nature of the disease means that regular assessments are required and adjustments to the level of care provided and support for care staff can then be made (Hammond & Beneditti in Janicki & Dalton, 1999). Prospective and regular assessments are required for this population since the general population baseline information is not adequate or specific enough for this population with diverse characteristics, Furthermore, retrospective information is usually not specific, for example to the cognitive modality affected, or detailed in terms of level of daily living skills (Oliver, in Janicki & Dalton, 1999).

Challenges to assessment of dementia in people with learning disabilities

The assessment of difficulties in people with learning disabilities is multidimensional in that information is derived from different sources and using different methods. However this characteristic also presents problems, in particular, informant derived information needs to be carefully evaluated. Whitehouse, Chamberlain and Tunna (2000) identified learning needs
among care staff regarding the presenting symptoms of dementia and the course of the disease. They found that staff viewed changes in behaviour attributed to dementia as likely to be ‘stable and uncontrollable’. They also viewed forgetfulness as the most likely indicator of dementia in a person with learning disabilities. In contradiction to this second point, a study by Holland, et al. (2000) reported that changes in behaviour and personality were most frequently reported by staff. A study comparing direct client observation, informant reports and informant attitudes is required in order to understand the role of these different components. Also relevant to this issue is the observation by Holland (2000) that the physical and emotional difficulties experienced by carers are considerable.

Another important observation is that mental health problems are common in people with learning disabilities, they may predate the onset of dementia and therefore may not be related to the diagnosis (Burt & Aylward, in Janicki & Dalton, 1999). As noted above, depression is common among this group and should be distinguished from the symptoms of dementia. Early identification of dementia can also prove to be problematic, with only poor retrospective information to work from and for this client group in particular, early signs may be masked particularly by the signs of the learning disability itself.

In the United States, it is standard practice to refer to longitudinal information in making a diagnosis of dementia (Alyward, et al., 1997). At present diagnoses of dementia are frequently made from retrospective information because of the lack of longitudinal information available. It is suggested that routine assessments should be made before the age of 40 years in people with Down’s syndrome and before the age of 50 years in people with intellectual disabilities (Burt & Aylward, 2000). The practical problem of maintaining notes is also highlighted by these authors as a barrier to achieving this aim.

Treatment

Current status of treatment for dementia in people with learning disabilities

The slow progress in the development of psychological, social and psychopharmacological interventions for people with learning disabilities with dementia is attributed by some to a lack of outcome evaluations (Woods & Roth, 1996; Holland, 2001). As noted above, the increased incidence of dementia in this group is a relatively recent occurrence. The diverse
range of psychological and social interventions that have been used with this group in the past
have often been non-specific and without empirical evidence for their efficacy. These past
approaches have included modified versions of interventions that are commonly used with
older people (Woods & Roth, 1996).

**Medical approaches**

The medical management of dementia in people with learning disabilities is conducted in
parallel with management of care (Janicki, Heller, Seltzer & Hogg, 1996). In terms of
treatment, current pharmaceutical approaches to the treatment of dementia focus on enhancing
cognitive functioning and on disease modification. Recently disease modification has been
targeted with the use of acetylcholinesterase inhibitors, these are indicated in the evidence for
a genetic and neuropathological basis of the disease (see section on dementia). There is
increasing evidence to suggest the possibility of using these treatments for people with
Down’s syndrome and a diagnosis of dementia (Holland et al., 2000).

**Psychosocial approaches**

A comprehensive approach to treatment has been described using a ‘stage model’ of dementia
as a framework (Kerr, 1997; Unkenstein, 2000). This model emphasizes the progressive
nature of the disease and the temporal features (Oliver, in Janicki and Dalton, 1999). An
example of the approach is shown in table 2., in general terms at each stage of the disease
there are some commonly observed impairments. Appropriate intervention strategies are
selected on the basis of the identified impairment and the defined intervention aims.

A critique of the ‘stage theory’ approach to describing dementia in the general population is
made by Bell and McGregor in Kitwood and Benson (1995). Their central concern is that the
theory inhibits progressive approaches and instead creates misconceptions and negative
attitudes towards people with dementia. An example of a negative consequence is that, as a
result staff may have limited expectations of the individual’s personal resources for coping
with their disease. The individuality of any disease experience is indicated by Kerr (1997) as
being due to the individual’s ‘personality, past experience and coping strategies’. Bell and
McGregor (1995) suggest that the model of the Disability Movement, which emphasizes the
human being first and their individual problem second, is better suited to promoting best
possible adjustment to disability.
Table 2. Stage approach with examples of symptoms of dementia and treatment strategies (adapted from Kerr, 1997; Unkenstein, 2000).

<table>
<thead>
<tr>
<th>Stage</th>
<th>Specific impairment</th>
<th>Intervention aims</th>
<th>Intervention strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early</td>
<td>Cognitive: short term memory function, performance</td>
<td>Compensation of memory loss and reduce load on memory.</td>
<td>Internal (e.g. mnemonics) and external strategies (e.g. written reminders), routines.</td>
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<tr>
<td></td>
<td>Disorientation</td>
<td>Orientation.</td>
<td>External prompts (e.g. newspapers, calendar).</td>
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<tr>
<td></td>
<td>Behaviour changes</td>
<td>Maintain self awareness Maintain independence.</td>
<td>Personal memory strategies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Simplify routines</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prompting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reassurance</td>
</tr>
<tr>
<td>Middle</td>
<td>Cognitive: short term memory function, performance</td>
<td>Increased support (e.g. self care)</td>
<td>Carer collaboration in use of external memory strategies and orientation.</td>
</tr>
<tr>
<td></td>
<td>Language</td>
<td></td>
<td>Techniques for specific disorders (e.g. apraxia use of distraction)</td>
</tr>
<tr>
<td></td>
<td>Specific disorders (apraxia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Confusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disorientation</td>
<td>Target specific difficulties</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inactivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Daily living skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prominent changes in personality and social behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Late</td>
<td>Cognitive: widespread cognitive disturbance</td>
<td>Manage cognitive impairment</td>
<td>Environment adaptation (e.g. simplify environment, clear labelling of accommodation</td>
</tr>
<tr>
<td></td>
<td>Widespread cognitive disturbance</td>
<td>Personal care (including pressure sores and infection)</td>
<td>facilities)</td>
</tr>
<tr>
<td></td>
<td>Confusion (e.g. recognizing people)</td>
<td>Safety issues</td>
<td>Orientation information and cues (e.g. access to a window, timetable)</td>
</tr>
<tr>
<td></td>
<td>Communication difficulties</td>
<td>Support carers</td>
<td>Respect and sensitivity to individual</td>
</tr>
<tr>
<td></td>
<td>Eating and drinking skills</td>
<td>Work on issues relating to terminal care and death</td>
<td>24 hour care</td>
</tr>
<tr>
<td></td>
<td>Walking and balance</td>
<td></td>
<td>Support for carers</td>
</tr>
<tr>
<td></td>
<td>Decreased mobility</td>
<td></td>
<td>Support for families and other resident</td>
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<tr>
<td></td>
<td>Seizures</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Stereotyped behaviour</td>
<td></td>
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</tbody>
</table>
The cognitive approaches that are used to treat dementia include those adapted from cognitive techniques used with the general population to address age related decline including memory loss. Examples of these techniques include: memory aids, orientation prompts and communication strategies. Individualized cognitive approaches are based on assessment results, in particular neurological findings highlighting unaffected abilities, strengths and cognitive impairments that need to be managed (Unkenstein, 2000).

Other approaches to addressing the problems experienced by older people are also used with this population. Examples of these techniques include reality orientation, reminiscence and validation therapy (Woods, in Kitwood & Benson 1995; Woods & Roth, 1996; Kerr, 1997). Reality orientation is employed as a group approach or in making environmental changes, few studies report changes in functional or verbal orientation. The use of reminiscence has undergone few evaluation studies. Validation therapy emphasizes the emotional content as opposed to the factual content of communication. These approaches either have produced little evidence of efficacy or received little formal evaluation (Woods & Roth, 1996).

In relation to people with learning disabilities as well as to dementia, interventions have focused on behavioural approaches and on understanding the impact of the care environment. Environmental factors can play a large part in the difficulties of adjustment that are experienced by these individuals. These difficulties are thought to often be triggered by the person’s level of skills of daily living and independent functioning. A link between environmental factors and cognitive function is suggested (Unkenstein, 2000). Work with care-givers has received increasing interest. This has focused on coping strategies including an analysis of cognitive factors causing stress and on supporting attitudes of care staff (Woods & Roth, 1996).

Finally, there is some preliminary information to suggest the potential of preventative strategies focusing on increasing premorbid levels of cognitive functioning. For example a longitudinal study of patients with Down’s syndrome found that, once age was controlled for, previous level of cognitive functioning was significantly and directly associated with decline (Temple, Jozsvai, Konstantareas & Hewitt, 2001). Cognitive functioning was found to be associated with environmental factors of level and years of education and employment.
Adjustment to dementia in people with learning disabilities and their families

It might be hypothesized that difficulties with adjustment to dementia are an indication of the individual’s response to the meaning of decline. The carers and friends of the person can also experience difficulties, particularly as they may begin the bereavement process whilst simultaneously in the process of caring for the individual with dementia and learning disabilities (Kerr, 1997). The physical and mental decline resulting from dementia can result in the loss of a person’s dignity, independence and individuality (Morrissey, in Morrissey & Coakley, 1999). Infantalizing or ignoring the person with the dementia are commonly reactions by care staff and are demeaning to the person with dementia and also to the person taking care of them (Davidson & Neale, 2001). Psychotherapeutic approaches to dementia provide the opportunity for the individual to explore the meaning of their decline, this is described by Sinason (1992). As noted in the introduction, to the individual already adjusted to some extent to their learning disability this approach may prove especially useful. However, currently little information is available on the efficacy of psychotherapeutic approaches with this population.

The families of people with learning disabilities also have experience of adjustment to loss. In the early stages of dementia, determining when to take on responsibility for the individual and adjusting to changes in level of functioning of the individual can present stress and difficulties for carers. Further deterioration may result in the need to move the person to more appropriate living accommodation. The demands of care, finding professional support and making decisions as the problem progresses may exacerbate conflict already in existence within the family (Morrissey, in Morrissey & Coakley, 1999).

In later life, aging parents of a person with a learning disability will become concerned to ensure their adult child will be cared for when they have gone. At present, dementia and eventual death from the disease generally occurs at an earlier age in this population. A case-study reported by Davis, in Janicki & Dalton (1999) illustrates how family members may experience mixed emotions including grief at the loss of their child mixed with the relief that the child will now not be left alone when they die.
Conclusion

Currently, assessment and treatment procedures for people with learning disabilities and a diagnosis of dementia are at an early stage of development. Techniques from the disciplines of learning disabilities and dementia are incorporated in assessment and treatment approaches. However, further integration of these approaches is required, for example in terms of formal evaluation studies. Longitudinal studies of the course and incidence of dementia in this population are also in their early stages.

This paper discusses the use of integrated theoretical perspectives to provide a framework for assessment, treatment decision making and care planning. Certain theoretical perspectives also have their own limitations, for example the stage theory of dementia is criticized. However, rather than being prescriptive and neglecting the individuality of the disease process, this perspective contributes to treatment by providing an indication of the relevant approaches at different stages of disease progression. Future research may indicate the role of family therapy and psychological interventions with carers for this group. The evaluation of early intervention, on-going psychological approaches and combined pharmacological and psychological interventions will also generate information on the most efficacious approaches to addressing the manifestations of this disease.
References


Critically discuss any two psychoanalytic concepts that a clinical psychologist might use to enhance their understanding and practice in work with children.

December 2002

Year 2
Introduction

Across psychoanalytic theories the unifying theme is the focus on the dominance of unconscious processes and instincts over external pressures in guiding infant behaviour. Psychoanalytic descriptions of adult mental functioning emphasize early childhood experience as a critical and formative period (Sandler, 1987). In the past two decades the understanding of child psychoanalysis has developed in terms of aetiology, theory and empirical research base, these are areas previously criticized as neglected in this field (Cohen, 1997). The two psychoanalytic concepts that will be discussed in this essay are ‘object relations’ and ‘container-contained’. Examples of these concepts as used in practice will be presented in order to make the argument that psychoanalytic ideas can complement other theoretical positions on child development, for example, those that focus on neurobiology, behaviour or cognitions.

Psychoanalytic perspectives on child development

Sigmund Freud’s ideas have been highly influential in the field of psychoanalysis. These ideas are characterized by a focus on the expression of instinctual drives and impulses in three early phases of infant development: the oral stage, the anal stage and the Oedipal stage (Hinshelwood, 1991; Gormez, 1997). Freud suggested that unconscious drives have a biological basis (e.g. sex) and are shaped by the child’s encounters with the environment and in particular with their primary caregivers. At each stage different issues and challenges were thought to be salient for the child. The goal of these early stages of child development was to establish reliance on self, negotiate control over their environment and relate successfully and happily with others. For example, Freud described the oral dynamics stage and suggested that at this stage the infant experiences schizoid anxieties at loss of integrity of the ‘self’ and employs defenses, including denial. Denial was thought to function as a defense by changing the infant’s perception of what was happening and therefore bypassing anxiety (Gormez, 1997).

Freud’s original work provided the concepts from which current psychoanalytic ideas have evolved (Hobson, 1997). More recently these ideas were conceived of as stages of ‘interpersonal relatedness’ and their equivalent mental representations in the infant (Hobson, 1997). These stages are relevant to understanding child development in that they are
considered to be the primitive constituents of psychosocial learning, in terms of other person’s minds or ‘theory of mind’ (Hobson, 1997). The integration of these constituents or ‘objects’ is also considered to be a key goal in the development of the young adult’s personality.

One psychoanalytic concept that has received interest is Klein’s conceptualization of complex defense processes, in particular ‘projective identification’ (Sandler, 1987). As part of ‘projective identification’, unwanted or feared parts of the emerging ‘self’ are forced into the representation of the other or ‘object’ and their emotional origins in the ‘self’ are denied. In general the concepts of projection, identification and projective identification have thus been viewed as shifts in mental representations or fantasy and as a mechanism for regulating unconscious states (Sandler, 1987).

In the therapeutic situation the psychoanalytic approach recognizes the therapeutic relationship as a primary means of change (Gormez, 1997). In the context of child psychology the mother-child relationship is also considered to be an important focus (Hobson, 1997). Attachment theory (Bowlby, 1969) is an empirically based and influential theory that focuses on the infant-mother relationship. It examined the infant’s anxieties specifically in relation to the loss of a primary care giver. Bowlby postulated that the social instinct to relate was aimed at survival and was based on biologically determined behaviours (Steele & Steele, 1998). The ‘secure attachment’ was considered to be the adaptive form of attachment relationship. In relation to the infant’s development, this interpersonal experience was thought to be represented in the infant’s internal working model (Steele & Steele, 1998). In general, psychoanalytic theories have increasingly included reference to the role of biological and constitutional factors in combination with psychoanalytic factors in explaining how the child reaches his/her developmental milestones (Cohen, 1997).

‘Object relations’ applied to work with children

Definition
‘Object relations’ theories have been defined as part of psychoanalytic theory, these theories have a narrower definition of the representational ‘object’ as a human figure (Steele & Steele, 1998). Concepts of ‘self’ and ‘object’ and their interrelatedness are regarded as the basic conceptual units in these theories.
A major contribution to this field is in the work of Melanie Klein. Klein characterized the first year of human life as a fearful experience and she suggested that ‘there are object relations from birth’ (Hinshelwood, 1991). Klein (1935) referred to the idea of ‘good’ and ‘bad’ objects, which are ‘split off’ as internal objects. For example, the mother may act as the prototype for separate objects, the ‘good’ object might be the breast that feeds the baby and the ‘bad’ object, the breast that ‘bites’ when the baby’s tooth is coming through. Klein thought that these ‘good’ and ‘bad’ objects later become integrated into a whole person/mother object. Klein called this early stage of infant development, the ‘paranoid-schizoid’ position and the infant’s goal of the integrating the ‘good’ and ‘bad’ parts of the object, the ‘depressive’ position (Steele & Steele, 1998). These observations on patterns of ‘object relations’ were thought to influence subsequent relating and formative experiences.

Klein’s original work focused on play and the symbolization process in children. Klein used a play technique and made her observations from the child’s manipulation of toys and spatial relations of ‘objects’ in the play setting. The patients that this work was based on were children with psychosis, Klein made observations on their inhibited formation and use of symbols in play (Hinshelwood, 1991). Klein’s therapeutic approach viewed play as representing externalizations of the active relationships between objects in the child’s ‘internal world’ to be modified by interpretations made by the analyst (Hinshelwood, 1991). In this way play was considered by Klein to be equivalent to ‘free association’, a psychoanalytic technique used with adults. This key assumption of child psychoanalysis is still the subject of debate. Yanoff (1996) suggested that transference and defenses are neglected in child therapeutic psychoanalysis and in addition, that play can be regarded as a form of communication and as a therapeutic factor to be enhanced in interpretations by the analyst.

The theoretical construct of ‘object relations’ and its constituent parts have been applied to a variety of contexts relevant to child clinical psychology, both in relation to understanding children with psychological difficulties and to aid understanding of models of normal development in children. Examples of these applications are discussed below, they include observations on attachment and normal development (Hobson, 1997; Steele & Steele, 1998; Fonagy, 1999) and on specific psychopathology, for example autism (Reid, 1999). In terms of practice, the concept of ‘object relations’ has been used to aid assessment of problems in children and selection of appropriate therapeutic approaches (Reid, 1999; Mori, 2001). ‘Object relations’ has also been applied to phenomena observed in other therapeutic approaches, for example, systemic family therapy (Brodie & Wright, 2002) and family therapy (Bower, 1995). There is also an increased appreciation among psychoanalytic
theorists of the influence of the family and the child’s external world on their development (Cohen, 1997).

**Normal development and attachment**

Hobson (1997) reviewed the state of psychoanalytic contributions to the understanding of normal early infant development. He argued for the central importance of interpersonal relations experiences over the necessity for the early infant to develop symbolic play and an awareness of the attitudes of other persons. He suggested that this is necessary for the child to develop an understanding of other person’s mental states or a ‘theory of mind’. Based on these observations he states that development of the normal child results in communication and social skills, ability to interpret others and to reflect his/her own wishes. Hobson (1997) noted that observational studies suggest that these capacities are impaired in children with autism.

Steele and Steele (1998) suggested that psychoanalytic approaches may be applied to Bowlby’s attachment theory to provide information on the internal and interpersonal perspective of the infant. It has been suggested that ‘object relations’ and in particular the concept of ‘projective identification’ may be useful in understanding ‘disorganized attachment’ style (Steele & Steele, 1998). Fonagy (1999) also suggested that attachment theory would benefit from the application of psychoanalytic ideas. He suggested that this could enhance explanations of systematic distortions of the external world, the development of object integrity and attachment formulations of psychopathology. In general psychoanalytic ideas have influenced attachment theorists by increasing awareness of the potential for working with mothers and infants therapeutically (Cohen, 1997), for example, as an argument for the importance of early intervention in cases where the child is deprived of a primary care giver.

**Autism**

Reid (1999) in describing psychoanalytic clinical assessment observed that the autistic individual is ‘not person or object related’ and that the common effect that they have on their teachers and parents is of eliciting ‘autistic, rigid, obsessional mechanisms’ in them. However, evidence is not available to support a direct relationship between parenting style or parenting quality and autism (Carr, 1999). Reid (1999) noted the impact that living with a child with autism has on the family, as well as individuals. Reid (1999) described the
example of an assessment of a four year old girl with autism. She engaged the parents of the
girl in thinking about the meaning of their child’s responses differently, for example by
examining their daughter’s behaviour closely. Reid (1999) described the worried reactions of
the parents to their child’s new choice of play with a mirror. She reinterpreted this to the
parents by comparing it with normal play in infants who are at the developmental stage where
they learn about the permanence of objects.

This type of psychoanalytic approach to working with children with autism is yet to be
supported by empirical evidence from systematic studies. Very poor outcomes were reported
in a chart review study of psychoanalytic psychotherapy for severe pervasive developmental
disorders (Target & Fonagy, 1996). However, published clinical case reports of individual
cases indicate that some very specific improvements can be made relative to the original
difficulties of the client (Sinason, 1992).

Mori (2001) described a long-term therapeutic intervention with a four year old boy diagnosed
with Autistic Disorder (DSM-IV, 1994), supported by the family and a therapeutic team. It
provided observations on the patient and therapist’s interpersonal relating in therapy, these
were interpreted in terms of ‘self-object’ experiences. The therapist reported interpreting the
boy’s actions in the initial stages of therapy as reflecting his ‘fragmented sense of self’ and his
isolation, for example, the child would sit with his back to the therapist. The therapist
reflected affect back to the child and made interpretations to him. The therapist aimed to help
the boy communicate through ‘projective identification’, to ‘introject’ his experiences and to
unify his experience of ‘self’. For example, the boy played the ‘aggressor-mother’ (e.g. bad
object) enacting everyday events, dragging the therapist along by the arm and abruptly
changing the emotional content of his comments, the therapist reported that he experienced
feeling abandoned. Mori (2001) noted that slow but decisive changes occurred in the boy’s
‘self-object’ relations over five years, to the point where the boy would involve the therapist
in verbal communication and play. Controlled studies of the effectiveness of psychodynamic
play therapy for children with autism are also unavailable, however interest in this area
continues (Carr, 1999).

**Systemic family therapy**

Brodie and Wright (2002) argue from a systemic family therapy perspective that ‘object
relations’ adds a useful dimension to their work. They argue that psychoanalytic concepts
may be used to explain how the dominant modes of learning and thinking within a family
originates. For example, they describe internal psychic identificatory processes that have potential to facilitate or block a child’s development, these include introjections, projection and adhesion (Brodie and Wright, 2002). As part of this approach to systemic family therapy they examine the family’s internal world or internal object relations and they suggest how this relates to external relationships. They give the example of a fourteen year old girl who suffered from overeating who was a member of a family experiencing traumatic loss of a baby/sibling. The interpretations of their two analysts included observations on a split within the transference and anxiety projected by the family into the daughter resulting in her overeating, this also acted as a defense in avoiding adolescence.

Bower (1995) also describes family therapy that uses psychoanalytic interpretations as a tool. She focuses on the mother’s internal world and the emotional meaning that the child has for the mother as being of importance. She argues that these ideas can aid assessment of child safety in the family environment.

‘Container – contained’ applied to work with children

Definition
A specific application of psychoanalytic ideas is in of the concept of ‘container-contained’ (Bion, 1970). Working from the basis of Klein’s original ideas on ‘projective identification’, Bion developed his ideas about ‘containing’ and ‘thinking’ (Bion, 1962; 1970). Bion’s aim was to enhance understanding of this specific interpsychic mechanism proposed by Klein that was considered to aid an infant’s mental development (Sandler, 1987). The original focus was the interpsychic communication occurring in the mother-infant dyad, via observations of non-verbal emotional interaction between mother and infant. The concept of ‘container-contained’ was used to refer to the mother’s capacity for reverie, to experience emotions, become disturbed herself by these and then to work with the meaning of this experience, for example, by modifying the content and handing it back in a tolerable form to the infant.

Bion’s (1970) ideas on ‘container-contained’ were also translated into an understanding of group processes. He made the analogy that the establishment of a social group ‘contains’ an individual and that as a process it suppresses individuals, disintegrates or achieves mutual adaptation. Bion (1970) also suggested that his ideas could encompass language and thinking
as ‘containers’ of emotional states and therefore, he suggested, these might be integral to development.

In describing ‘projective identification’ Bion (1959, cited in Hinshelwood, 1991) differentiated between normal and abnormal forms of this phenomenon. This distinction was considered to be a major contribution to Melanie Klein’s ideas (Hinshelwood, 1991). The concept of ‘container-contained’ is based on one type of projective identification. In this type of projective identification part of the self is projected into the external ‘object’ (Sandler, 1987). The patient’s enactment in the therapeutic setting or ‘transference’ is treated as a communication regarding the child’s needs for containment (e.g. of his perceived fears and dependence). In this context the therapists response to ‘counter-transference’ or feelings as an indication of the patient’s state of mind (Hinshelwood, 1991) provides the experience for the child of maternal ‘containment’ of being understood. This is also thought to act as a representation of mental stability (Sandler, 1987).

Bion (1970) elaborated on the different types of the ‘container-contained’ relationship. These types were symbiotic, parasitic and commensal. The commensal relationship represented mutual adaptation, where two objects share a third to the advantage of all three. Sandler (1987) suggested that development of neurosis and extreme forms of psychological difficulties may result from extreme and prolonged situations of a mismatch of empathic understanding of the mother with the child’s feeling state. This may induce affective responses in the child that act as communications regarding his/her feeling state, as the normal function of maintaining a cohesive structure.

A criticism of Bion’s concept of ‘container-contained’ was made by Meissner (1980) cited in Hinshelwood (1991). He argued that clinical observations of clients with extreme psychological difficulties formed the basis for the concept, but that in contrast Bion applied it freely as a metaphor. A further criticism of this concept is that it refers to relational or cognitive phenomenon where ‘self’ and ‘object’ are appreciated as real, that Meissner argued more closely represent ‘projection’.

Psychological trauma and fostered children
The concept of ‘containment’ has been applied to investigate the experience of psychological trauma in fostered children (Lush, Boston, Morgan & Kolvin, 1998). This empirically designed, single case study referred to an adopted boy of 11 years old, who had experienced a
disrupted childhood with early deprivation and psychological trauma or abuse. Lush, et al. (1998) reported that psychoanalytic therapy revealed an ‘inner world of turmoil’ that impacted on his relationships in general, his adaptation to family life and abilities at school. The objectives of the intervention were to offer the experience of ‘containing attention’, to focus on the child’s inner world and on his ‘internal images’ of parents. The aims were to develop self-esteem and facilitate permanent placements, avoid breakdown of placements and aid adjustment at school. At end of therapy and at four year follow-up, Lush, et al. (1998) reported that good adjustment was found. They argued that this improvement was due to therapy on the basis that the study was an empirically designed single case study.

Attention deficit/hyperactivity disorder
Gilmore (2002) described the application of psychoanalytic concepts to understanding developmental disorders as part of a comprehensive approach. Attention Deficit/Hyperactivity Disorder (AD/HD) is characterised by impulsivity, hyperactivity and inattentiveness (DSM-IV, 1994). AD/HD relates to deficits in attention and executive function or complex high-level cognitive processes (Gilmore, 2002). This approach is based on the relationship between developing mind, ego capacity and mental structure or ‘diagnosis, dynamics and development’. Gilmore (2002) described a four year old adopted girl with AD/HD. The psychoanalytic perspective on the girl’s problems provided observations on difficulties with attachment and the mother’s ability to supplement her child’s emotional self-regulatory capacities. It also suggested difficulties with internalising objects for example, she did not relate warmly to others and lacked a fantasy life, as demonstrated in her play. Gilmore (2002) used these concepts to explain the origin of specific problems in cognitive and emotional development in a child how have significant strengths in other areas, such as good language skills.

Parenting
The concept of ‘container and contained’ was combined with the concept of ‘reciprocity’ (Bion 1970) in the ‘Solihul Approach’ (Douglas, 2001), a health visitor led intervention for parenting. Bion (1970) used the concept of ‘reciprocity’ to convey ideas including changes in the roles between mother and infant and the effect of the change itself. Bion observed the negative effects that the ‘container-contained’ relationship could incur in the therapeutic situation without recognition of ‘reciprocity’ in roles. The second stage of the ‘Solihul
Approach’ involves behavioural techniques adapted to the needs of the child, taught to the parent and then applied.

The similar concept of ‘containment’ was described in the context of a single case study of an approach to parenting (Puckering, Evans, Maddox, Mills & Cox, 1996). This study described the provision of a group called ‘mellow parenting’ giving both support and parenting skills. The participants were mothers who had experienced marital violence and the breakdown of their marriage. The case study reports that the group enabled a participant to achieve her own emotional containment and to contain the psychological distress of her infant son (Puckering, et al., 1996). One possible criticism of this study is that whilst the intervention is described, the operationalization of the concept of ‘containment’ is not described with sufficient detail to enable precise replication of the intervention.

Social institutions
Menzies Lyth (1995) examined the concepts of ‘container-contained’ and of therapeutic ‘introjective identification’ in relation to children who are cared for in social institutions. She presented a formulation on ‘ego strength’ and development of ‘self’ in these children. This work is based on extensive observations including studies of the cot unit in the National Orthopaedic Hospital, residential childcare, nurseries and schools. Menzies Lyth (1995) made observations on the ‘boundaries’ of the cot unit functioning successfully to ‘contain’ anxiety rather than allowing inappropriate and anti-maturational defences to develop. In relation to children experiencing psychological disturbance in institutional care, Menzies Lyth (1995) gave the example of the ineffective control of the deprived child’s projections of the idealised parent that they have been denied. She viewed this in terms of a transaction projection that may result in compelling the carer to act in response, rather than view the projection as a communication. She applied these ideas to inter-group processes between staff and children within institutions. For example, she cited inappropriate identifications made by adolescents in institutions in the search for identity. As another example she described social defence systems among care staff that act against confronting disturbance and distress in a potentially painful yet therapeutic way in work with cared for children.
Critique of psychoanalytic concepts applied to work with children

In addition to the criticisms mentioned above there are several reasons for the need for a cautious approach in applying psychoanalytic knowledge. These cautions apply to the context that is the current understanding and practice of clinical psychology work with children.

The theoretical basis of psychoanalytic knowledge is founded on detailed observations of clinical practice, however these observations arise from contrasting sources. Whilst psychoanalytic concepts were derived in part from observations on newborn babies and infants, they are also informed by theory based on clinical observations of severely disturbed adult patients. Fonagy (1999) goes as far as to suggest that psychodynamic theory and practice are independent.

Related to this issue is the problem of observing psychoanalytic phenomenon. Steele and Steele (1998) recounted the objection to Klein’s emphasis on inner fantasy over biological, psychological reasons and actual experience in guiding child behaviour. It might also be argued that psychoanalytic theories have not been updated to reflect progress in other areas of research. Gilmore (2002) argued that the tradition within psychoanalysis of discounting symptomatic behaviour and its focus on explaining internal conflict has compromised its potential to date. Gilmore (2002) gave the example of the potential contribution of psychoanalytic theory to the assessment and treatment of children with disorders with a biological explanation that affect learning (e.g. AD/HD).

In general, psychoanalytic interventions are commonly based on theory but lack any empirical evidence for their basic propositions (Bateman & Holmes, 1995). One practical example of this issue is the controversy over the capacity of the therapist to observe ‘counter-transference’ and themselves as ‘object’, as a specific phenomenon in the therapeutic encounter. For example, Urwin (1989), in reporting on two cases of psychoanalytic work with children, made the point that the analyst relies heavily on information from the ‘counter-transference’. The balance to this criticism is that psychoanalysis is based on language, meaning and interpretation rather than mechanism (Rycroft, 1985, cited in Bateman & Holmes, 1995). One logical extension of this idea is towards the practice of narrative work that focuses on the internal consistency of psychoanalytic constructions (Bateman & Holmes 1995; Larner, 2000). Another aspect of this issue relates to the precise definition of
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psychoanalytic terms and the difficulty of ensuing rigour in their application. The major psychoanalytic concepts have changed over time in terms of their definition, this progress has been studied as a subject in itself as recorded by Hinshelwood (1991).

The main exception to the lack of systematic research on this area is the empirical work on attachment theory. More recently advancements have been made with techniques for systematically investigating specific internal representations derived from attachment theory (George & Solomon, 1996; cited in Howe, Brandon, Hinings & Schofield, 1999; Warren, Emde & Sroufe, 2000). For example, play has been formalised as a part of the assessment process. The story-stem play narrative method focuses on predictors of anxiety in 5-6 year old children (Warren, Emde & Sroufe, 2000). This method has been developed to investigate predictors of psychopathology in children. Attachment has also been assessed in 6 year olds with a doll-play story using the beginning of an attachment sensitive story (George & Solomon, 1996). These assessments are based on the psychoanalytic ideas of projection and internal representations. The concept of internal representation as part of attachment theory is examined by George and Solomon (1996) through the medium of story play. They aim to assess an internalised set of expectations for self and others based on the young child’s experience with caregivers.

There is little information on the systematic evaluation of the effectiveness of psychoanalytic interventions with children (Target & Fonagy, 1996). Only the preliminary results are available of a case-controlled study (Target, 2002). The methodological problems of studying these types of intervention include difficulties with outcome evaluation, the specification of treatment techniques and ensuring the integrity of the intervention (Target, 2002).

Conclusion

Psychoanalytic theories provide convincing examples of processes that are thought to be important in both mental functioning and development in infants and children. The focus of this theoretical frame is the role of the infant’s unconscious experience of interpersonal relations and its interactions with other variables (e.g. biological and life-events) and the resulting experiences across the life span.

In general, these concepts provide information on what contributes to normal social and emotional development in children. This information might be used by the clinical
psychologist to help them determine what is abnormal in terms of 'symptoms', behaviour or interpersonal relating for the child at a specific developmental stage. In general, psychoanalytic theorists agree on the importance of early interactions with a caregiver as the basis for development. This might also be used to predict what difficulties might occur given specific life experiences e.g. the experience of trauma or separation from primary carers during the infant's early development.

The aim of psychoanalytic therapy of integrating unconscious complex and conflicting processes shows potential for work with children, but requires careful implementation and systematic evaluation. There is also the need for empirical evidence to support psychoanalytic theories and phenomena given the criticisms and controversy surrounding this subject. In particular, the challenges are in accurately observing and measuring psychoanalytic phenomena and in monitoring their usage, given their varied applications.
References


What factors in older people (a) cause “depression” and (b) are addressed in treating depression psychologically.

August 2003

Year 2
Introduction

Until recently mental health problems in older people, aside from dementia, were neglected by health service policy makers in the USA (Lebowitz, et al., 1997) and in the UK (Davies & Collerton, 1997). They remain a public health concern, for example, symptoms of depression in older people are found to be associated with increased use of general health care services (Bula, Wietlisbach, Burnand & Yersin, 2001; Lebowitz, et al., 1997).

In this essay the term ‘adult’ is used to refer to people aged 16-65 years. ‘Older people’ refers to people over 65 years and ‘elderly people’ specifically refers to people over 75 years.

This essay describes the factors causing depression in older people and those that are addressed in psychological treatment. It outlines the theoretical basis of one of the currently recommended psychological treatments for depression in older adults: cognitive behavioural therapy (CBT) (Department of Health, 2001). The essay explores recent developments in psychological treatments for depression in older people. In addition, research on screening for depression in older people and pathways to care are considered. These developments have the aim of ultimately improving functioning and quality of life in older people through the use of appropriate interventions.

Clinical features and diagnosis

There is preliminary evidence that the symptom profile of depression in older people is different to that in younger adults. This is only partly explained by the symptoms of normal aging (Baldwin, 1998; Gottfries, 1998). The presenting symptoms for depression in older people include: somatic symptoms, anxiety, low mood, retardation and cognitive impairment. These are given in table 1. The symptomatology of depression in adults is characterized by: depressed mood, anxiety, reduced activity and somatic symptoms (Gottfries, 1998). The general classification for depressive disorders DSM-IV (American Psychiatric Association (APA), 1994) encompasses major depressive disorder and dysthymic disorder. The criteria for major depressive episode (DSM-IV) are given in appendix one. The diagnosis of depression in older people using DSM-IV criteria is problematic since this classification was developed from clinical research with an adult population (Gottfries, 1998).

Somatic symptoms are the most frequently reported symptoms in depressive disorder in older people (Gurland, 1976; Gottfries, 1998). The most common somatic symptoms associated
with this condition in older people are: asthenia, headache, palpitations and pain (Gottfries, 1998). Hypochondrical complaints were found in 60% of a sample of elderly in-patients on admission for treatment for depression (Kramer-Ginsberg, Greenwald, Aisen & Brod-Miller, 1989). These symptoms reduced with treatment. This suggests that somatic symptoms indicate both state and trait phenomena in depressed patients (Kramer-Ginsberg, Greenwald, Aisen & Brod-Miller, 1989). Low mood and irritability are reported less by older people with depression compared to younger people (Gottfries, 1998).

The diagnosis of depressive disorder in older people using the DSM-IV criteria is also made complicated because of the presence of cognitive deficits in depression. These effects, known as pseudodementia\(^1\) are similar to the effects of normal aging. For example, a characteristic symptom of depression is memory failure. This is also a symptom of normal memory aging. The differential diagnosis of 'pseudodementia' from early symptoms of dementia is a procedure frequently drawn upon in this context.

Table 1. The presenting characteristics of depression in older people (adapted from Gottfries, 1998).

<table>
<thead>
<tr>
<th>Symptom category</th>
<th>Presenting symptoms in older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed mood</td>
<td>Low mood (reported infrequently in older people).</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Worries; physiological response such as autonomic system arousal; hyperventilation; irritability (reported infrequently in older people).</td>
</tr>
<tr>
<td>Retardation</td>
<td>Retardation of activity; slow, restricted and repetitive thoughts.</td>
</tr>
<tr>
<td>Somatic symptoms</td>
<td>Asthenia; headache; palpitations; pain; dizziness; abdominal pain; sleep disturbance; loss of appetite; weight loss.</td>
</tr>
<tr>
<td>Cognitive impairment (pseudodementia)</td>
<td>Memory deficits.</td>
</tr>
<tr>
<td>Psychotic symptoms</td>
<td>Paranoia; hallucinations; psychotic symptoms (occur in severe depression only in older people).</td>
</tr>
</tbody>
</table>

The diagnosis of depressive disorder in older people is made complicated by significant levels of psychiatric and medical co-morbidity. Depression in older people can occur co-morbidly with dementia (Baldwin & O’Brien, 2002), cognitive decline (Paterniti, Verdier-Taillefer, Dufouil & Alperovitch, 2002) and medical illness (Koenig, et al., 1992). Among medical in-

\(^1\) Pseudo-dementia is defined as severe cognitive impairment in people with depressive symptoms (Paterniti, Verdier-Taillefer, Dufouil and Alperovitch, 2002).
patients, major depressive disorder was diagnosed in 5% of a population of 1,046 older adult men (Koenig, et al., 1992). Only 25% of these patients had been diagnosed with depression prior to their admission. Diagnosis is also complicated by the fact that some illnesses in old age present initially as depression (Gottfries, 1998). The service developments that address some of these issues are discussed in the section on ‘pathways to care’.

Prevalence

The prevalence of ‘clinically significant depression syndromes’ in older people in the US is between 1% and 3% in community settings and 12-30% in institutional settings (Unutzer, Katon, Sullivan & Miranda, 1999). Again, discrepancies in the prevalence rates for depression in older people may be because they are derived from use of assessment tools including the DSM-IV developed in clinical work with younger adults (Kantona, 1990). Of at least equal concern to major depression is the high prevalence of minor depression or sub-syndromal depressive symptoms in older people (Blazer, 1991). Gender differences have also been found in respect to depressive symptoms in older people. Ried and Planas (2002) report that, among people aged 65-70 years, 12.8% of men and 23.1% of women reported ‘high depressive’ symptoms. Whereas, in elderly people, depressive symptoms were reported similarly by approximately 25% of men and women (Ried & Planas, 2002).

Causative factors

Among adults, the onset and course of depressive disorder is determined by a combination of biological, historical, environmental and psychosocial variables (Fennell, 1989). The aetiology of the condition in older people is also the result of a range of heterogeneous factors (Arean, Uncapher & Satre, 1998).

Psychosocial risk factors may have a direct impact by precipitating depression in older adults. An example of a precipitating factor is of an unexpected bereavement life event, in particular, in the absence of a confiding relationship (Grace & O’Brien, 2003). Generational or cohort factors may also have a role in precipitating depression in older people. For example, severely traumatizing events in the current affairs media may trigger re-traumatization in those who had suffered traumatic symptoms from being involved in the Second World War. Psychosocial factors also have an indirect impact, as factors that predispose older people to depression. An example is that an older person may be predisposed to develop depression as
a result of physical disability and reduced mobility as part of aging. Bruce (2002) reported on a review of longitudinal cohort studies of psychosocial risk factors for depressive disorders in older people. The report found that bereavement, medical illness and injury, disability, functional decline and lack of social contact were associated with incident or new onset of depressive episodes. Many of these problems are specific to old age (Kantona, 1990). A cross-sectional survey of 2,137 elderly people from an urban population recorded a hierarchy of characteristics that are associated with depressive symptoms (Kennedy, et al., 1989). The hierarchy was as follows: illness, disability, isolation, bereavement and poverty (Kennedy, et al., 1989). In general, these psychosocial risk factors for depression are found more frequently in older people than in other adults. The extent to which they increase vulnerability to depression in older people remains to be investigated fully (Bruce, 2002).

Bereavement and losses in the person’s social support network are also factors predisposing older people to develop depression. Loss is reported to be a common theme in psychotherapy with older people (Glantz, 1989). Older people also experience life role changes and they experience stress in response to changes in their relationships with their children and family (Glantz, 1989). Older married spouses are at a lower risk and older people who are carers of people with dementia are at a higher risk of depressive disorder (Gottfries, 1998).

Cognitive decline in terms of limited problem-solving skills is found in older people as part of normal aging (Baldwin, 1998). Less active and more passive coping strategies are also found in older people. Older people experience practical problems. If they suffer from cognitive impairment the effects of these problems are compounded and as a result they may experience stress. Examples of these problems are financial concerns and difficulties with housing (Glantz, 1989). Older people experience problems resulting from social and cultural attitudes to older adults and they are vulnerable to discrimination and abuse (Department of Health, 2001). They may have problems in dealing with technology, bureaucracy and institutions (Glantz, 1989). These difficulties are also intensified in older people by frequent low levels of self-esteem and self-efficacy (Glantz, 1989).

In the early stages of vascular dementia, the dysfunction of brain systems is thought to be a risk factor for depression (Baldwin & O'Brien, 2002). This has been named the ‘vascular depression’ hypothesis. One explanation for this is that impairment of executive function results in a reduction in cognitive capacity. This causes difficulties in completing previously routine tasks (Baldwin & O'Brien, 2002).
Depression in older people in general health settings can be coincidental with illness and contribute to admission via deliberate self-neglect or refusal of food (Pitt, 1991). This may be a result of stress, caused by psychosocial changes resulting from ill-health. Examples of these changes include: increased financial demands, changes in relationships, disability and pain (Arean, Uncapher & Satre, 1998). Depression can also be intrinsic to a medical illness as a result of physical or chemical changes (Pitt, 1991). Tissue damage that results in chemical and physiological changes such as stroke or concussion can cause depression (Pitt, 1991). A common cause of concussion in older people is as a result of a fall. Depressive disorder can be a consequence of medical illness, as in an adjustment disorder (Pitt, 1991). Coronary artery disease and chronic obstructive pulmonary disorder are associated with depressive symptomatology. This effect is associated with disability. Depression in medical illness can also be 'iatrogenic', that is, caused by pharmacological treatment (Pitt, 1991). Physiological change resulting from substances (e.g. alcohol) as well as medications are reported to be related to depression in ill health (Arean, Uncapher & Satre, 1998).

A community study of self-reported co-morbid symptoms of depression and a range of chronic illnesses in 359 older people was reported by Mills (2001). He found that depression was significantly associated with digestive disorders, respiratory ailments and heart problems. The study proposed that this is explained, in part, by disease characteristics such as disability and illness controllability. Additional factors included psychosocial effects from reduced activity and reduced social contact. Mills (2001) found a lack of association between self-reported cancer or arthritis and depression symptoms. However, this is an uncommon finding. A review of the literature reported that depression was found in these patient groups (Arean, Uncapher & Satre, 1998). Mills (2001) gave the explanation that people with these conditions held expectations that chronic illness and discomfort were part of normal aging. Mill's (2001) controlled study found that personality in terms of neuroticism was associated with depression across age groups in older people. A measurement issue remains as to whether assessment of personality traits is confounded by state mood. This requires further investigation with longitudinal studies.

Factors protecting against and mediating the causes of depression in older people include: individual factors, such as cognitive ability at planning and problem-solving and environmental factors, such as availability of social support (Arean, Uncapher & Satre, 1998; Bruce, 2002). Social support among adults (Brown & Harris, 1978) and in older people, having a close confidante (Grace & O'Brien, 2003) are known factors protecting against onset of depression.
Early onset depression in older people is also reported to be associated with different factors to depression in older people with onset at a later age (Lebowitz, et al., 1997). Life events such as bereavement and psychosocial factors such as lack of a significant confiding individual are specifically related to earlier onset of depression in older people (Grace & O’Brien, 2003). Organic features such as vascular abnormalities are related to later onset depression in older people (Baldwin & O’Brien, 2002). Also in support of this age related hypothesis, is finding that personality changes in terms of increased extraversion and neuroticism are also more common in depressed older people compared to controls. It is possible that this indicates neurobiological factors (Grace & O’Brien, 2003).

The problem of identifying definitive cause-effect relationships between associated variables is an on-going challenge in psychopathology research (Davison & Neale, 2001). For example, correlational studies do not indicate cause or directionality in a relationship between two variables or whether a third factor produces the correlation (Davison & Neale, 2001). Longitudinal and prospective studies are therefore needed in addition to simple study designs.

**Prognosis**

Whilst the rate of recovery from episodes of depressive disorder in older people is good, the longer-term prognosis is poorer than in younger adults (Baldwin, 1998). No significant differences in mortality outcome were found for older people with major depressive disorder compared to adults with the condition at one year and 3.8 year follow-up (Brodaty, et al., 1993). Mortality at three year follow-up is predicted by duration and severity of depression in older people with chronic depression or chronic intermittent depression (Geerlings, Beekman, Deeg, Twisk & Van Tilburg, 2002). A prospective seven year study of 2,558 older people in the USA found that the mortality rates for depression were comparable to mortality rates in patients with chronic medical disorders such as emphysema or heart disease (Unutzer, Patrick, Marmon, Simon & Katon, 2002). A prospective 11-year study of 2,584 older people in the UK reported on depression in people with hypertension, as an example of a high-risk group (Abas, Hotopf & Prince, 2002). The study found a modest association between mortality and depression after controlling for gender. This association was not explained for by ‘conventional cardiovascular risk factors’ or cognitive decline (Abas, Hotopf & Prince, 2002). Depression is also associated with higher risk of cognitive decline at four year follow-up (Paterniti, Verdier-Taillefer, Dufoil & Alperovitch, 2002).
Depressive symptoms in elderly medical inpatients were found to be associated with increased risk of hospital readmission, nursing home placement and death in a study by Bula, Wietlisbach, Burnand and Yersin (2001). These effects were found to be independent of functional status and health status. This suggests a particular need for attention to the management of depressive symptoms in elderly populations in order to improve prognosis (Bula, Wietlisbach, Burnand & Yersin, 2001).

This also applies in community studies where poor prognosis in older people with clinical levels of depression has been found to be associated with physical illness, bereavement and family history of depression (Denihan, et al., 2000). Depression was also found to be an independent risk factor for suicide in older people (Conwell, Duberstein & Caine, 2002). It mediated the impact of risk factors including physical illness and functional impairment in predicting suicide outcome (Conwell, Duberstein & Caine, 2002).

Cognitive theory of depression

The cognitive model of depression considers the condition to be the result of an interaction of symptoms in the domains of behaviour, cognition, emotion and physiology (Beck, 1976; 1987; Beck, Rush, Shaw & Emery, 1979) (see figure 1). This model suggests that people's perceptions, their behaviour and their evaluation of themselves are based on a series of assumptions or 'schema' resulting from early experience. Dysfunctional assumptions are those, personally held, assumptions that are rigid and counterproductive. For example, a person might assume what 'must be' in order for them to be happy or to feel worthwhile (Fennell, 1989). In a person with these predisposing assumptions, a critical incident that relates to the individual's 'schema' may trigger their dysfunctional assumptions about themselves (Fennell, 1989). This also causes increases in the person's negative automatic thoughts about themselves, others and the future. These thoughts result in depressive symptoms in the form of: behavioural symptoms, such as lowered activity; motivational symptoms, such as loss of interest; emotional symptoms, such as anxiety or guilt; cognitive symptoms, such as problems with concentration and physiological symptoms, such as of loss of sleep. A vicious cycle is formed whereby the presence of depressive symptoms increases the intensity of negative automatic thoughts. This reinforces the person's belief in them. An example case study of treatment, that is based on this model, is given in the section on psychological treatment.
Figure 1. Cognitive model of depression (Fennell 1989).

Early experience

\[ \downarrow \]

Formation of dysfunctional assumptions

\[ \downarrow \]

Critical incident(s)

\[ \downarrow \]

Assumptions activated

\[ \downarrow \]

Negative automatic thoughts

Symptoms of depression

\[ \uparrow \]

Behavoiural
Motivational
Affective
Cognitive
Somatic
Psychological therapies for depression in older people

Psychotherapeutic treatments for depression in older people aim to extend the independent survival of older people by addressing their problems that are modifiable (Kennedy, 1989) and increasing their coping skills (Morris & Morris, 1991). CBT for depression (Beck, Rush, Shaw & Emery, 1979) is the most widely adopted and fully evaluated psychotherapeutic treatment for depression (Fennell, 1989). General modifications have been made to adapt structured psychotherapy to be suitable for older people (Dick, Gallagher-Thompson & Thompson, 1996; Pinquart & Sorensen, 2001). The adaptations made include addressing both therapist attitudes to older people and the patient’s beliefs about psychotherapy and help seeking. In addition, hurdles in socialization to the CBT model and the nature of in-session and between-session tasks are a focus in adapting the approach. CBT needs to meet the older person’s sensory and information-processing deficits. For example, CBT with older people tends to focus on concrete problems and their maintenance, coping skills and locating supportive resources (Pinquart & Sorensen, 2001). The treatment is often used as part of an interdisciplinary approach (Dick, Gallagher-Thompson & Thompson, 1996).

The relationship between activity and depressed mood is the focus of behaviour theory applied in the treatment of depression (Lewinsohn, Biglan & Zeiss, 1976, as cited in Dick, Gallagher-Thompson & Thompson, 1996). Social learning and reinforcement are key concepts in behaviour theory. They have a particular role in the development and maintenance of depression in older people who may experience discrimination on the basis of their old age. Therapeutic tasks in behaviour therapy include instigating and monitoring activity.

The role of information processing in the mechanism of depression is the focus of cognitive therapy (Beck, 1976; 1987). The cognitive deficits found in depression such as selective attention are addressed in cognitive therapy. Characteristic belief patterns such as over-generalization and negative self-attributions are also a focus of therapy (see also the section on cognitive theory). The key therapeutic tasks are for the patient to learn to recognize and challenge dysfunctional beliefs and to learn effective coping strategies, such as the use of distraction techniques.

These behavioural and cognitive therapeutic elements are combined in CBT. This allows for a comprehensive understanding of depression as an interaction of response to stress and use of coping and problem solving skills (Arean, Uncaper, & Satre, 1998). Additional basic
therapeutic elements include: goal setting, mood monitoring and behavioural experiments. In older people, another a particular focus of therapy is on addressing low self-esteem (Morris & Morris, 1991). CBT is implemented successfully in individual or group format with older people (Gatz, et al., 1998).

An example of CBT with an older person is described by Dick, Gallagher-Thompson and Thompson (1996). Mr B, was a 74 year old man who cared for his wife. He presented with depression and anxiety. His wife suffered from emphysema and had declining health. He was finding his carer role difficult. CBT was used to address the stressful beliefs that accompanied his care-giving activities. It aimed to increase his pleasant and social activities and to support him to be assertive in interactions with his wife. The sessions taught relaxation skills, assertiveness skills and time scheduling. They also taught how to identify and work with dysfunctional thoughts. Mr B felt he was a bad care-giver for needing time for himself and for engaging in pleasant activities. The intervention included training Mr B to identify and evaluate his beliefs about his responsibility and efficacy as a carer.

CBT for older people with depression has been adapted to address the needs of particular groups such as stroke patients (Hibbard, Grober, Gordon, & Aletta, 1990). CBT for stroke patients needs to allow for the moderating effects of cognitive deficits that result from a stroke and for fluctuations in the patient’s medical status. Behavioural interventions are used in the initial stages when cognitive deficits are severe or when the patient may be minimizing depressive symptoms (Hibbard, Grober, Gordon, & Aletta, 1990). Educational strategies are used, such as enhancing new learning, recall and generalization of information. Attention is given to losses and the reinforcement of small gains (Hibbard, Grober, Gordon, & Aletta, 1990). The approach also aims to recognize the effect of the stroke patient’s losses on family members.

Life review or reminiscence therapy is a psychotherapeutic approach for working with older people. Erickson’s (1950) theory sets out the tasks involved at different life stages. ‘Life review’ as described by Butler (1963) incorporates these ideas and aims to address the ‘problem of death and loss’ that is central to older people. It provides constructive reappraisal of past events and insights of past strategies for problem solving and coping. The objective of the approach is to promote a positive view of self, one’s abilities and purpose in life. Fry (1983) describes ‘structured reminiscence’. This focuses on the memories that a person finds distressing such as intrusive thoughts arising from stressful life events. The specific aim is to
modify irrational beliefs. In this way it shares some similarities with life review and also cognitive therapy.

In addition to CBT and life review approaches, psychosocial interventions for older people include a broad range of techniques. Compared to psychological therapies these are not necessarily led by a trained professional, they may be peer led as with a self-help group (Pinquart & Sorensen, 2001). Examples of these interventions include: psycho-education including retirement preparation, health promotion, promoting leisure activity and other activity to increase feelings of competence. ‘Supportive treatments’ aim to enhance the focus of patients on a goal and they provide supportive interaction, via a socializing peer group or clinician led group. ‘Control enhancing treatments’ for patients in nursing homes focus on increasing the older person’s awareness, the quality of the environment and their means of control (Pinquart & Sorensen, 2001).

Reminiscence therapy and cognitive therapy are found to result in a clinically significant decrease in depressive symptoms in older people (Scogin & McElreath, 1994). Psychosocial interventions are reported to produce slightly more improvement in subjective measures of well-being compared to psychotherapeutic interventions (Pinquart & Sorensen, 2001). They show less impact on self-rated depression and similarly large improvements in clinician rated depression compared to psychotherapeutic interventions (Pinquart & Sorensen, 2001).

Biochemical imbalances that are a symptom of depression in adults and older people respond to pharmacotherapy treatments such as antidepressants. Systematic reviews report that antidepressants are effective for elderly, geriatric, senile or older adult community patients with depression (Denihan, et al., 2000). However, there are differences in the response of older people to antidepressants compared to younger people. They have a slower response to treatment in the acute phase (Wilson, Mottram, Sivanranthan, & Nightingale, 2003). This type of treatment for older people is complicated by interactions with: age-related problems, other medications and side effects. Side effects of antidepressants may also exacerbate common disorders of age such as cardiac arrhythmias, impaired vision, and cognitive impairment (Flint, 1997).

2The main classes of antidepressants are tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs) and monoamine oxidase inhibitors (MAOIs) (Flint, 1997).
Evaluation of psychological treatments

There is evidence for the cost effectiveness of psychological therapy for treating depression in older people in terms of reduced subsequent medical costs (Davies & Collerton, 1997). Thompson, Coon, Gallagher-Thompson, Sommer and Koin (2001) describe an outpatient study of older people. They compared the effectiveness of up to 20 weeks of treatment with pharmacotherapy, individual CBT or combination treatment. This study found CBT to be effective in improving symptoms of depression consistently across severity, when used in combination with medication compared to medication alone. Thompson, Coon, Gallager-Thompson, Sommer and Koin (2001) reported that CBT has an ‘essential’ role in the treatment of depression in older people.

The findings from studies comparing psychotherapeutic approaches for depression in older people are limited because of the small number of protocol-based studies available (Baldwin, 1991). A systematic review of outcomes of psychotherapeutic treatments for adults with depressive disorders has been reported (Churchill, et al., 2001). This review compared CBT, psychodynamic therapy, interpersonal therapy and supportive therapy. Individual CBT resulted in significantly more patients being regarded as ‘no longer clinically depressed’ compared to other therapies (Churchill, et al., 2001). However, no differences in self-report symptoms were found (Churchill, et al., 2001). There is preliminary evidence to suggest that depressive disorder in older people treated with CBT compared to younger adults responds better and with less likelihood of relapse (Davies & Collerton, 1997). Gatz, et al., (1998) adopted the APA criteria to document effective, empirically validated, psychosocial interventions. Cognitive therapy, behavioural therapy and brief psychodynamic psychotherapy were all categorized as ‘probably efficacious’ for treating depression in older people (Gatz, et al., 1998). Life review was also categorized as ‘probably efficacious’ for treating depression and ‘symptoms from living in settings that restrict independence’ (Gatz, et al., 1998). The effectiveness of CBT for depression in older adults with socially, ethnically and clinically diverse groups is also yet to be assessed (Thompson, Coon, Gallagher-Thompson, Sommer & Koin, 2001).

The validity of these currently adopted treatments requires consideration. With the exception of life review and reminiscence, psychological treatments have been developed to treat depression in adults and then modified for older people. Information on their efficacy is limited as the routine age cut-off in major outcome studies excludes older people (Gatz, et al., 1998). As shown in the section on diagnosis, older people with depression present differently.
to younger adults. Also, in general, these types of interventions do not map to clinical practice (Gatz, et al., 1998).

**Pathways to care**

It is suggested that under-treatment in primary and secondary care settings may contribute to the poor prognosis of depression in older people (Baldwin, 1991). Current barriers to older people being treated by mental health services include: the nature of the mental health care system, therapists' attitudes and older peoples' attitudes (Pinquart and Sorensen, 2001). Older generations may be less likely to seek services because they perceive stigma in relation to seeking help. Both service providers and older people may hold assumptions that difficulties are part of old age, disability or ill health (Mills, 2001). Older people may avoid a broad range of psychosocial interventions that are available to them, because of their beliefs about centre-based activities being associated with institutionalization. They may also have difficulties with access and mobility (Pinquart & Sorensen, 2001). Another barrier to effective care is the tendency of older people to somatize or normalize their symptoms on presentation to their general practitioner (GP). A patient may explain fatigue as due to over-exertion or a minor medical complaint, rather than emotional exhaustion. Similarly, the relationship between the attribution style of the clinician and the detection rate for depression in adults is supported by research findings (Kessler, Lloyd, Lewis & Gray, 1999). GPs detected depression in less than half of adults and older people who had scored highly for depressive symptoms on the general health questionnaire (Kessler, Lloyd, Lewis & Gray, 1999).

Barriers to effective provision of primary care include: GPs' knowledge of the efficacy of treatments, diagnostic skills and clinical management skills (Unutzer, Katon, Sullivan & Miranda, 1999). A small-scale survey of ten GPs found a preference to refer patients to the community psychiatric nurse for treatment of depression. The GPs were unfamiliar with psychological treatments for late life depression and clinical psychology services for older people in general (Laidlaw, Davidson & Arbuthnot, 1998). The study also found that GPs treated depression in older people themselves, but referred patients to other services for treatment for anxiety. Another study of GPs' attitudes suggested that beliefs and knowledge of treatments of late life depression, rather than perceived diagnostic confidence, predicted successful treatment of depression (Dowrick, Perry, Dixon & Usherwood, 2000). Skills for diagnosing depression in older adults were associated with a preference for psychotherapy, belief in ease of management and success of treatment in general practice. Training in this area is required, to increase the diagnostic acumen of GPs and to increase appropriate
treatment or referral to psychotherapeutic services (Dowrick, Perry, Dixon & Usherwood, 2000). A further study of GPs treating depression in older people with antidepressants found they were confident in general. However, those in practice for longer and without previous psychiatric training perceived a need for additional information (Rothera, Jones & Gordon, 2002).

There is also evidence to suggest that the treatment of depression in settings such as general medicine is inadequate. In a study of hospitalized medically ill older men, only half of those with depression were receiving treatment (e.g. antidepressants) (Koenig, et al., 1992). Neither detection nor management strategies impacted on the outcome of these patients after discharge (Koenig, et al., 1992).

Conclusion

Recent research has improved the understanding of depression in older people. Differences have been identified in the etiology of depression in older people compared to younger adults and in older people according to age of onset (Grace & O’Brien, 2003). There is evidence for the efficacy of adapted versions of CBT for depression on older people to complement or as an alternative to pharmacological treatment. Further evidence is required to examine the role of socio-economic and racial/ethnic factors in the occurrence of depression and the implications this has for treatment. Modifiable factors have been identified that may be addressed in the prevention of depression in older people and in the provision of treatment interventions. They may also be used in order to structure services appropriately (Kennedy, et al., 1989). This work is currently limited by the lack of assessment tools and treatments that originate from empirical research on older people.
References


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Appendix 1 – Diagnostic criteria for depression

Criteria for a Major Depressive Episode - taken from DSM-IV (APA, 1994)

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note.: In children consider failure to make expected weight gains.

(4) Insomnia or hypersomnia nearly every day.

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) Fatigue or loss of energy nearly every day

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
Overview

In this section the clinical experience gained on training placements and the clinical case reports are outlined. A summary of each placement undertaken in the process of training is given. Brief summaries of each case report are included from the core placements in: adult mental health, learning disabilities, children adolescents and families and older adults. A brief summary of the case report for the specialist placement in eating disorders is given. Each case report represents a psychological intervention that was carried out during the placement. The full case reports, placement contracts, evaluation forms and log books of clinical experience are contained in Volume Two of this portfolio. Volume Two contains confidential information and is held at the Psychology Department at the University of Surrey.

The summaries are presented in the order that the placements were completed. All client names and any identifying information have been changed in order to preserve anonymity.
Core Adult Mental Health Placement
Placement details

Dates: October 2001 - March 2002

Supervisors: Fiona Will (clinical psychologist)
Peggy Easton (clinical psychologist)

Region: Chichester, West Sussex

Summary of placement experience
The placement provided experience of working with cognitive behavioural models for a range of adult mental health problems in the context of a community mental health team and a rehabilitation and continuing care service. Clinical work included assessment interviews for psychological intervention, detailed psychological assessment, psychometric assessments and short-term psychological interventions. The treatment approaches used included: cognitive and behavioural techniques, graded exposure and relaxation techniques. I assisted with an outpatient group for adults with generalized anxiety, led by a specialist CBT nurse. The group was based on cognitive behavioural principles. I co-researched and designed a group with a consultant clinical psychologist and an assistant and co-designed the evaluation tool. The group was on social confidence. It was for people attending a rehabilitation service who lived in the community, it was based on cognitive behavioural and psychosocial principles. I facilitated two sessions of the group.

Clinical skills and experience
The presenting problems I gained experience of working with included: depression, simple phobia, panic disorder, social phobia, obsessive compulsive disorder, post-traumatic stress disorder, memory problems and severe and enduring mental health problems. The assessment procedures used included: WAIS-III, BDI, BAI, ATI, FNE, AMPBI, NART, Graded Naming, Wechsler, Recognition Memory and Trauma Brief Inventory.
Meetings, seminars, visits and research

As part of the induction I visited care units in the community, an in-patient community home and an adult day hospital service. I observed a clinical psychologist in multidisciplinary team meetings, within an in-patient adult mental health service. During the placement I also met with clinical psychologists working in the following settings: an assertive outreach team, a neuro-rehabilitation unit, an acute mental health service and a drug and alcohol service. I also observed practitioners at work in an assertive outreach team for a morning; I attended a team meeting and made use of the opportunity to discuss their role with them.

I completed a service related research project entitled ‘A comparison of primary care and community client referrals to an adult mental health psychology service’. I presented the findings at a meeting of the adult psychology department. I also gave a talk entitled: ‘Two treatment models of eating disorders’ this evaluated the evidence base and it concluded with a discussion of service implications.
Case Report Summary

Assessment and treatment of a phobia of eating in public using cognitive behavioural therapy with a 61 year old man

All personal details have been altered to preserve the anonymity of the client.

Referral
Mr Smith was referred by his general practitioner for the treatment of a social phobia.

Presenting issues
The main presenting problem was that Mr Smith experienced social anxiety when eating in social situations. Mr Smith's levels of anxiety and depression were controlled with medication prescribed by his general practitioner.

Assessment
Mr Smith attended for two assessment sessions. The assessment was conducted by the trainee clinical psychologist and the supervising clinical psychologist.

Assessment tools
At assessment Mr Smith scored 13 on the Beck Depression Inventory Second Edition (BDI-II) (Beck, Steer & Brown, 1996) these symptoms were within the normal range. On the Anxious Thoughts Inventory (ATI) (Wells, 1994; 1997) Mr Smith scored: 13 for social anxiety, 9 for health anxiety and 17 for meta worries. These scores were most similar to norms except, the meta worries score that was similar to scores of social phobic patients (Wells, 1994). Mr Smith indicted a range of fears on the Fear of Negative Evaluation scale (FNE) (Watson & Friend, 1969). He reported moderate distress in social situations on the Social Phobia Rating Scale (Wells, 1997). Mr Smith’s problem had an impact on his social life, his family relationships and home management.
Formulation

Mr Smith’s difficulty was understood within a cognitive behavioural model of social phobia (Clark & Wells, 1995). Unique to the social phobia model is the concept of processing the self as a social object. The formulation hypothesized that Mr Smith had responded to a critical incident, with the activation of thoughts, resulting in a cycle of cognitions and somatic symptoms of anxiety and related safety behaviours. These symptoms served to reinforce the processing of dysfunctional assumptions of the self as a social object and this potentially exacerbated his anxiety symptoms further.

It was hypothesised that Mr Smith’s anxiety symptoms had been precipitated by his taking early retirement and moving home twice. A minor car accident was the critical incident that triggered his panic attack. The formulation allowed for an understanding of Mr Smith’s predisposition to experience anxiety states in specific situations, that was possibly a result of his experiences in early childhood. In his adult life he had had a career, a successful marriage and had managed to cope. Taking medication and avoidance of socializing acted as safety behaviours for Mr Smith.

Intervention

Mr Smith attended for 9 sessions of a CBT, evidence-based intervention, carried out by the trainee. The series of therapy sessions was limited because of the trainee’s placement ending.

Outcome

Mr Smith showed a reduction in depressive symptomatology to a score of 8 (BDI-II). He showed an increase in social anxiety score to 16, and health anxiety score to 11 and a decrease in the meta worries score to 14 (ATI). Responses to the FNE indicated some positive change and insight on effects of anxiety on performance, but he maintained a fear of not being approved of. These were supported by behavioural change outcomes. Mr Smith showed a slight reduction in self-consciousness and avoidance in social situations (SPRS). Mr Smith indicated that he used a wider variety of coping strategies to deal with social anxiety but with less frequency. He reported improvements in his social life and leisure activities.

Prognosis

A meta-analysis of treatments provides evidence to suggest that improvements would increase during the initial period (3-6 months) following treatment.
Critique

Proper exposure and reattribution regarding Mr Smith's ability to manage his anxiety and deal with daily life stressors was achieved with limited success. The critical evaluation of the work discussed Mr Smith's ambivalence to his medical treatment and how he might approach withdrawal from medication. Motivational interviewing and relapse prevention strategies were suggested as providing a structure and a set of techniques to approach this difficulty.

References


Core People with Learning Disabilities Placement
Placement details

Dates: March 2002 - October 2002

Supervisor: David Cotson (clinical psychologist)

Region: Wandsworth, London

Summary of placement experience

The placement provided experience in the context of a specialist assessment and intervention team and a community team for people with learning disabilities. I worked with people with a range of learning disabilities, carers, families and professional support systems. Clinical work included practical experience in applying the basic principles of the psychoanalytic approach with two clients, under supervision. In addition, experience was gained of using cognitive and behavioural techniques, systemic ideas and life span perspectives, working directly with clients and indirectly with care staff. Further experience of psychometric assessments was gained. The placement also provided experience of working with clients from a range of ethnic backgrounds.

Clinical skills and experience

Presenting problems that were worked with included: generalized anxiety, eating disorders, complicated bereavement response, clients with behaviour challenging to services including obsessive compulsive behaviours, anger problems and inappropriate sexual behaviour and an alleged sexual abuse experienced by a client. The assessment procedures and tools used included: Mini PAS-ADD, Adaptive Behaviour Scale, HONOS and a schedule to assess autistic spectrum disorders. Psychometric assessment tools used included: WAIS-III, Wisconsin Card Sort Test, LEITER and Ravens Matrices. I contributed with psychological and psychosocial assessments to a multidisciplinary extended assessment of a client. I provided training on bereavement issues to care staff at a residential home in the community.
Meetings, seminars, visits and research

As part of the induction I visited professionals and services in the community. I attended a network meeting to feedback on an extended assessment of a client who was challenging to services living in a residential home. I attended training in Makaton for carers and families and a half-day of bereavement training for care staff.

I attended bi-monthly group supervision sessions facilitated by Valerie Sinason, an experienced psychoanalytic psychotherapist who has extensive knowledge on this subject. I learned from the other therapists in this group about general the dilemmas in their work and those specific to learning disabilities. I took up the opportunity to present my work to this group on two occasions. I attended monthly multidisciplinary supervision team meetings.
Case Report Summary

Psychodynamic based treatment of a 52 year old man with a learning disability experiencing a parental bereavement.

All personal details have been altered to preserve the anonymity of the client

Referral

Mr Jones was a man with a mild learning disability\(^1\). His one to one worker made the referral because of Mr Jones's difficult bereavement in reaction to the loss of his father.

Presenting issues

Mr Jones said he was experiencing grief at the loss of his father. He was pending court or other outcome of an alleged incident.

Assessment

The assessment and intervention were explained carefully and Mr Jones agreed to take part. An assessment interview was carried out over two sessions, the first jointly by the trainee and a qualified clinical psychologist. Mr Jones's key worker, home manager and community team staff were consulted. Mr Jones was assessed for suitability for psychotherapy with people with learning disabilities (Bates in Waitman & Conboy-Hill, 1992).

Assessment tools

As Mr Jones had a relatively high level of cognitive functioning, measures that are used with the general population were employed. Mr Jones's score for the Beck Depression Inventory (BDI-I) (Beck, Steer & Brown, 1996) was 21, indicating 'moderate' depression. Mr Jones's score for the Beck Anxiety Inventory (BAI) (Beck & Steer, 1987) was 21, indicating 'moderate' anxiety.

\(^1\) British Psychological Society definition: significant impairment of intellectual functioning, significant impairment of adaptive/social functioning and age of onset before adulthood (BPS, 2000).
Formulation

The formulation was based on a psychotherapeutic approach incorporating psychodynamic principles. The psychodynamic principles employed focused on the interpretation of unconscious communication and rapport to determine the individual's sources of anxiety and their defense mechanisms acquired to manage these. The formulation used two psychodynamic models outlined by Malan (1995) and concepts from attachment theory (Bowlby, 1973) were referred to.

The formulation proposed that Mr Jones's difficulties had origins in his early attachment patterns that arose in his response to variable levels of care his childhood, although he had established a satisfactory attachment. Mr Jones's difficult grief response was viewed as reflecting unresolved emotional issues in his relationships.

The formulation speculated on the possibility that Mr Jones felt he was responsible for past family events and his recent, distressing life events because of his learning disability. In psychodynamic terms, his life events may been experienced by Mr Jones as loss of control of his 'self'. Mr Jones's adult life had been settled. He had a job that he experienced as a socially valued role and this avoided the physical segregation that people with learning disability may experience when placed in day services.

Intervention

A short-term therapy intervention consisting of ten sessions were completed as planned. The basic principles guiding therapy included the use of clear time boundaries and confidentiality within the limits of therapy. The sessions aimed to understand the person's experience and make the opportunities for them to respond differently (Hollins, 1997).

Outcome

There was evidence of an improvement in Mr Jones's well-being over the course of therapy. At end of therapy his scores were improved and below the clinical threshold, he scored 6 for depression (BDI-II) and 8 for anxiety (BAI).

Mr Jones was focused on the present and future plans by the final session. It is possible to speculate that this is the result of the psychodynamic therapy process. Another interpretation is that this represents an over compensation for his difficulties. In the last session Mr Jones
referred to distressing experiences, creating a transference. A view of the end of therapy as an analogue for loss suggests that, Mr Jones’s response to this was to some extent adaptive.

**Critique**

It seemed significant that successful engagement was achieved and that Mr Jones accepted and worked to the intervention. This intervention was short compared with standard psychotherapy treatments. It seems that through making the interpretive links, some of Mr Jones’s more discomforting feelings were being accessed towards the close of therapy. The issue of outcome measurement was discussed in the critique.

**References**


Core Children, Adolescents and Families Placement
Placement details

Dates: October 2002 - March 2003

Supervisor: Peter Jakob (clinical psychologist)

Region: Margate, Kent

Summary of placement experience
This placement provided extensive experience of working with children, their families, foster carers and schools using systemic theory, narrative therapy and solution-focused family therapy in the context of a multi-agency service with combined input from social work, health and education staff. The service provided intervention for highly complex cases. It was an opportunity experience using cognitive, behavioral, solution-focused and systemic ideas in a teamwork approach to clinical practice that focused on the change process rather than problem formulation. Each case was assigned two staff to work with them and cases were reviewed regularly at weekly team meetings and case consultation meetings that included experience of the reflecting team approach in practice. The placement also provided valuable experiences of giving a variety of consultations in schools. The ages of children worked with ranged from 2 to 17 years. These clients were worked with directly or indirectly by working with parents.

Clinical skills and experience
The placement provided experience including work with children and families experiencing: domestic violence, physical abuse, substance abuse, sexual abuse and/or physical and emotional neglect. I observed and then took part in co-worked assessments. Presenting problems included depression, post traumatic stress, mild learning disability, low self esteem, suicidal ideation, self-harm and challenging behaviour and a parent with a diagnosed severe and enduring mental health problem. I researched and offered a presentation to foster carers on post-traumatic stress in children. I experienced using solution-focused and therapeutic approaches in written communications. Psychometric assessments were made using the WISC-III. Assessments were made using a standard service evaluation form, pre and post self ratings, and scaling questions as part of a multidisciplinary approach.
Meetings, seminars, visits and research.

The induction included visits to local health and voluntary services for children and young people. Weekly multi-agency meetings involving team members, a community paediatric psychiatrist and educational psychologists were attended. I attended a team away day.

On placement there was the opportunity to attend a training event of the network of family and systemic practice on ‘Domestic Violence – Risk assessment: Risk management’. I attended ‘Healthy Minds for young people referrers forum’, a one day event with presentations from professionals and voluntary sector workers with the aim of improving referrals and working together.

I gave a presentation on ‘attachment and communication’ on placement to the team. This included reference to the ‘Hanen’ approach used at a local speech and language therapy service to work with families whose child has delayed language development.
Case Report Summary

A systemic, solution-focused psychotherapeutic intervention with a 16 year old girl presenting with suicidal ideation.

All personal details have been altered to preserve the anonymity of the client

Referral

Jane Taylor was referred by her school welfare officer because of concern for her safety and her emotional welfare.

Presenting issues

Jane's sister and mother had reported to the school that Jane was self-harming and that she had also made suicide plans.

Assessment

An initial interview was made with the school welfare officer. One session of co-work and one session of live supervision were carried out with the placement clinical supervisor. Jane's sister Clare attended all sessions with her. Throughout, consultations were made with social workers.

Assessment tools

Scaling questions were used for assessment and throughout treatment (De Shazer, 1988; Berg, 1994). Scaling questions such as scaling safety have validity as they are centred on the client's individual difficulties.

Current risk of self-harm and suicide was assessed for. Jane was asked if she wanted assistance related to her past or a current difficulty. After consultation with Jane, the school and the clinical supervisor, Jane was considered ‘Gillick competent’ to consent to treatment (Jenkins, 2002).
Formulation

The formulation was based on a social constructionist approach. This emphasizes the social processes underlying the individual's accounts of a phenomenon (McNamee & Gergen, 1992). Social constructionist ideas from systemic family therapy (Berg, 1988) and solution-focused therapy (De Shazer, 1988) were applied in the formulation. The work was based on current guidelines for treating adolescents with severe depression.

Several of Jane's childhood experiences were regarded as risk factors that would predict long-term negative effects on her health, development and well-being (DOH, 1999). The formulation allowed for an understanding of Jane's difficulties as representing a socially learned predisposition to experience psychological difficulties on the basis of the life experiences of significant others. The meanings that Jane derived from her relationships were hypothesized to reinforce her feelings of low self-esteem and low self-efficacy. Jane experienced a sense of powerlessness in response to recent life events this had precipitated self harm behaviour and suicidal ideation.

Jane's psychological difficulties were perpetuated by systemic factors, for example interaction patterns in the family. Protective factors included Jane's demonstrated coping skills at school and her ability to achieve supportive relationships with peers and others.

Intervention

Ten sessions were carried out, with a review meeting after six sessions. Following this, the responsibility for the case was passed on to the clinical supervisor, because the trainee had completed the placement.

Outcome

The preliminary goal of reducing the symptoms identified was partly reached. The objective behavioural markers of outcome were, that Jane made academic improvements at school and that others reported she seemed more at ease. The scaling question provided an indication of Jane's improvements as her happiness at school had improved by the last session.

Prognosis

Whilst it is problematic to delineate the action of the therapy it was intended that, in systemic terms, specific improvements in certain areas would generalize into other areas of Jane's life.
This piece of work formed the first stage of possibly longer-term psychotherapeutic work with Jane and her sister.

**Critique**

The therapeutic approach was effective in engaging and working with the client. The solution-focused emphasis on building on the client's personal resources and working at their pace in the early stages may have contributed to the success of the work. The success of this initial intervention was also due to the high level of commitment from the client. The use of standardized measures may have indicated more specifically the areas of improvement that resulted from the intervention.

**References**


Core Older Adult Placement
Placement details

Dates: April 2003 - September 2003

Supervisor: Farzad Shamsavari (clinical psychologist)

Region: Tolworth Hospital, Surbiton

Summary of placement experience

This placement provided valuable experience of using cognitive behavioural therapy, behaviour therapy, integrative, systemic and psychodynamic ideas and life review approach working with older people in the context of an out-patient psychology department and community mental health team. I gained experience of working with clients, their families and carers. I worked with clients in the context of their own homes, in a psychiatric out-patients day centre, psychiatric in-patient service and out-patient psychology department. I co-worked with psychiatric nurses to provide assessment. The placement provided experience of working with clients with ages ranging from 67 to 95 years.

Clinical skills and experience

Experience was gained of a range of presenting issues including depression, Alzheimer’s and other dementias, memory problems, memory problems with co-morbid schizotypal symptoms, obsessive compulsive disorder / Diogene’s syndrome, relationship difficulties, aggressive verbal behaviour, generalized anxiety disorder, panic disorder, health anxiety in the context of chronic health conditions, somatization disorder and bereavement. Psychological assessment tools used included: GDI, BAI, ATI and GDS. A variety of neuropsychological tools for assessment and screening were used including: CAMCOG/CAMDEX, WAIS-III, NART, AMIPB, MEAMS, WMS-III, WTAR and Doors and People. I worked with care staff at residential homes regarding clients with challenging behaviour and used behavioural monitoring interventions. I applied basic therapeutic principles and relaxation training in work with clients. I gained experience of formulating with schema-focused ideas and observed the placement supervisor applying schema-focused techniques. I observed an affective communication skills group for patients with depression or anxiety.
Meetings, seminars, visits and research

In addition to meeting with professionals during the placement the trainee visited a stroke rehabilitation ward and observed an assessment by a clinical psychology assistant. The trainee attended monthly psychology local meetings.

Over the placement presentations attended included: ‘advocacy’ given by a voluntary organization, ‘borderline personality disorder in later life’ given by a clinical psychologist and ‘memory disorders’ given by a neurologist and ‘psychoanalytic perspectives on suicide’ given by a clinical psychologist. I researched and delivered a presentation on ‘non-verbal communication in older people’ to the older adult psychology directorate monthly meeting.

During the placement the trainee attended a one-day workshop on Post Traumatic Stress Disorder at the Institute of Psychiatry.
Case Report Summary

Psychometric assessment of a 67 year old lady presenting with memory problems.

All personal details have been altered to preserve the anonymity of the client

Referral
Mrs Robertson was referred by her general practitioner because of 'significant memory problems affecting her functioning and with progressive worsening over the past year'.

Presenting problem
Mrs Robertson was concerned about being increasingly forgetful. She experienced sleep problems and she was worried about having a stroke.

Assessment
The initial assessment interview was carried out by the trainee and the clinical psychologist supervisor with Mrs Robertson. Formal testing was carried out by the trainee. Assessment of the problem explored the history of the problem, medical, developmental, personal and family histories. Testing took place over three sessions of two to three hours.

Hypotheses
The possible hypotheses were that Mrs Robertson had a neuropsychological profile consistent with: 1.) Alzheimer's dementia, 2.) Psychiatric disorder, or, 3.) Normal memory aging.

Rationale
The rationale was based on a literature review of normal memory aging, depression and pathological memory loss, including the dementias. The psychometric tests used were those
found in test batteries for the diagnosis of dementia used in assessment centres in the UK and USA (Bucks & Loewenstein, 1999).

**Behaviour during testing**

Mrs Robertson was articulate and she responded appropriately to the assessment context. She appeared anxious and low in mood during testing.

**Findings**

Mrs Robertson’s pre-morbid IQ score was 109, slightly lower than predicted. No significant differences were found between her predicted IQ, her memory scores and her actual performance on WMS-III and WAIS-III tests. Mrs Robertson’s Full Scale IQ score was 99 (95% Confidence Interval (CI)=95-103) indicating functioning in the Average level of intelligence. Verbal and Performance IQ scores suggested functioning at an Average level.

Mrs Robertson’s memory scores on the comprehensive memory test battery (WMS-III) indicated an Average level of memory functioning, although several of her memory scores were invalid. Mrs Robertson’s working memory index score was Average (WAIS-III). Her level of functioning on verbal memory and forgetting was Average (Doors and People test).

Mrs Robertson reported having symptoms of anxiety and depression. Her depression score on the BDI was 7, below clinical significance. Her anxiety score on the HADS was 6, below clinical significance.

**Interpretation**

Mrs Robertson’s cognitive assessment did not indicate that she had impaired brain functioning. Her valid memory scores were not impaired compared to norms for her age group. This suggested that dementia was not a likely causal explanation for her difficulties. The assessment results partially supported two hypotheses explaining Mrs Robertson’s problems. They suggested that Mrs Robertson had some impairment from normal memory aging. It seemed that this was accentuated by her mental health and her current concerns.

**Formulation**

Mrs Robertson’s difficulties were viewed as a combination of normal memory aging and mental health symptoms. The difficulties that she reported seemed to be impaired by
symptoms of depression and anxiety, by the cognitive load of a decision about moving home and by concerns about her health

A psychotherapeutic intervention was offered to Mrs Robertson after the findings of the assessment had been discussed. She had begun a course of anti-depression tablets and was considering requesting a prescription for treatment of early onset dementia (i.e. Aricept).

**Recommendations**

Recommendations were made on the basis of the profile from the psychometric assessment and formulation. Mrs Robertson was also referred to the old age psychiatry service for support and advice about pharmacological treatment for early dementia.

**Critique**

The critique of the assessment considered the limitations due to several invalid test scores. The need for improved tests for early detection of cognitive decline in the elderly (de Jager, Milwain, & Budge, 2002) and the need for a local memory clinic in order to improve rehabilitation services were discussed.

**References**


Specialist Eating Disorders Placement
Placement details

Dates: October 2003 – March 2004

Supervisor: Katherine May

Region: Farnham Hospital and Centre for Health

Summary of placement experience
The placement provided valuable experience of working with the cognitive behavioural model, motivational techniques, narrative/solution focused approaches and psychodynamic process ideas with in a bio-psychosocial framework with adult clients in the context of a multidisciplinary eating disorders service. It provided the opportunity to work within a team approach to treatment. I also liaised with assigned care coordinators in local CMHT’s given the severe and enduring nature of eating disorders. I had the opportunity to observe the day patient programme by taking part in the weekly multidisciplinary team review meetings. I worked directly with the day patient programme by observing sessions of the body image group. Following this I researched, produced and led two sessions of psycho-education with the group. The placement enabled the trainee to consider issues relating to the maintenance of mental health difficulties, relapse prevention and re-referrals to a service. Experience was gained of working with clients whose ages ranged from 18 to 42 years.

Clinical skills and experience
The diagnoses of eating disorders worked with included: bulimia nervosa, anorexia nervosa and eating disorders otherwise not specified. Co-morbid difficulties to the eating disorders included: early emotional abuse and neglect, alcohol abuse, complicated bereavement reaction, difficulties in relationships, depression, social phobia and diagnoses of personality disorder. The assessments used by the trainee included: a semi-structured assessment interview, Stirling Eating Disorders Questionnaire, St Georges Eating Disorders Questionnaire, BDI and BAI.
Meetings, seminars, visits and research

The induction included meetings arranged with individual staff at the service and discussions with professionals visiting the service. A wide range of talks were attended at the service. Presentations given by a variety of health professionals included: ‘an audit of GPs’ and CMHTs’ views of the eating disorders service’, ‘the National Institute for Clinical Excellence guidelines for eating disorders’, ‘attachment and eating disorders’ and ‘child protection’. Weekly referral meetings and regular department business meetings were attended. Multidisciplinary team supervision meetings were attended regularly, supervision given to the team by a systemic therapist and a CBT therapist.

A day seminar meeting of the Division of Clinical Psychology faculty for Eating Disorders Special Interest Group was attended. A lunchtime psychology department journal club presentation was attended on the subject of mental health problems and negative care giving experiences of carers of people with bulimia nervosa/EDNOS.

A mini audit of care plan record keeping and communication for the day patient programme was carried out by the trainee. I reviewed policy and local guidelines on care plans. I interviewed members of staff for their views on the use of care plans and auditing records. This was feedback to the eating disorders service multidisciplinary team.

The major research project was conducted on this placement. A presentation was made to the staff at the service to explain the background to the study. The project was presented to staff at another local eating disorders service who also recruited participants for the study.
Case Report Summary

Cognitive behavioural therapy within a systemic framework with a 29 year old lady with bulimia nervosa.

All personal details have been altered to preserve the anonymity of the client

Referral
Yvonne was referred to a specialist eating disorders service (EDS) by the psychiatrist of a community mental health team (CMHT).

Presenting issues
Yvonne was diagnosed with bulimia nervosa by the multidisciplinary team at the EDS assessment. Yvonne’s problem had persisted despite her use of self-help books. Yvonne’s psychiatrist had prescribed the anti-depressant, Fluoxetine.

Assessment
An initial assessment was carried out by a clinical psychologist and dietician at the EDS. The trainee clinical psychologist carried out two assessment appointments. The client’s case remained open with the CMHT. She did not present as at risk of suicide or self-harm. Risk was actively managed throughout treatment.

Assessment tools
The St Georges Eating Disorders Questionnaire (copyright of Dr Lacey) was used to assess the history and development of Yvonne’s eating disorder and relevant family history. On all subscales of the Stirling Eating Disorders Scale (SEDS) (Williams & Power, 1995) Yvonne’s score was clinically significant. On the Beck Depression Inventory (BDI-II) (Beck, Steer & Brown, 1996) Yvonne’s score was 11 and below clinical significance. On the Beck Anxiety Inventory (BAI) (Beck & Steer, 1987) Yvonne’s score was 5, indicating minimal symptoms.
Formulation

An individualized model of cognitive behavioral therapy (CBT) for treating bulimia nervosa was used to formulate Yvonne's problem (Fairburn, Marcus & Wilson, 1993). The conceptualization was presented within a systemic framework for bulimia nervosa Kayrooz (2001) because of Yvonne's significant interpersonal, familial and cultural issues.

Yvonne's eating disorder symptomatology was conceptualised as the manifestation of mental health difficulties relating to problems of identity and psychological adjustment. It was hypothesized that Yvonne's vulnerability and negative core beliefs were due to her childhood experience that was emotionally traumatic and included few positive experiences. 'Core beliefs' are the beliefs that shape a person's appraisals and assumptions about themselves and the world (Beck, 1995).

Several psychological factors had contributed to Yvonne's difficulty in establishing an independent adult identity. Yvonne's forthcoming marriage may have exacerbated her symptoms. Yvonne's difficulties were maintained by self-evaluation on the basis of her appearance, weight and shape and by perfectionistic thinking. Negative self evaluations resulted in low mood and increased the likelihood of her restricting her food intake. Her physical response to restriction affected her mood, resulting in her loosing control of her eating. She self-induced purging to compensate.

Intervention

Yvonne attended for 10 appointments. She cancelled two appointments and did not attend for one appointment. She attended for three appointments with the dietician. The CBT model and diet monitoring were introduced with an emphasis on the cognitions and behaviours that maintain the eating disorder. Attention was given to process issues such as fluctuations in the therapeutic alliance and the client's state (Safran & Segal, 1996). The sessions were planned to end with a review because the trainee was completing the placement. The ending and possibilities for further work were discussed regularly.

Outcome

By the forth session Yvonne had reduced the number of episodes of purging per week by eliminating vomiting at work. In the last session, Yvonne described leading a normal life at work. She remained frustrated with her slow progress and did not fully acknowledge the gains she had made. Outcome data from questionnaires was not available because the ending was
not completed as planned. From the trainee’s perspective Yvonne had made good use of therapy to begin to process her emotional difficulties. The ending to the therapeutic work was anticipated and risk was managed.

Prognosis

Yvonne’s problems were of a complex nature and her progress was likely to be slow. Given the enduring nature of her problems referral for long-term psychotherapy was appropriate.

References


Specialist Pain Management Placement
Placement details

Dates: April 2004 – September 2004

Supervisor: Hilary Rankin and Claire Copland

Region: Sutton Hospital

Summary of placement experience
This placement provided experience of working with cognitive behavioural models (CBT) to treat problems of persistent pain in a general health context within a multidisciplinary team approach to pain management. I built on my existing knowledge of clinical health psychology gained prior to training. Clinical work included: individual psychology assessments, multidisciplinary assessments and short-term CBT interventions. Treatment techniques included: cognitive and behavioural techniques, psycho-education, communication skills, goal setting and pacing, relaxation and mindfulness ideas. Clinical experience was gained of the group pain management 8-week programme, observing, then leading limited sessions. Experience of service development was gained within the cardiology rehabilitation department, including giving a presentation on stress management to a group of patients.

Clinical skills and experience
The presenting problems included back pain, headaches, undiagnosed pain, painful medical interventions, degenerative disease, neuropathic pain, health anxiety, rehabilitation following heart attack and heart surgery. The assessment tools used included: BDI, BAI, HADS, McGill, Pain Self Efficacy Questionnaire, Visual Analogue Scales, COPE and structured interviews. I produced a patient leaflet on depression for patients in coronary rehabilitation

Meetings, seminars, visits and research
For the induction I attended: medical consultant’s pain clinic, acute pain nurse hospital round, TENS clinic, liaison psychiatry team and GUM psychologist. I attended presentations on: the Expert Patients Programme, the Special Interest Group on Pain meeting and a half-day on Using Psychology within Cardiology run by the Faculty of Clinical Health Psychology.
Overview

The research dossier contains the research assignments that were completed in the course of clinical training. It includes the Service Related Research Project that was completed in Year One, the Qualitative Research Project completed in Year Two and the Major Research Project that the trainee completed in Year Three.

The Qualitative Research Project was a compulsory assignment but it does not form part of the formal assessment process on the course. It is included here to demonstrate the additional research skills acquired and psychological models considered in the course of the clinical training.
Service Related Research Project

A comparison of primary care and community client referrals to an adult mental health psychology service

June 2002

Year 1
Acknowledgements

Acknowledgements to my university supervisor Dr Vicky Senior, University of Surrey, Guildford. Thank you to the information officer at the trust headquarters who obtained the activity data sample. Thank you to my adult mental health clinical placement supervisor for both information and support, to the clinical psychologists who agreed to take part and to the patients who formed the study sample.
Abstract

Aim: This study aimed to compare primary care and community mental health team (CMHT) referred patients treated by an adult mental health psychology service.

Design: A retrospective cross-sectional survey including between group comparisons of primary care and CMHT referrals.

Method: Activity data for 436 patients treated by the service during the study period August 1999 to August 2001 were analysed. The main measures for the study were the characteristics of the patients (age and gender) and the treatment undertaken (duration and number of sessions). A random sample was taken and a coding system was generated to classify the characteristics of the patients' presenting problems.

Results: The primary care and CMHT referred groups had similar proportions of men to women and similar mean ages. There were no significant differences between primary care and community referrals in terms of treatment duration, number of treatment sessions, sessions cancelled and sessions not attended by patients. There was a low inter-rater reliability for the coding system, therefore an analysis of the patients' problems for the two populations could not be conducted.

Conclusion: This study found no differences in the duration of treatment or number of treatment sessions between primary care and CMHT referrals to an adult mental health psychology service. These findings provide preliminary evidence to support decision making on the structuring of services as they suggest that referrals from primary care to the adult psychology service might be appropriate. Further research is needed to generate a reliable coding system.

(247 words)
Introduction

Rationale

The examination of psychological assessment and intervention records is an aspect of the ongoing audit of psychology services (Firth-Cozens, 1993; Baker, Pistrang & Elliott, 1994). This study compared the activity information for a cohort of patients referred from two sources; primary care and community mental health teams (CMHT’s). The aim of the study was to determine whether these groups differed in terms of demographics, duration of treatment and patients’ problems. This question is pertinent because it has implications for service planning, in particular in determining the location of adult mental health psychology services within the service structure. For example, whether the service should be specialised and based centrally or whether it should be provided in different settings, such as primary care.

Background

Recent studies and reviews have attempted to explain the referral behaviour of primary care services (Ross & Hardy, 1999) and of CMHT’s (King, 2001). Ross and Hardy (1999) suggest that a range of possible factors underlie the decision to refer patients to psychology services from primary care. King (2001) examines the perceptions of CMHT clinical staff that guide their caseload management decisions. Both papers suggest that referrals are often led by a number of factors in addition to patients’ needs. They also make the point that referral patterns may have an effect on the shaping of services.

The provision of psychology services is discussed in a government report on psychological therapies (DoH, 2001) and as a by-product of recent NHS philosophy that bases the provision of services in primary care (DoH, 1999). These papers propose that the majority of psychological problems would be most appropriately treated in the primary care setting and that ‘complex’ cases should be referred to specialised psychological services for assessment and treatment and to continuing care.

In general, there is little routine information on patients’ problems collected by adult psychology departments for audit purposes. In this study therefore, information on patient measures was identified by referring to research on treatment outcomes. Individual client factors such as severity, complexity, problem duration and the characteristics of treatment have been considered as factors influencing the outcome of patients’ well-being (Roth &
There is some evidence for the positive effects that generic treatment factors such as the therapeutic alliance and treatment duration have on treatment outcome (DoH, 1999; 2001). The DoH (1999) overview of effectiveness of psychological therapies suggests that better quality evidence is needed to support these findings.

The number of treatment sessions has been considered in addition to the length of treatment that the patient undergoes. A review of brief dynamic therapies for depression reported by Roth and Fonagy (1996) found that treatments ranged in length from 12-36 sessions (mode of 12 sessions). They conclude that longer treatments (16 sessions or more) and also follow-ups seem to be associated with better long-term outcome in patient well-being. They advise that simplistic conclusions on the relationship between treatment duration and outcome should be made with care. For example, they note that to some extent the type of therapy may dictate treatment length (e.g. long term interpersonal psychotherapy has increased long term effectiveness). Roth and Fonagy (1996) also note that severe cases of a condition may be less likely to respond to psychological intervention and result in an increased risk of relapse.

The Sheffield Psychotherapy Project reported by Shapiro et al. (1994) found an interaction of initial severity (stratified in terms of BDI score into groups: low, moderately or highly depressed), duration (either 8 or 16 weeks), and type of treatment (cognitive behavioural therapy with psychodynamic or exploratory psychotherapy) on outcome. This study failed to be replicated by the Collaborative Psychotherapy Project (Barkham, et al., 1994). However, Roth and Fonagy (1996) note that this is possibly due to differences in the characteristics of the study populations.

The DoH (2001) paper on treatment choice in psychological therapies includes observations on duration of treatment. It reports that, in studies where associations have been found between treatment duration and psychological well-being these are positive. It concludes that, treatments with fewer than eight sessions are unlikely to be optimal and that sixteen sessions or more may be required for long-term effects. The authors also note that simple phobias and panic disorders respond to brief therapies. The concept of ‘complexity’ is discussed by Tarrier, Wells and Haddock (1999), they consider the modifications to psychological therapies necessary for the treatment of ‘complex’ cases.

In clinical psychology as well as other professions methods are being developed to incorporate this type of information into decision making in developing a caseload
management strategy. This approach aims to balance workload among team members (Fortune & Ryan, 1996; Papthanasiou & Lyon-Maris, 1997; Sherman & Ryan, 1998; Slade, et al., 2000).

Under the circumstances described above it might be expected that the two groups considered in this study would differ, for example in terms of type of problem and duration of treatment. It might be expected that patients referred from CMHT’s would require more treatment sessions than primary care referrals. The investigation of this question is necessary as it may provide information for service planning at the study site in the absence of routinely recorded information on patient’s presenting problems. This information may also provide a useful indication of current practice, possibly to inform the generation of a local protocol or to contribute to other means for effective linking of services.

**Characteristics of the studied service**

At the study site, the adult mental health psychology service consisted of 4 (full-time equivalent) clinical psychologists, a trainee clinical psychologist, 1.5 (full-time equivalent) counseling psychologists and a cognitive behavioural therapy nurse specialist. These clinicians worked from models including: cognitive behavioural, cognitive analytic, autogenic training, behavioural and psychosocial approaches.

Referrals to this service from primary or secondary services were sent an ‘opt-in’ letter this was an invitation to the patient to accept a place on the waiting list. The service did not use a pre-assessment or a standard outcome measure. Activity data was collected each month with each clinical psychologist submitting information including the referral date, opening session date and number of contacts for each client. This information was processed by an information management company.

**Hypotheses**

The first aim of the study was to compare demographics and treatment variables for the patient population. There were no significant differences expected in the age or gender proportions between CMHT and primary care referrals. The hypothesis was that:
a) The CMHT referred patients would undergo a greater number of treatment sessions than primary care referrals.

The second aim of the study was to develop a coding system for patients’ problems with the hypothesis that:

b) The CMHT referred patients’ would have problems that were of longer duration, more ‘complex’ and more severe than primary care referred patients’ problems.

Method

Participants
To address the first aim of the study 436 patient cases were audited. To address the second aim 58 patient cases were audited. All cases were adults between the age of 18 and 65 years. All cases were closed cases, treated by the adult mental health psychology service during the period of August 1999 to August 2001. At the time of the study the recording system at the study site did not include information on cultural background. The study population inhabited rural and semi-urban settings, it can only be hypothesised that the cultural mix of the study population would be mostly Caucasian and representative of this context.

Procedures
Activity data were requested from the Information Technology department at the study site for the defined period, see appendix one for a list of the fields requested. The clinical psychologist supervising the project advised that cases with one contact should be excluded, as for a comprehensive assessment of a patient’s problem a minimum of two sessions were necessary. Also, cases with more than 80 contacts were to be excluded as ‘outliers’. Please see appendix two. for a list of the exclusion criteria used to refine the activity data sample.

To address the second aim there was insufficient time to examine all 436 cases in detail. A random sample of 90 cases were extracted from the patients’ records filed in the psychology department. Of these 90 cases the notes of 58 cases were located that meet the study

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1 This sample was taken before the activity data became available, the sample was therefore taken from a ‘first draft’ of the activity data.
exclusion criteria. Sixteen patient’s records were not found in the department filing system. Six patients were recorded as not seen. Ten cases were excluded as they attended only one appointment.

A range of ethical issues were considered in the design of this study, the hospital audit department provided advice on this matter. In particular, anonymity and confidentiality of patient material was protected by removing all personal details. Patient information was identified by a number only, the key to this was stored in a separate and secure place.

Main measures
The main measures for aim one were:

- Demographic information.
- Duration of episode and number of treatment sessions.

The measures for aim two were:

- Severity, complexity and duration of problem.

Statistical analysis
Data were analysed using SPSS. In order to determine the appropriate use of parametric tests the distributions of the data were also examined for normality.

Development of a coding system for patients’ problems
The presenting problem described in the assessment letters and in patients’ notes was examined and categorised. The coding system used was based on a review of relevant literature that was indicated in the introduction (see section on background). The final system was decided by discussing this collected information with the project supervisors, who included a clinical psychologist working at the study site. The decision was made to classify the patient’s presenting problem for severity, complexity and duration of problem and the operational definition for each of the codes was agreed. Please see appendix three and appendix four for examples.

\(^2\)The ‘duration of episode’ was calculated as duration from first contact to discharge, as the date of final contact was not available.
Results

Demographic information

Activity data for 436 patients were selected from the Adult Mental Health Psychology Service records for the two-year period August 1999 to August 2001.

Table 1: Composition of the sample; mean age, proportions of male and female patients and proportions referred from primary care and CMHT's.

<table>
<thead>
<tr>
<th>Activity data (n = 436)</th>
<th>Age (years) Mean (s.d.)</th>
<th>Gender</th>
<th>Referrer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>38.35 (12.94)</td>
<td>Male</td>
<td>167 (38.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td>269 (61.7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary care</td>
<td>266 (61.7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMHT</td>
<td>170 (39.0%)</td>
</tr>
</tbody>
</table>

Comparisons of activity data sample grouped by referrer

Between groups comparisons were made for the activity data sample by comparing patients grouped by referral source (see table 2). The group of patients referred from primary care did not differ significantly from the group referred from CMHT's in terms of their gender, using a chi square statistic or average age, using an independent samples t test (see table 3).

Table 2. Gender proportions for the primary care and CMHT referred patients.

<table>
<thead>
<tr>
<th>Referrer</th>
<th>Primary care</th>
<th>CMHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>n</td>
<td>Pearson Chi Squared (asymp. sig.)</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>102 (38.3%)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>164 (61.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>266</td>
<td>170</td>
</tr>
</tbody>
</table>
The distributions for the number of treatment sessions and episode duration were skewed, therefore the non-parametric Mann Whitney U test was used for between groups comparisons. The difference in the mean number of treatment contacts between the two groups was not significant (see table 3). The difference was not significant when cases with one contact were included in this comparison. The mean number of contacts for primary care and CMHT's, including single contacts, were 4.76 (s.d=6.76) and 5.23 (s.d=6.71) respectively (Mann Whitney U = 55298.00 and asymp. p=0.83). The difference in duration of episode between the two groups was not significant (see table 3.). There was a significant difference between the clinicians in the mean number of patient contacts (Kruskall Wallis = 19.84, d.f=7, p=0.006) and the mean duration of episode (Kruskall Wallis = 15.41, d.f=7, p=0.03). Bar charts showing the clinician's mean scores are given in appendix five.

Table 3. Activity for primary care and CMHT referrals in the study sample.

<table>
<thead>
<tr>
<th>Referrer</th>
<th>Primary care (n=266)</th>
<th>CMHT (n=170)</th>
<th>t test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>38.46 (13.44)</td>
<td>38.18 (12.15)</td>
<td>0.22 (d.f.= 434, p=0.82)</td>
</tr>
<tr>
<td>Direct contacts (count)</td>
<td>6.57 (5.57)</td>
<td>7.66 (7.42)</td>
<td>21593.5 (p=0.42)</td>
</tr>
<tr>
<td>Length of episode (days)</td>
<td>279.79 (242.4)</td>
<td>357.74 (392.25)</td>
<td>20371.50 (p=0.14)</td>
</tr>
</tbody>
</table>

The primary care and CMHT referrals did not differ significantly in terms of the percentage of clients who cancelled their appointment or those who did not attend (see table 4.).

Table 4. Cancelled appointments and clients who did not attend.

<table>
<thead>
<tr>
<th></th>
<th>Primary care (n=226)</th>
<th>CMHT (n=170)</th>
<th>Pearson Chi Squared (asymp. p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not attend (count)</td>
<td>80 (30.1%)</td>
<td>42 (24.7%)</td>
<td>1.48 (d.f=1, p= 0.22)</td>
</tr>
<tr>
<td>Cancelled appointment (count)</td>
<td>126 (47.4%)</td>
<td>83 (48.8%)</td>
<td>0.09 (d.f=1, p=0.77)</td>
</tr>
</tbody>
</table>
Sample of patients’ problems

Complete data were available for 58 patients of the random sample of 90. The size of the sample was limited by the time available to the researcher. The mean age was 41.15 years (s.d=12.48). The sample consisted of 25 (43.1%) men and 33 (56.9%) women. There were 31 (53.4%) primary care referrals and 27 (46.6%) CMHT referrals. There were no significant differences in terms of age (independent t test=1.64, d.f=56, p=0.11) or the gender proportions of the two groups (pearson’s chi squared=0.12, d.f=1, asymp. p=0.74). The mean number of contacts was 6.81 (s.d=5.01) for primary care referrals and 10.11 (s.d=7.12) for CMHT referrals. The difference between these approached significance (Mann Whitney U=306.50, p=0.08). There were no significant differences between the groups in terms of numbers of clients cancelling or who did not attend appointments.

The inter-rater reliability was low for the scoring system used in this study. The second rating of the patients’ case notes was completed for 10 (17.24%) of cases by the clinical psychologists who had seen the patients. This was limited by the number of psychologists available. The inter-rater reliability scores were as follows: complexity kappa = 0.07, severity kappa = -0.07 and duration kappa = 0.38. The poor inter-rater reliability for the coding system meant that an analysis of the data grouped by these codes would not be valid.

Discussion

The first hypothesis for this study was not supported. There were no significant differences in contacts and duration of treatment episode between patient cases referred from primary care and from CMHT’s. This might be taken as preliminary evidence of the similarities in the range of patient problems that are referred to adult mental health services by primary care and CMHT health professionals. However, there are a variety of other possible explanations for this finding. In particular, as noted in the introduction, it is possible that type of treatment may determine treatment duration to some extent (DoH, 1999). Since this was an explorative study and as therapy was not standardized under a protocol, a comparison of types of treatment could not be made to determine whether there was an effect. A difference was found between clinicians in terms of duration and number of sessions, this is discussed below. Another point of interest is that there was a relatively short average duration of episode and number of sessions compared to that described in the literature (Roth & Fonagy, 1996). Furthermore, the length of episode might be regarded as an overestimate of treatment duration.
since there is the potential for a delay between end of treatment and patient discharge. One explanation for this difference is that in this department psychological treatments are being shortened in order to meet the demands of the patient waiting list. It is imperative that there is sufficient resource allocation in order for treatment provision to be maintained. This interpretation has implications for a possible effect on treatment outcome and ultimately on patient well-being.

The difference that was found between clinicians in the mean number of contacts and duration of episode requires further investigation. It may indicate differences between clinicians in the method of recording activity data. For example, some clinicians may only record direct contacts, others record all indirect and other types of contact. In particular, the direct comparison made of the number of sessions recorded by clinicians needs to be considered with caution. This study finds that an audit of clinician recording practices is required at the study site as a basis for ensuring that the recording of routine information is standardized.

This study was also limited by the range of information that was recorded in a routine and standardized manner on each patient case. It proved to be difficult to determine problem complexity or severity from the clinical assessment records using the current classification system.

The overall impression from this study is that for duration of episode and number of contact sessions there are few significant differences between primary care and CMHT referred cases. This preliminary evidence requires substantiation with information on the characteristics of the patients’ problems, it seems that the literature at present does not support a reliable coding system for the classification of patients’ presenting problems. This study could be followed with an investigation of constructs of patient problems such as complexity and severity and the development of an explicit operational definition of these. This could be used to inform decision-making on both service provision and caseload management in clinical psychology.

The main finding of the study is interesting as it may be taken tentatively as an indication that cases from primary care include a proportion of more severe or complex cases. This particular issue is not commonly addressed in formal clinical guidelines (DoH, 1999; 2001) and it may be important in that it suggests a role for centralised adult mental health psychology services. However, the interpretation of these findings needs to be made with caution, in the context of the limitations of this study and the potential alternative explanations for the findings that are considered.
References


Ross, H. & Hardy, G. (1999). GP referrals to adult psychological services: A research agenda for promoting needs-led practice through the involvement of mental health clinicians. British Journal of Medical Psychology. 72, 1, 75-91.


Appendices
### Appendix 1. – Data entry

Table 5. Study sample fields for patient information.

<table>
<thead>
<tr>
<th>Field</th>
<th>Data type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Hospital number</td>
<td>Number</td>
</tr>
<tr>
<td>2 Origin</td>
<td>Text/category</td>
</tr>
<tr>
<td>3 Date of birth</td>
<td>Date</td>
</tr>
<tr>
<td>4 Gender</td>
<td>Text/category</td>
</tr>
<tr>
<td>5 Referrer</td>
<td>Text/category</td>
</tr>
<tr>
<td>6 Psychologist</td>
<td>Text/category</td>
</tr>
<tr>
<td>7 Number of sessions</td>
<td>Number</td>
</tr>
<tr>
<td>8 Referral date</td>
<td>Date</td>
</tr>
<tr>
<td>9 Open date</td>
<td>Date</td>
</tr>
<tr>
<td>10 End date</td>
<td>Date</td>
</tr>
<tr>
<td>11 Length of time</td>
<td>Number</td>
</tr>
<tr>
<td>12 DNA’s</td>
<td>Number</td>
</tr>
<tr>
<td>13 Cancellations</td>
<td>Number</td>
</tr>
<tr>
<td>14 Other health professionals</td>
<td>Text</td>
</tr>
<tr>
<td>15 Closed date</td>
<td>Date</td>
</tr>
</tbody>
</table>
Appendix 2. – Exclusion criteria

Exclusion criteria used for activity data and for the random sample:

- Cases who were self referrals, those referred from other secondary care medical services, referrals from non-medical services and those cases referred from other clinical psychologists working in other services.
- Cases below 17 years old at the time of referral.
- Cases were excluded if only one contact was recorded. Cases with more than 80 contacts recorded were excluded.
## Appendix 3. – Coding system

Table 6: The coding system used to determine complexity, severity and duration of presenting problem.

<table>
<thead>
<tr>
<th>Category</th>
<th>Level</th>
<th>Description (source of material)</th>
</tr>
</thead>
</table>
| Complexity | Complex | ‘Complex cases – patients with extensive co-morbidity, chronic unremitting conditions, enduring vulnerabilities, psychotic conditions, persistent difficulties with social relationships, de-stabilising social problems’  
‘Anger, self esteem, abuse, shame cut across disorders ... in formulating complex cases’  
(Tarrier et al., 1999) |
|            | Simple | Cases other than the above. |
| Severity   | Severe | ‘Many symptoms in excess of those required to make the diagnosis or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.’ (DSM-IV)  
‘Significant impairment of physical, psychological or social aspects of daily living including impact on job and family’. (discussion with clinical psychologist supervisor).  
‘Safety, risk, needs and disabilities’ (Slade et al., 2000) |
|            | Mild | ‘Few if any symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning. ’(DSM-IV) |
| Duration   | Acute | <6 months (discussion with clinical psychologist supervisor) |
|            | Chronic | >6 and <24 months (discussion with clinical psychologist supervisor) |
|            | Enduring | >24 months (discussion with clinical psychologist supervisor) |
### Appendix 4. – Coding decisions

Table 7: Examples of coding decisions.

<table>
<thead>
<tr>
<th>Category</th>
<th>Level</th>
<th>Examples from patients’ notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>Acute</td>
<td>(patient’s problem was indicated as less than 6 months)</td>
</tr>
<tr>
<td></td>
<td>Chronic</td>
<td>‘Stressful events over the past year’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘for many years’ problem in context of recent bereavement</td>
</tr>
<tr>
<td></td>
<td>Enduring</td>
<td>‘10 years’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘symptoms became noticeable 2 years ago’</td>
</tr>
<tr>
<td>Complexity</td>
<td>Complex</td>
<td>'abuse' and 'dysfunctional family relationships'</td>
</tr>
<tr>
<td></td>
<td></td>
<td>'depressive symptoms', 'PMS', 'self esteem'</td>
</tr>
<tr>
<td></td>
<td></td>
<td>alcohol, ‘stresses’ relationship with family.</td>
</tr>
<tr>
<td></td>
<td>Simple</td>
<td>(cases where no co-morbidity was referred to)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘avoidance (minority/cultural issues) loss issues.’</td>
</tr>
<tr>
<td>Severity</td>
<td>Severe</td>
<td>'suicidal ideation’ self conscious, self critical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>'impairing life-style significantly'</td>
</tr>
<tr>
<td></td>
<td></td>
<td>low self esteem ‘past trauma’</td>
</tr>
<tr>
<td></td>
<td>Mild</td>
<td>'stress.. anxiety' 'anxiety eating in public'</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘sleep’, ‘temper control’, ‘work.’</td>
</tr>
</tbody>
</table>
Appendix 5. – Clinician data

Figure 1: Mean length of episode by clinician

Figure 2: Mean number of contacts per client by clinician
Appendix 6. – Letter following feedback to service
13 November 2002

Emma Harrold
Trainee Clinical Psychologist
University of Surrey
Guildford
GU2 7XH

Dear Emma,

I am writing to thank you for an interesting and informative presentation of the results of the study you undertook while you were on clinical placement in our Department. As one of your supervisors, Fiona Will, has left the Department, and the other, Dr Peggy Easton, was unable to attend your presentation; I am writing on their behalf.

I was curious whether there would be a distinction between referrals from Primary Care (GP direct referrals) or via the CMHT (team referrals). It was interesting to discover that based on your study there is no significant difference between them.

You also highlighted some significant differences in data recording between colleagues, and recommended an audit of our data recording practices. As I am on the Trust’s IT committee which is looking into this matter (among others), I will carry this recommendation forward.

Our Department has benefited from the results of your study, and we are grateful to you for the time and effort required to gather and analyse this data.

Please accept our best wishes as you go forward in your training.

Yours sincerely,

Dr John Miles Evans, Consultant Clinical Psychologist
Interim Head of Psychology for Working Age Adults, Chichester Locality

Cc: Dr Peggy Easton, Consultant Clinical Psychologist
Mary John, Head of Psychology and Psychological Therapies
Qualitative Research Project

An exploration of expectations and experiences of a reflective practitioner group using the co-operative inquiry approach

April 2003

Year 2
Introduction

'Reflective practice' is recommended as a basic principle in professional training, including clinical psychology. However, 'reflective practice' as a concept has been variously defined and applied. Ideas about 'reflective practice' originate in the work of Dewey (1933), they link theoretical knowledge to application in practice. Schon (1983) describes it as a personal and tacit knowledge resulting from intrinsic learning from practice. Schon's (1987) critique suggests that 'reflective practice' is not recognized as a legitimate form of knowledge. The concept of 'reflection' remains to be clearly defined (Ixer, 1999). Furthermore it is criticized, in that in training the vulnerability of the learner has potential to be in conflict with the reflective agenda (Ixer, 1999).

A reflective practitioner group (RPG) is provided for trainees on the University of Surrey Clinical Psychology course. The group has an external facilitator, it is confidential, compulsory and regarded as an essential part of the trainee's professional development. 'Reflective practice' is defined in the course handbook as 'learning from experience and clinical practice'. An expectation for therapeutic gains from the RPG is inferred as it appears in the text alongside a discussion about personal therapy (University of Surrey, Clinical Psychology Course Handbook, 2001). The limited research on the efficacy of support groups suggests that, frequently staff support groups based on a 'broadly psychodynamic model' do not satisfy identified needs (Reid, et al., 1999). Specific techniques have been described for reflective practice in adult education (Brookfield, 1998) and in counselor training (Irving & Williams, 1995; Takeda, Karchel & Gaddis, 2002). The latter paper describes the use of autobiographical techniques and a reflective journal. It also describes group work with reference to the emotional environment, group dynamics and interactive group dialogue.

The trainee clinical psychologists who undertook this research had a range of motivations (see process diary, appendix three). My interest was in understanding the my own views and experiences of the RPG and those of the other RPG members. I was also interested in exploring the use of the RPG. Since the research group formed a sub-set of the RPG itself it seemed that the co-operative inquiry research approach (Reason, 1988) would be appropriate. A focus group was used to gather data, with the aim of enabling the research group members to share and compare ideas (Morgan, 1998).
The main characteristic of 'co-operative inquiry' is that the traditionally separate roles of researcher and passive researched are combined. The initial process called 'contracting' is of genuine negotiation and confrontation over the research question (Reason, 1988). It shares characteristics with other forms of qualitative inquiry in that it enables 'voices', provides 'advocacy' and 'reflexivity' (Henwood & Duckett, 1998). The co-operative inquiry approach has been used in research on community development and health promotion. In this application it resulted in the participants' on-going involvement with the subject and constructing positively evaluated identities (Daniels & Coyle, 1992).

It would seem pertinent to explore phenomenological and contextual influences given the subjective nature of the RPG. The interpretive phenomenological approach (IPA; Smith, 1996) is used in this inquiry to explore the content and process of the group and the experiences of group members. Criteria for the validity of qualitative research are considered in the discussion section (Elliott, Fischer & Rennie, 1999)

Method

Methodological issues

The research question originated as one of a list of possible projects suggested in the qualitative research methods class, taught by Adrian Coyle, course lecturer. One person nominated the question and the other members of the research group were self-selected. The main participation criterion for the study was for individuals to have some interest in the research question. The method chosen for the research was 'co-operative inquiry' using a focus group. This was agreed in the early stages of the research process as result of consultation between the research group and Adrian Coyle (see appendix three).

The validity of 'cooperative inquiry' was ensured with procedures aimed at enhancing the coherence of the resulting account with the participant's experiences. These specific procedures were 'bracketing', this is described as moving between active and passive modes during the inquiry; research cycling; balancing reflection and experience; accepting chaos and managing unaware projections (Heron, 1988).

The IPA approach used reflects an epistemological stance based on a 'critical realist' concern with cognitions and meaning (Smith, Jarman & Osborn, 1999). That is to say that the
emerging report is a co-construction by participant and analyst, as a result of the analyst’s engagement with the participant’s account of the process. In this research study the analyst is also a participant. The two main criteria for assessing validity of the IPA approach are ‘internal coherence’ and presentation of evidence (Smith, 1996). ‘Internal coherence’ is used in this application to indicate an internally consistent argument that is justified by data. Evidence is presented sufficient to enable the reader to consider the interpretation offered for themselves.

Participants
Eight participants formed the research group. Six were female, two were male. All were Caucasian and their ages ranged from 25 to 32 years. All participants held undergraduate degrees in psychology, two held postgraduate academic qualifications. All were currently in their second year of training on the Clinical Psychology Doctorate Course at the University of Surrey.

Procedure
The participant researchers held a focus group lasting one and a half hours, this was videotaped.

The research question itself was defined over a series of initial discussions, this process is integral to the inquiry approach and is similar to that described by Reason (1988) as ‘contracting’ (see also introduction). ‘Contracting’ involves ‘managing the tension resulting from negotiation of expectations of different members’, this took place within the research group and also between the group and the course leader.

A list of topics was compiled to guide the focus group discussion. The rationale for the choice of topics is based on individual experiences of the RPG, the research base and the course documentation (see appendix five). Roles were assigned to each member before the focus group in order to facilitate the discussion (Reason, 1988) (see appendix six). A pilot study was not carried out since time was limited, and it was not thought relevant given that the research topics were self-generated and were thought pertinent by the participants.
The focus group was videotaped and copies were made of the tape. Approximately 12 minutes of tape were transcribed by each member of the group.

Materials
The focus group took place in a purpose designed video suite in the psychology department. The discussion topics were written on a white board for all the group to see.

Findings

Analytic procedure
A copy of the focus group transcript is given in appendix one. The Interpretative Phenomenological Analytic (IPA) procedure (Smith, 1996) was conducted over three meetings in a collaborative process involving all the group. The IPA approach is concerned with participants’ perceptions and accounts of a phenomena and recognizes that these are then shaped by the researcher (Smith, Jarman & Osborn, 1999). The procedure used in this inquiry comprised of reading and re-reading the script, first noting interesting or significant categorizations and then noting emerging themes. The analytic procedures and the process of the analysis are recorded in appendix seven. The presentation of the analysis uses excerpts from the transcript in order to illustrate the abstract themes with examples of the focus group discourse (Elliot, Fischer & Rennie, 1999).

Analysis
This section presents the findings of the analysis, there were three broad themes relating to the expectations and experience of the RPG. The full list of themes, sub-themes and examples is given in appendix two. These were ‘purpose’, ‘power’ and ‘process’. Only the overarching theme ‘purpose’ is described in some detail, this is because of limitations of space in this report. For a full list of the themes and sub-themes see appendix.

Theme one: Purpose
The first theme was ‘purpose’, this was originally named ‘searching for purpose’. This theme was omnipresent in the focus group and related to the two other main themes. For example,
an understanding of 'purpose' appeared as a basis for reflections on the 'process' (see theme two) and was seen to be an indication of the manifestation of 'power' in the group (see theme three). A diagram illustrating the relationship between these three themes is given in figure 1.

The examples of how 'purpose' appeared in the discussion ranged from a variety of concrete ideas (e.g. support group, therapy or criticizing the course) to ideas about social processes that determine 'purpose'. In the latter, 'purpose' was used to suggest ideas about socially negotiated meanings. These were thought to occur within the RPG, between the RPG facilitator and course team and between focus group and RPG. There were several sub-themes linking round this aspect of 'purpose', these included 'searching for a purpose', 'assumptions of purpose', 'higher meaning' and 'different levels of purpose'. An excerpt is given below to demonstrate several of these sub-themes as they occurred in the process of the focus group discussion e.g.:

P7: 'I was wondering if there was going to be a part of it that was about how we relate to other professions and what our role is in terms of the people that we're working with so thinking a bit more in terms of the practitioner... (...) ...where we were in terms of professional development.'
(example of 'purpose' being defined)

P8: 'There was sort of, some bits of that were touched on a bit, in terms of how you're seen as a trainee and how that makes you feel and how you think people perceive you because you're not actually qualified it did get discussed a bit but not maybe so much.'

P2: 'Do you think that, that that would be the purpose of it...to reflect on...?'
(example of 'searching for a purpose')

P7: 'No I just thought it would sort of come up, and I feel like it hasn't. I thought it would be sort of an on-going element of it and it's sort of indirectly referred to... I think.'
(example of 'purpose' being defined continued)

P1: 'If you were to write, say terms of reference for what the, for the purpose of the group what do you think they would be say if you were the course director?'
(example of 'higher meaning')

'Purpose' also encapsulated the sub-theme 'theoretical orientation'. The focus group considered on several occasions whether or not the RPG was experienced by its members as being a therapeutic group. Generally the theoretical orientation that was suggested was
psychodynamic therapy and this indicated the 'process' in the RPG also. The trainees experienced these RPG therapeutic situations as mostly negative and problem-focused with only very specific circumstances allowing for discussions of positive experiences. The participants' ideas about their emotional responses to the RPG were one way that ideas about 'purpose' were linked to the themes of 'process' and 'power'. Illustrative examples are as follows:

P3: 'There might be a theme for a week or two or even longer than that and then it will just disappear and it’ll take on a completely different characteristic and that’s not necessarily a bad thing but it does make you feel that you don’t know what is it appropriate what is it okay to bring up in the group, and also what do you feel comfortable about bringing up in the group.'

P1: 'Because there isn’t a set agenda and nobody’s ever said this is, this is what we’re going to be doing. There’s no lead. It is really lead by us.'

P3: 'But it’s never, we don’t lead it'

P1: ‘That’s because we don’t want to’ (laughter)
('Purpose' - links to 'power')

P1: 'I get a feeling that’s not the purpose that’s more what we use it for as opposed to what it’s meant for, I just feel that sometimes it just gets used as a platform for moaning about the course.'
('Purpose' – links to 'process' and 'power')

Figure 1. The main theme and its relation to power and process.
Theme two: Power

The second theme was 'power'. This theme recurred in both descriptions of individual and shared experiences of the RPG. 'Power' included the suggestion that the participants associated threat with their participating in the RPG. The sub-themes relating these fears were risk taking, uncertainty, loss of control, fear of size. 'Evaluation' was also a theme in discussions about 'power' and anxieties, the participants related this both to clinical work and to feelings about the RPG itself. In another usage 'Power' referred to relationships within the RPG, the facilitator, the roles of various members of the RPG and experiences of powerlessness. There was variation in the degree to which the participants felt able to change the discussion or bring in a new topic. This was explained in terms of whether they felt it appropriate or whether they perceived there to be covert rules in operation in the RPG. Selected examples of these include:

P6: ‘Sometimes the group is quite anxiety provoking ...it can be it can allow you to see what things you don’t like and can allow you to be more self-aware.’

P3: ‘You mean the things you can tolerate?’ (p14)

Uncertainty / insecurity/ safety.

P3 ‘I think it’s really difficult isn’t it to weigh up. Is this something that really needs to be brought out and it is helpful to talk to everybody about it, or is it one of those things that actually isn’t that big, but if I bring it up it turns into something huge... which is a bit scary and unhelpful, that’s what I am constantly struggling with in the group, should I open my mouth or not.’ (p7)

(Loss of control)

Theme three: Process (aka Group process)

The third theme was 'process'. The references made to 'process' in the discussion included cohesion, learning to tolerate and artificiality of the group. Examples of these are given below.

P4: ‘I felt a sense that lots of people in the group are sort of struggling or feeling a certain way so to sort of have that on mass although its a bit depressing can also be reassuring.’ (p6)

(Cohesion)
P2: One good thing about the group is that it kind of normalises your feelings or anxiety a bit, but then it does kind of make me feel a bit isolated when I don’t feel anxious about some things and then it just gets into the group and then I feel myself withdrawing (p7)
(learning to tolerate)

P8 ‘The fact that you don’t have any choice about being there makes it seem more artificial, that it’s. this is your time and you do feel you have to...you have to have things to talk about.’ (3)
(Artificial)

The theme of ‘process’ also included interactions in the RPG, roles and ideas about judging the facilitator, these linked to the theme of ‘power’.

P2 : I just wonder if that if the kind of interaction actually keeps certain people talking and actually that contributes to some people not saying anything.
(Interactions in the RPG - links to power)

P5: I think some people feel more responsible for guarding the group than others.

P8: What they... they feel or they is it that they feel more anxious with the silences? (17)
(Interactions in the RPG - links to power)

Furthermore, ‘process’ related to sub-themes on the use of metaphor and ideas about silence in the group. These were related, silence was one of the recurrent themes in the RPG. Metaphor was often used to make sense of silence occurring in the group e.g. when communication fails it was described as like it falling into a ‘chasm’ (13). This idea was also equated with the physical distance across the chairs in the circle. Silence was also viewed by some as problematic. It was viewed as an indication of conflict with the facilitator and suggest a psychodynamic orientation to the RPG.
Discussion

This discussion considers the validity of the study against criteria for evaluating co-operative inquiry and qualitative research. Then it briefly presents two theoretically based observations on the RPG.

The traditional separation of roles of researcher and researched is dissolved by the 'co-operative inquiry' approach (Heron, 1988) and this was evident in this study. In general, the study meets the validity criteria for 'co-operative inquiry' described by Heron (1988). The inclusion of feedback from the RPG on the research would increase its validity further with 'research cycling', this is planned to take place after this report is written. A criticism of this study might be that the commentary does not extend to how participants managed their personal motivations throughout the inquiry. It might be noted however that there was a sense of satisfaction among the focus group members at its conclusion. In the same way, a 'co-operative inquiry' project in health promotion reported an increase in self-esteem and reduction in the sense of isolation for its participants (Daniels & Coyle, 1993).

The co-operative inquiry itself can be regarded as an extension of the RPG. Negotiation and confrontation, the initial stages of co-operative inquiry described by Heron (1988) were reflected in the main themes that emerged in the analysis. In the literature on groups, problematic experiences have been explained under different theoretical frameworks as due to: a lack of a structure (Reid, et al., 1999), a stage of group formation (Yalom, 1995) and aspects of group dynamics (Stock Whitaker, 2001). Under Yalom's (1995) model of the formative stages of a group, the initial stage is of orientation, participants search for meaning and dependence; a second stage is of conflict, dominance and rebellion; a third stage, the beginnings of group maturity, is of cohesiveness. The descriptions of the RPG on several occasions reflected the beginnings of group maturity, however they also frequently represented the initial phases of group formation.

Reflective practice and psychodynamic based perspectives also provide useful interpretations of the RPG. The preoccupation of the group with 'purpose' and the frustration and confusion at the conflict experienced over this subject could be interpreted as a defense mechanism against reflecting on practice. This mechanism indirectly allows for emotive issues such as individual experiences of the RPG and feelings of responsibility to be ventilated. This interpretation of a defense mechanism provides a different perspective on Reid, et al.'s (1999)
finding that mental health staff report ‘lack of structure and agenda’ as preventing them from discussing problems and obtaining support from their group. Alternatively, Rifkind (1995) suggests that a groups’ experience of anger towards the group conductor is part of a process of moving from feeling understood to sensing self-efficacy. A theoretical implication of this study is that the definition of reflective practice (Schon, 1987; Irving & Williams, 1995) could be developed to hypothesize on its relationship to phenomena including intellectualization as a defense mechanism and conflict arising from a sense of powerlessness.

It is of interest that whilst was not explicitly presented as a therapeutic group by the course team, the discussion kept returning to this contentious theme. One interpretation of this is that it reflects the participants’ sense of powerlessness and of what it is like to be a patient. In the context of staff consultation groups, Rifkind (1995) describes these groups as an appropriate setting where members can safely communicate their experiences including powerlessness.

The practical implications of this inquiry are that the RPG was experienced as a learning exercise to some extent. In particular, whilst not therapeutic by definition it did provide experiences with which to compare a long-term therapeutic group, particularly in terms of problems of size. The group was less able to explicitly link the functioning of the RPG to their experiences of educational or personal development. This study makes tentative links between the RPG experience and ideas relating to reflective practice. The potential for use of ‘reflective practice’ as an additional frame of reference requires further exploration. This further research would benefit from an investigation using a qualitative approach because, as the introduction suggests, the theoretical basis for this reflective practice and wider questions encompassing staff support remain contested and lacking in coherence.
References


Appendices
Appendix 1. Sample from transcript

Note: Due to limited space in this portfolio a sample from the whole transcript is included here. This is the first half of the typed transcript. Permission to include the transcript has been given by members of the research group, contacted by e-mail.
REFLECTIVE PRACTITIONER FORUM - TRANSCRIPTION

DATE: 11th March 2003

PRESENT (Clockwise): P5, P4, P6, P2, P7, P3, P8, P1.

LOCATION: University of Surrey

P5: Is there a purpose to the reflective practitioner group?

GROUP SILENCE, SMILING AT EACH OTHER.

P5: LAUGHTER

P1: Well before we started the group did we think there was a purpose to it? (PAUSE, LOOK AT THE GROUP) Did we know why we were going to the group or was it just something on the agenda, something on the timetable?

P4: I think I thought it might have been a support group, erm, you know I'd experienced support groups in jobs before and probably what I had in mind.

P2: What do you mean by that type of group, support group?

P4: Erm... Well I suppose where a group where everyone talks quite a lot about particular issues and you might sort of decide on an agenda at the beginning, if you've had a problem with a client, you know I've done it in nursing teams essentially erm, and everyone's usually quite fired-up about it and talks erm...

P3: Is it kind of problem solving so if you've had difficulties with that particular situation whether it's client or not?

P4: Erm...

P3: Was that how it worked?

P4: Kind of but also not necessarily about problem solving more about, letting people get all the sort of emotions attached to working with that client out into the open really.

P8: So sort of a bit, maybe a bit like supervision in a way (P4: Yes (nodding))) but sort of serving the same function as supervision

P3: I thought is was going to be more like, like that but a bit more like therapy. (P8: mmmm). I thought that the ... either the group dynamics or the facilitator would take more of a therapy role, urm, I think that when I came to the first meeting of the group that made me quite resistant to it. I haven't got anything to be therapised about (group acknowledging laughter)...yet anyway. That's what I started off thinking that was all.

P8: I think I had, erm, I had yeah I had sort of I had these ideas that it was going to be very very American, and they'd be lots of people in tears and group hugs and stuff (GROUP LAUGHTER) which erm, yeah, which I don't, which yeah I err made me quite resistant didn't really, want to, yeah, want to have to do that (LAUGHING) or have to sit and I don't know then have to be present to be able to, I don't know...

P4: So it sounds as if our, umm, expectations gave us feeling about the group before we even got the group... (SOME AGREEMENT SOUNDS FROM GROUP).
P1: Yeah similar to you P4 I kinda thought there was going to be, I thought, I had quite a positive outlook on it, outlook? Expectations of it before hand, I thought it was going to be almost like a group supervision where anyone who wants comes up with something they find difficulty with and we all reflect on similar experiences and how we’ve overcome it, so it almost like a problem solving approach. I thought it was going to be quite useful (general laughter)...but (some laughter in group).

P3: Why are we all laughing?

P6: I thought it was going to be more bringing maybe cases, similar to support group, but maybe bringing cases that you wanted to discuss that you could find out how other peers sort of trainees would approach that case and maybe get a flip chart out and sort of more sort of presentations and a bit more active than it is.

P2: That’s exactly how I thought and I that made me really nervous about having to think about presetting in front of you know 24 people (P6: Mmm), and having to show your work it made me feel really anxious about that.

P6: Mmm.

P8: (To P6) Did you think it was going to be much more, I mean it sounds like people thought it would be much more to do with what you did on placement rather than sort of academic, the academic side.

P6: Yeah, I thought it would be more to do with our, bringing our placement experiences and sharing our sort of experiences rather than maybe moaning about the (??? UNCLEAR) of the Course.

P8: Mmm

P5: I think I thought it would be a small support group type group in that I’d experienced groups like that before and, but I thought it would be not only talking about client and difficult clients but also about how your personal life impacted on work and work on your personal life so I’d envisaged it would be a more personal but I think I realised that it can’t be like that because there is too many of us.

P3: I think I was frightened that it was going to be like that, which I felt was, it made me feel more vulnerable I think because of the size (P5: mmm), just as you (looking at P5) were saying (P5: mmm) it didn’t, it’s really not possible for it to be effective like that.

P2: Is that is that a sense of sort of trying to expose yourself as a person is that (LONG PAUSE), is that one of the reasons you felt worried?

P3: Yeah, it does seem very artificial because we’re going along once every two weeks, and then at that point you suddenly have to go into what are my problems-(PAUSE)-mode, what’s, you know, and, yeah, and it feels artificial and unnecessary sometimes.

P8: (To P3) And I think probably there’s, I think it even came up, and the fact that you don’t have any choice about being there makes it seem more artificial, that it’s, this is your time and you know, you have to, I don’t know, and you do feel that you have to, I dunno, you have to have things to talk about, and (P3: Mmm), that it’s not really (LONG PAUSE), I don’t know it doesn’t seem to, it never seems to start very naturally, well it’s always...(LONG PAUSE)

P6: Could you say a bit more about that?
P8: I don't know it just-makes-me-feel-like...you your, other people feel sort of under to pressure to say something, uhm, that they may not've (PAUSE), been, they may not've said otherwise (P6: Mmm (P6 & P4 nodding)).

P5: I wonder if it's interesting you saying about how it's a bit artificial and you go along and you have to, kind of, try and think about things to say and that, you know, we don't have a choice about being there, and, thinking about how that might be similar to how a client feels sometimes, and they have to come along and, not all of them have made a choice to come to therapy and, and uhm (P3: Yeah), and they may feels it's artificial that one hour a week they have to come along and talk about there problems...

P3: But mostly their more, they've either been at a position where they've wanted to come along in the past, or..., it's clearer who wants them to come along and why...(PAUSE), I don't know, it feels, it somehow feels even more, slightly different than that but I know what you mean there is some insight into that side of therapy for me.

P7: I was wondering if there was going to be a part of it that was about...(PAUSE), urm, how we relate to other professions, and what our role is in terms of, uhm, the people that we're working with so thinking a bit more in terms of the practitioner...

P3: Gosh that would be really interesting I hadn't thought of that (GENERAL AGREEMENT).

P7: So I was sort of thinking that they'd be err, yeah quite a variety of thing that we were talking about that they'd be an element of uhm, uhm, thinking about like sort of, where we were in terms of professional development.

P8: There was sort of, some bits of that were touched on a bit, in terms of what, you know, how you're seen as a trainee, and I remember that and how that makes you feel (P7: Oh yeah) and how you think people perceive you 'cos your not (PAUSE), actually qualified, it did yeah, it did get discussed a bit but not maybe...(PAUSE), (SOME AGREEMENT) so much.

P2: Do you think that err, that that would be the purpose of it...(PAUSE), (P7: Erm...) to reflect on...?

P7: No I just though it would sought-of come up, and I feel like it hasn't. I though...-I thought it would be sort of an on-going, yeah an on-going...element of it and...it's sort of, uhm, indirectly referred to (PAUSE), I think.

P1: If you were to write, say terms of reference for what the, for the purpose of the group what do you think they would be say if you were the course director, and you were to write down terms of reference? 'Cos I've got to say I'm still unclear (LAUGHING) (SOME AGREEMENT).

P3: Definitely. And it is like..., talking about uhm, themes that go through it, there might be a theme for a week or two or even longer than that and then it will just disappear and it'll take on a completely... different characteristic and that's not necessarily a bad thing but it (PAUSE) does make you feel that you don't know... what is it appropriate what is it okay to bring up in the group, and also what do you feel comfortable about bringing up in the group (P1 NODDING), 'cos it does so kind-of... floopy uhm.

P1: Because there isn't a set agenda (SOME GENERAL AGREEMENT), and there's no, nobody's ever said this is, this is what we're going to be doing. There's no lead. It's really lead by us.

P3: But it's never, we don't lead it...

P1: (INTERRUPTING) That's because we don't want to (LAUGHING).

TIME: 00:11:59
P2: So are you saying, are you saying that, uhm, that now the purpose of the group changes, sort of fluctuates or (PAUSE), what would you say the purpose of the group is? (UNCLEAR)

P3: I still don't know...really...(SOME AGREEMENT)

P8: What sort of...?

P3: ...and it, yeah, I think at the same time as not knowing I think it does fluctuate which I don’t know if that makes sense?

P6: Yeah (AGREEMENT).

P1: I, I get a feel, I get the feeling that's not the purpose that's more what we use it for as opposed to what it’s meant for, I just feel that sometime it just gets used as a, as a platform for moaning about the course.

P2: I completely agree with you, I think that that, that that’s my sort of experience at the moment (P1 AND P3 LAUGH, SOME AGREEMENT IN THE ROOM), is just people to come in and sound off about the course.

P1: And more than likely that's not the purpose that the course directors intended it for I’m sure (LAUGHING).

P5: Do you think that’s bad, do you think that’s negative then that that’s what we are using it for?

P1: I think it’s a good forum but I think, I (PAUSE)... It is probably a good, it’s good for us to use it as that I mean it’s nice to be able to do but then we can do that, in pairs or over lunch or...

P2: Uhm, I’m just wondering if it is a good forum, ‘cos you can sound off but it’s not a place where anyone can take that away because of confidentiality is it?

P1: Uhm, but but also you’re there and you’re you’re on the spot and you might not want to share your views with... 24 other people (SOME NODDING AGREEMENT).

P4: But on the other hand I'd, sort of thinking about slightly more positively, uhm, I do think they've been times when... the whole... group has, well not maybe absolutely everyone but, we’ve got a... I felt a sense that lots of people in the group are, are sort of struggling or feeling a certain way, so to sort of have that on mass, although that's a bit depressing can also be re-assuring (GENERAL AGREEMENT), you know, whereas on a one-to-one if you having sort of lunch with, one other person they might say ‘oh yeah I feel like that too’, but to actually hear that...(SOME AGREEMENT) (PAUSE) lots of people are...

P7: So do you mean it’s useful to sort of check out with other people how they’re feeling about...

P4: ...How they’re experiencing training...

P8: Well I think it is quite good ‘cos you're, because you are so isolated when you’re on placement really, in terms of sort of you know you don’t see people from one week to the next, and you don’t know, I...it is yeah, I I’ve found it quite nice to know that people are anxious about....or having problems with the same, sort of things as I am (SOME NODDING).

P2: But one of the best forms of sort of defence is just to avoid or, or just to avoid thinking about it, when you...don’t have to.

P8: Is that one of the best forms of defence?

P2: Well, well maybe not the best (GENERAL LAUGHTER)..., but but certainly a good way for me to, to get through it is to...
P8: Mmm...

P3: I think it's very difficult isn't it, to weigh up... is this something that really needs to be, brought out, and is it helpful to talk to everybody about it, or is it one of those things that actually isn't that big but if I bring it up, it turns into something huge (GENERAL AGREEMENT), which is a bit...

P7: Yeah (GENERAL AGREEMENT)...

P3: ...Scary and unhelpful, that's what I'm constantly struggling with in the group (GENERAL AGREEMENT), should I open my mouth or not? (GENERAL AGREEMENT) Is it worth it? (GENERAL AGREEMENT)

P7: I felt occasionally like I want to talk about an issue that something that everyone's experiencing anyway and maybe it's not something that, wants to be brought in, so you could be in that way increasing the anxiety by (P6: Yeah) (SOME NODDING)...raising it.

P8: Do you think it's difficult as well, considering because there are 24 of us, who have, and there's no sort of, there is no structure as to, or no agenda as to what this group, what the purpose of this group is, everyone's got, all 24 people have differing, differing ideas about what it is. It makes it very difficult for it to have (PAUSE), a purpose I think...

P6: I think 24 is a ridiculously large number (SOME AGREEMENT), and I think in any organisation it wouldn't be practical to discuss, you know sort of, issues to do with work and to do with the training, in a such a large size(SOME AGREEMENT).

P5: Mmm, but in my experience, as before with support groups have been a lot smaller, uhm, and that's kind of been a difficulty for me, and trying to put those experiences onto, to now and I think, that's why I've had difficulty using it, because of the number of people really (SOME AGREEMENT).

P2: I, I think uhm, also just going back a bit, uhm, about, uhm one really I mean one good thing about the group is that it kind of normalises, erm, kind of your feelings of anxiety a bit, but then it does, it does kind of make me feel a bit isolated when I don't feel anxious about some things, and then it just gets into the group, and then, I can feel myself withdrawing you know, and, and (PAUSE), I think for people who didn't feel anxious at certain times I think we all you know actually tend to sometimes, but, it can be quite a, quite like an isolating experience to me (SOME AGREEMENT).

P5: I'm wondering whether the other purposes that, of the group I think that has been mentioned in the group and I'm not sure who it as mentioned by Sally or by one of us, in that, urm it's to get an experience of being in a group, and the group dynamics (SOME AGREEMENT). I don't know what anyone makes of that?

P3: I don't agree with that 'cos I personally, am not a particularly experienced therapist but I would never run a group with 24 people (SOME AGREEMENT). So I don't think it is a very good experience actually.

P1: I'm just, kind of, added to that, that is the purpose to carry it on for three years (GENERAL LAUGHTER). I'm experienced enough it's okay.

P8: Do you think, I sort of feel like it's sort of, which I know has come up in the group, that it's a bit like, because we're the only (PAUSE), we're the only sort of profession with, you know, unlike counselling psychology or like psychotherapy we don't have therapy, and although it's not supposed to be therapy it's like, it's their way of, I don't know, of sort of if giving you, 'oh here's some time that you can, you know, if you have problems you can, you know you can sort of talk about it', and it's a bit like...

P3: It's a pacifier?
P8: Yeah I think they just, I don't know I feel a bit like...

P2: In your face.

P8: ... 'well there you are, and you can, this is the time, you have a facilitator and you can do what you want, you can use it how you want, and that's sort of what you get instead, because that's, that's what we can afford', you know what I mean, and I think that's a bit of a...

P5: Kind of 'that's your source of support, use it'. (SOME LAUGHTER)

P8: Yeah, but erm..., I feel a bit like that (GENERAL AGREEMENT). But then maybe that's a reflection of...

P2: Just a kind of add-on (SOME AGREEMENT).

P1: Do you think their facilitator has been given a role, a certain 'this is..., the agenda you're supposed to set this week, you're supposed to be doing?'. Do you get the feeling that's what's been said or what...? (GENERAL DISAGREEMENT SOUNDS).

P8: I don't feel like it is, she's trying to get you to, erm, I think she's trying to get people to talk, so she's facilitating in that way but I don't think she has any...

P2: She doesn't do a very good P5b of it....(UNCLEAR) does nothing. (GENERAL LAUGHTER).

P7: She makes interpretations sometime (SOME AGREEMENT, LAUGHTER).

P2: Which, which actually makes me shut-up rather than talk when she makes these interpretations.

P7: Why is that?

P2: Well I think it is...

P7: Becoming more aware of it or...

P2: I, I think it's going back to the...something somebody said about the group actually makes a problem a lot larger, I think P3 you were saying actually... kind of, kind of inflames upon them, so I just think that actually... part of that is her sort of interpretation. I feel that perhaps, that's sort of that process I don't know.

P7: So it feeds in to sort of hysteria of...potential hysteria of...

P2: (SNIGGERING) very good word, yeah...

P5: Just to say, do you think we're now talking about roles from purpose by the way... (GROUP AGREEMENT)...we've moved.

P2: Do people err, think that, that us as a year group have got closer, from the group?

P6: I don't think so...

P3: I wouldn't say it's a result of the group (SOME AGREEMENT)...

P8: No.

P6: Although there have been times in the group when, if once someone's had a particular problem and the whole group have shown their support then, it has felt like, perhaps we have grown closer but it...it's not maintained week-after-week that closeness...

P8: Not in the group...
P6: No.

P8: No I don’t think it is.

P1: I think generally we’re quite a cohesive group anyway, we’re quite, we’ve...we’ve bonded.

P3: But I think also it’s something that I’ve noticed from lectures and I think I’ve mentioned this in the group once, is that we’re not that kind of effusive or exuberant, you know everyone talking at the same time, even in lectures, and that comes across in the group as well. So... I don’t know whether this group would work better with a slightly different year that was more, erm, what’s the word, extravert? I don’t know... (SOME AGREEMENT),

P6: When you say work better...what would you...?

P3: Yeah, ‘cos I feel somehow it’s not entirely satisfactory now...

P6: Why?

P3: ..Because, you know we do turn up and we sit there in silence for a long time...

P2: But is that, is that something to do with us, or is it something to do with the, the context and the process of what... ?

P3: Both, I should think.

P7: Erm, I was wondering about the uh, the process over time as well, so have we got to a certain... stage in the group, because groups can have, can go through stages of development, and I was wondering, also whether, our deciding to have this focus group has had any effect on how things have been discussed in the Reflective Practitioner Group (SOME AGREEMENT).

P6: I think something’s are attributed to the Focus Group, that may not be, for example a silence in the group might be attributed to...fear of, speak you know, fear of speaking in case the Focus Group reflects on that, but I don’t always think that’s the case (SOME AGREEMENT).

P8: Does anyone believe that? Does anyone... agree with that?

P6: I don’t, no.

P8: I didn’t think it was... did you think it was that different ‘that’ week than...

P6: ...No.

P8: ...the week before?

P6: No.

P5: I think, I think there has been some slight shift and change in the group since we’ve started talking about this in that, one week we did spend a bit of a period of time talking about more process issues (SOME AGREEMENT), and thinking about the group and what it’s about and, people... confronting each other and things, those kind of process issues which I felt had never been touched on before (SOME AGREEMENT), and I was really interested in why they hadn’t been touched in before, and then they were brought in, and I’m really hopeful that they will be again after we feedback (SOME AGREEMENT). I think that’s been a shift.

P6 I think some things are attributed to the focus group that may not be for example the silence in the group might be attributed to fear of speaking in case the focus group reflect on that but I don’t always think that’s the case

P8 Does anyone believe that does anyone agree with that
I don’t think it was ... did you think it was that different that week with

No

With the time before

I think there has been some slight shift and change in the group since we started talking about this in that one week we did spend a bit of a period of time talking about more process issues thinking about the group and what it’s about and people confronting each other and those kind of process issues that I think hadn’t been talked about before and I was really interested in why they hadn’t been touched on before and then they were brought in and I’m really hopeful that they will be again when we feed back, (P3: mm). I think that’s the issue

So do you think this focus group could actually help the er.... wider group come to some opinion about what the purpose is?

Personally I don’t feel concerned at all about what the purpose I really don’t (P8: titter) um, I don’t care. I’m like we are there and we should make the most of what it is and whatever they the course saw for as a purpose that’s there area and we should just go with what we want to, a purpose could change every week and I feel that that is fine and acceptable and I’m not concerned about it. I think that this can will help the group to shift and move but

I think this might help cause it just might give I don’t know it might sort of focus people on different you know things to think about which I just don’t feel that there is really, well I don’t know from my personal (inaudible word) I just sort of sit sit there and think I just haven’t got there is nothing really that I want to talk about and then sometimes when something you know gets brought up then I will say something because then I think about something but then I’ve never gone there with a burning desire to discuss anything and when she you know when you get asked what is happening for people in this silence well there is nothing that I really have to say well there is not much really apart from thinking about what I have to do

Maybe that is the purpose for you

Mm

Reflecting on......

How much I’ve got to do

But thinking back about how um this group could be helpful and you saying it might be easier you know for people to talk in the group about the sort of purpose or the process and that sometimes it does feel in the group um that people don’t feel safe to talk and that could be just be me interpreting how I feel and I sort of a structured focus group outside of the group that has brought up these issues when we go to the group and this is raised its almost like a cue card we could talk about this now so I think it might be safer for people to talk about aspects of group

Yeh because you are not worried about I think it was you who said you were worried about whether it was appropriate to you know is this appropriate to I can’t remember who said it actually but whether this is appropriate to talk about or you know inappropriate or whatever because it is like we are going to talk about this

Its like we’re giving permission to certain topics by talking about them in this smaller group (P6: Yeh, yeh) (P2: oh right)

I still feel its something to do with the size of the group though because you haven’t got that same one-to-one interaction. I remember saying something once and it was about the process issues of when you say something and then you get this silence and you know whatever what
you just said falls into a chasm and I know that once I’ve said this it will fall into a chasm when no one will respond and I saw someone across you know all the way across the circle kind of make a bit of a face as if they were a bit surprised that I said that. Now if it had been a small group like this I would have been able to say well you know do you think that was right or don’t you feel that? But I just couldn’t because it was so big it felt it was all the way over there and you know how am I.... it felt very much that’s a judgement and I can’t touch it I can’t do anything about it (Group: sympathising noises) and it made me feel a bit quaky inside

P6  Yeh. And it does seem to be with this big space in the middle between cause there is so many of us there does seem to be it seems to be quite intense this space and quite, well to me it seems quite symbolic of quite a lot of sort of anxiety within that group

P5  Has anyone else noticed that sometimes when the chairs are slightly cause some weeks the chair are spaced a lot more wider and sometimes they seem a lot closer together and I don’t I don’t think it is always that less people are there but I feel I do feel really anxious when they are a lot more spaced out (P6: Yeh I do) and I do notice the difference that sometime we a lot more it feels a lot more tight knit and close and sometimes we’re it everyone can be seems even further away across the other side of the circle (Group shows agreement). Good its not just me then!

P1  I find that I get a really good one-to-one connection with the person who is directly opposite me whether its just eye contact or whether if they say something I can actually respond because their, they, I suppose have to look around this vast chasm

P2  Do you always find that it is often the same person? (Group laughs)

P1  It is quite often you (directed at P2)

P5  I often find that I sit opposite you (directed at P1)

P2  It’s funny how we are sitting opposite (directed at and pointing at P1)

Group laughs

P2  Yeh its really weird I feel that I make a strong connection with one person in the group which I don’t I don’t necessarily have outside of the group em, yeh, I find that quite interesting

P8  Yeh no I would have to agree thinking about it I find that quite often I end up sort of talking directly to one cause it is quite difficult cause you can’t talk to everyone its not like a presentation or (inaudible word) I think that is the problem with it being such a large group

P1  That you do have to focus on one person as suppose talk to whole group cause then it gets lost there

P2  And I just wonder if that if that kind of interaction actually keeps certain people talking and actually that contributes to some people not saying anything because

P3  Cause there are the usual suspects aren’t there

Whole group agrees

P6  And I find that um when I start talking that I talk to maybe someone that who I know that might respond (Group laughs: P3: Its true) someone who doesn’t look like they are asleep (Group laughs).

P2  You know you know I think that’s really important

P5  But that maintains the kind of who talks in the group by the fact that you know you are going to talk to someone you know there’s a higher chance of talking back to you
P7 Are you talking roles here?
P5 I think we might be
P2 I think we've moved on

Group agrees

P2 And I think...
P7 Does anyone want to say anything else about purpose, I don't know?

Silence

P6 I did have one purpose... I don't know (looking at white board) in terms of and I'll be quick.... in terms of personal development, I think that's one of the purposes of the group (Group: yeh, um)
P5 What do you mean personal development?

R In terms of although sometimes the group is quite anxiety provoking um in terms of the anxiety provoking experience of the group it can be it can allow you to see what things you don't like and can allow you to be more self-aware of ...
P3 You mean the things that you can tolerate?
P6 Yeh

P2 And and eh .. also sort of being able to talk in that environment I think a good experience (Group: yeh)
P1 I would use the same term as you (looking at P6) but probably describe it slightly different because I thought it would also be a bit of personal development but more academic development and that you were going to learn from it and I don't think I'm really getting anything from it aside from guilt in that I'm not doing anything better with my time (P6 agrees, group laughs)
P3 I don't feel that I learn that much from it

P6 In terms of um personally academically... in what way?
P3 ...both

P8 Do you think that do you have um... I mean I find that some weeks I do find it more useful than others and other weeks I don't find it useful at all (Group laughs)
P1 You mean that some weeks it goes quicker than others (Group laughs)
P4 Can I just ask if anyone um ... I don't know how quite to phrase it but if anyone sort of almost at times looks forward to the group and likes the sort of consistency

30:00

P5 Yeh I always look forward to the group a lot.... which I know is a different opinion to a lot of people

P4 Cause I do sometimes you know this varies for me but sometimes I do actually think I quite like the fact that every other Tuesday afternoon I know exactly, as we said the purpose seems to
change but for me it is now coming familiar whereas for a long time it wasn’t …. but I do feel there is something positive there for me

Pause

P2 That falls into a chasm doesn’t it

P8 I don’t feel like I go with any expectations because it because I don’t see although its consistent because of the time and you know the people I don’t feel that what happens in it is consistent so I don’t think I don’t go with any expectations cause I don’t think I every really feel like what’s its what’s going to come up...

P5 Maybe some of this of like anxiety that people experience is about their perhaps not being able to tolerate the not knowing and the fear of what that hour and a half is going to be (Group agrees) and that cause I’m guess I’m picking up from people about concerns about purpose and not knowing and how irritating that it is and but personally like I’ve said I’m really not focussed on purpose at all and never have been and I don’t know if that’s why I find it easier because I do go in there and I’m not really thinking about what’s it for and am I doing what I should be doing (P6: Yeh)

P2 Well then I also wonder if its also about knowing you are going be you know sitting there listening to people who might be quite upset and that might be quite anxiety provoking (P5: umm).
Appendix 2. Themes

A list of themes was generated. These were then grouped. The first session of grouping themes resulted in five themes, these were:

- Purpose
- Powerlessness
- Group processes
- Agency and impact of focus group
- Linking group to therapy

In the end we collapsed all the themes into three main ones. The three tables below gives each theme and its related sub-themes. For each sub-theme a limited number of examples from the transcription are shown, this is not an exhaustive list of examples from the transcription (the examples are indicated by page number followed by line number):

### Theme 1: Purpose

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<td>Search for orientation</td>
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<td>Clinician versus client.</td>
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### Theme 2: Power

<table>
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<td>Loss of control</td>
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<td>Uncertainty / insecurity/ safety.</td>
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<td>Powerlessness</td>
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<td>Theme 3: Process (aka Group process)</td>
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<td>-----------------------------------</td>
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<tr>
<td>Cohesion</td>
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<td>Artificial</td>
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<td>Judging the facilitator</td>
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<td>The silence (positive and negative)</td>
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<tr>
<td>Use of metaphor (chasm!)</td>
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<tr>
<td>Interactions within the group</td>
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<td>Agency for change</td>
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<tr>
<td>Impact of focus group on RPG</td>
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</table>

NB: These 3 themes can be linked in a model shown in figure 1 in the findings section.
Appendix 3. Process diary

Wk 1 (27/1/03)
Eight individuals on the course formed a group in order to research the Reflective Practitioner Group (RPG). It was noted that each had a personal agenda or motivations in respect to the issue, whether this was to experience the research exercise or learn about group processes or for other interests. Discussed research design, Adrian suggested co-operative enquiry. Agreed to carry out literature review. Brainstorm of questions.

Wk 2 (3/2/03).
Devised research question via a discussion and then a vote. The question was "To explore past and current expectations and experiences of the group process". Started to think about our motivations for doing this (** see below). Started to brainstorm areas to explore in the focus group (FG). Hypothesis was suggested that the research group would mirror the roles in the reflective practitioner group.

04/02/03
The research was discussed in the RPG itself and permission was gained from the group members to carry out the study. Care was taken to explain how confidentiality would be maintained. Some members of the RPG were reserved but there was also an expressed interest in the study and in feedback.

Wk3 (10/2/03)
From last weeks brainstorm, collapsed to make key topic areas. These were
"Roles (e.g. our roles in the group, participation)."
"Recurrent themes (e.g. laughter, process, content)."
"Theoretical orientation (e.g. facilitator, safety, agenda)."
"Group purpose" and "Personal learning and safety"

Wk4 (17/2/03)
Video use agreed on.
Discussed literature searches that had been carried out and who would order which articles. Each member of the group had independently researched a complementing area, the issues that arose are presented here grouped here under four topic headings, the discussion around each search topic took the following form:

Search 1. Group dynamics, support, stress and clinical psychology, trainee support groups.
Qualitative research and group processes.
At this point a discussion took place that recognized the idea that the focus group discussion was being influenced by having pre-discussions. In other words that this was part of the process.

Search topic 2. Psychologists reflecting on experiences and uses of groups.
At this point a discussion took place on ownership of the group, and whether the psychodynamic ‘hidden agenda’ was enforced by the facilitator.

Search topic 3. Clinical psychologists and reflection; reflective, professional and peer support groups.
Methodology of qualitative group research; peer groups.
At this point a discussion on facilitation and ownership of the group.

Search topic 4. Insider research and negotiating identity.
Reflective practice; group processes.
At this point a discussion on speaking in the group, vulnerability to questions and the facilitators comment about not speaking.

Wk 5 (24/2/03)
The group devised the roles:
Confidentiality monitor
Linking discussion back to research question.
Maintaining focus on topics.
Ensure all heard equally.
Bring in those who had not spoken for a while.
Keep time
Stop interruptions

Decided to have 4 topics, eliminated the last 2 from the list. A final fifth topic was added, this was - any other issues and reflection on the focus group. 20 mins for each topic and 10 mins for the 5th topic. Adrian recommended topics to be in form of key words to act as a guide to the focus group discussion rather than more prescriptive questions. The possible analytic procedure was discussed as being grounded theory analysis or interpretative phenomenological analysis.

Wk6 (3/3/03).
Put topics into order
1. Purpose.
2. Theoretical orientation.
3. Recurrent themes.
4. Roles in the group.
Revisited roles and allocated through random procedure (except P1).

P2 Confidentiality monitor
P5 Maintain focus on topics.
P8 Ensure all heard equally.
P3 Keep time
P7 Stop interruptions
P6 To be curious
P4 Linking discussion back to research question
P1 Technical support

Wk 7 (10/3/03)
Reassigned P1's role. As had technical support provided by dept. P1 shared P4's role – P1 focus on expectations whilst P4 focused on experiences. Focus group took place.

A note on experience of the group.
My personal experience of the group was that it seemed quite pressed although this did not seem to mean that peoples' comments were not reflective. Maybe it prevented developing and giving reflective space to each idea that someone put forward so that it could be explored to its full extent. To use a mapping analogy this is like mapping the peaks or the distant shapes of mountains without 1) the detail, 2) finding the routes between each. I wonder if we could have just discussed one of the topics. Although an overall theme seemed to emerge this being about the function/purpose of the group. It felt time limited us to exploring ideas and making a contribution.

Wk 8 (17/03/03)
Split transcription process between the 8 members of FG each transcribed approximately 12 minutes. Agreed to include verbal 'umms', 'errs', laughter, pointing at each other, and pauses longer than 5 seconds. 1st time we became aware of how being in focus group changed one's perception of RPG.

Wk 9 (24/03/03)
Brief discussion about the members' experiences of the transcription process. Problems of transcribing included volume of some peoples' voices, the time involved in transcribing from the tape.

Wk 10 (15.04.03) (full day)
Analysis of transcript. The group read the transcript aloud. This was difficult because it required multitasking. First each member of the group read the part of the person to their left in the group but this seemed to be too much of a distraction from the task of looking for codes and themes. The agreed method was for two people to read all parts in the transcript until a natural break in the dialogue and then the group stopped to discuss codes and themes saying what they found to be important.
It was noted that analyzing the transcript as a participant it was necessary to be aware of the need to keep to the script. There was a tendency to move on from the dialogue that had occurred in the focus group rather than keep to the task of analyzing it. In other words there was a tendency to discuss (explain what we had meant in the focus group) more than analyze.

A comment was made that the research was a way for each individual taking part of asserting independence from the group. A comment was made about use of metaphors. A comment was made about tendency to equate the group with therapy. The tendency to make assumptions/imaginings about the ideas of other RPG members was noted e.g. that not taking meant the person was not committed. Comment was made on difficulty of identifying emotion as it occurred in the focus group from the transcript. The discussion became briefer over time in the group. The handbook was referred to and it was decided that it infers the process of the group is therapeutic. There were some feeling of anger expressed regarding this confusion.

Wk 11 (22.04.03)(full day)
Analysis and listing of themes. The method for defining themes was to go through the transcript again reading out each name of those who spoke and stopping to discuss categories linking to themes as they came up. The second half of the transcript was divided in two and was worked on in two groups.

Wk 12 (28.04.03)
Collapsing themes. A list was compiled of all the main categories and themes

29.04.03
Collapsing themes continued. Each member of the group listed their top 5 themes made of amalgamated categories. These were discussed until the final 5 were agreed.

Wk 13 (11/05/03)
Discussing writing up and swapping chapters and journal articles.

Motivations of the members of the group in taking part in the research

P1: My motivations for taking part in the research were for an exploration of mine and other perceptions of the group in a hope of drawing some positive angel on attending and participating in the RPG.

P2: Motivation for the research was a feeling of frustration towards the group process not fulfilling its potential. Also, as the purpose of the group was not made explicit I wanted to gain a greater understanding of what the potential of the group might be. Finally, I suppose I thought my role in the
reflective group might have been one of challenger, and I wanted to extend this role further by doing the research and thereby challenging the group.

P3: Anyway, my motivation for doing the research was kind of similar to yours - I felt there were a lot of thoughts and opinions about the group which did not seem to have been made explicit. Certainly, I had some of these and had not told many people! I was therefore curious to know what others’ attitudes towards the group were as I did not feel they were sufficiently or comprehensively discussed in the group. Doing some research about the group seemed an ideal way to find them out! Secondly, I was interested in how we, as clinicians felt about the whole group experience, given we would presumably promoting such an approach in our future practice.

P4: To explore my own and others thoughts and experiences of the reflective practitioner group. I particularly was interested to know whether anyone had a clear idea of the purpose of the group as I was unsure myself!

P5: As discussed this afternoon - we agreed to email around our individual motivations for taking part in the research, so we could make them explicit in the write-up. I think mine is that I had noticed that a number of processes (both verbal and non-verbal) were occurring in the reflective-p group and felt unable to discuss them in that forum and thought it would be a good opportunity to talk about them.

P6: My motivation for doing this research was that I was curious as to the purpose of the group and wondered what other peoples ideas were about the purpose. Another reason was that I was finding the group quite a struggle and wondered what other peoples experiences of the group was. Unfortunately I felt that I couldn’t address these curiosities in such a large format as the RPG as I felt quite inhibited by it.

P7: My motivation for joining this research group was to join in with a discussion of insights on the RPG. As a member of the RPG, I was interested in helping develop an explanation of how the RPG is currently used and what the challenges are. I thought it also a good opportunity to consider the concept of reflective practice and how we can and do apply it.

P8: My main motivation for participating in this research was simply to find out how other people perceived the RPG, whether they were satisfied with how it was (which I was not) and if not how they would like it to be and how this might be achieved.
Appendix 4. Interview guide

1. Is there a purpose to the group?

2. Are there roles in the group?

3. Are there recurrent themes?

4. Is there a theoretical orientation?
Appendix 5. Rationale for interview guide

1. Purpose to the group
   - There appears to be no shared understanding in the Reflective Practitioner Group of its purpose.
   - The purpose of the group has been a point of discussion in the Reflective Practitioner Group.
   - Some individuals expressed the need to know the purpose and how they found it difficult that they were so uncertain.
   - The research literature review did not bring up an obvious model.

2. Theoretical Orientation
   - Is the facilitator shaping the group?
   - Why has the theoretical orientation not been made explicit?
   - Should there be a theoretical orientation if the group is not designed to be therapeutic?
   - Individuals in the group may bring their own orientations and roles.
   - Does the theoretical orientation serve an academic purpose, to increase our learning and knowledge?

3. Recurrent Themes
   - Recurrent themes have been experienced.
   - How, why and what are the recurrent themes about?
   - Recurrent themes may help to describe the group.

4. Roles
   - Individuals expressed personal interest in their own roles and how they had come about.
   - Roles may help define expectations
   - The social psychology literature indicates that roles are intrinsic to group formation, was this the case for the Reflective Practitioner Group?
Appendix 6. Roles

- Monitor confidentiality
- Maintain focus
- Probe on the research question (by focusing on expectations and experiences of the RPG)
- Ensure groundedness (defined as keeping questions open, being alert to assumptions and shared meanings)
- Ensure all are heard equally
- Bring in those who have not spoken for a while.
- Keep to time
- Stop interruptions
Appendix 7. Description of the analysis

1. The analytic procedures
1.1. As a group decide on how to transcribe (i.e. to include ums, hmms and to indicate pauses where they last more than 5 seconds)
1.2. Each member of the group transcribes approximately 12 minutes of the video tape.
1.3. Each member of the group familiarize themselves with the transcript by reading and re-reading.
1.4. As a group read the transcript together two people reading alternate parts. Other members of the group noting codes in the left-hand column of text as the text is read. Stopping at a natural break of three or four minutes to discuss each members’ codes.
1.5. As a group working from the beginning of the transcript identify emerging themes to describe groups of codes via discussion of each page of the transcript. These were marked in the right-hand column of the text.
1.6. Each member to consider how they might tentatively arrange themes.
1.7. As a group decide on and define main themes and decide on their interrelationships.
   The aim of this stage is to condense data with a focus on the main phenomenon that emerged in the inquiry.
1.8. Individually produce an account of the meaning of the participant’s experience the group emerging in the inquiry process.

2. The analytic process
The analytic method for going through the transcript was developed in the process of the analysis by the group. For example, it was a distraction from the text to have all members of the group reading, therefore pairs of the research group members took turns to read all parts aloud to the group.

The allocation of codes and then of themes was a lengthy process taking two days. This was because the process was made collaborative with all members giving their interpretations of the text. Whilst it was recognized that the analysis was a continuation of the research process of the group, care was taken to keep to analysis and interpretation of the text. Where diverging discussion of the research question occurred this was noted.
Major Research Project

Information Processing and Motivation in Eating Disorders

July 2004

Year 3
Abstract

Background
Motivational approaches are shown to produce an effect on treatment outcomes for people with eating disorders. Studies of information processing biases provide support for evidence based cognitive behavioural treatment models. This study explores the link between motivation and emotional processing in people with eating disorders.

Aim
To determine whether people across motivational stages of recovery from eating disorders differ in their levels of disorder salient information processing biases and problems with emotional processing (alexithymia).

Design
A between groups design comparing people who have low levels of motivation with those with high levels of motivation on measures of information processing.

Method
Twenty-eight patients were recruited from an eating disorders service. The participants completed the dot probe task on a computer to assess for information processing. Self-report measures for symptoms of alexithymia, motivation, eating disorder symptoms and general psychopathology were completed. Data was collected at an appointment lasting approximately one hour.

Results
No significant differences were found between participants grouped for motivation on the dot probe task. Participants with low motivation reported significantly more alexithymia symptoms and significantly greater psychopathology than participants with high motivation. A modest, significant correlation was found between reaction times for positive weight stimuli on the dot probe task and difficulty in identifying emotions, a subscale of alexithymia. A modest, significant correlation was found for reaction times for positive emotion stimuli and negative weight stimuli on the dot probe task and externally orientated thinking, also a subscale of alexithymia.
Conclusion

This study found that emotional processing was related to level of motivation in people with eating disorders. Motivation indicates the person’s state of recovery from eating disorders that includes overcoming difficulties in emotional processing, that are characteristic of the disorder, as well as cognitive and behavioural psychopathology. An alternative interpretation of the dot probe data was developed to speculate on general effects on information processing in response to weight/shape and emotion stimuli.
1. Introduction

1.1 Summary

People with eating disorders have a range of symptoms including difficulty in emotional functioning. These people report problems with experiencing emotions that can be demonstrated through difficulties with naming emotions. For example, in experiments, on information processing tasks people with eating disorders show interference in processing responses to weight, shape and eating related stimuli and also to emotion related stimuli compared with control groups without eating disorders.

There is preliminary evidence to suggest that motivation is a predictor of therapeutic change in people with eating disorders. This study examines whether these differences in information processing biases correspond to differences between people with eating disorders, in terms of their level of motivation to change.

This literature review will provide background information on cognitive, emotional and motivational perspectives on eating disorders. It will not cover other explanations for eating disorders in any depth. The review will cover in detail empirical studies of information processing among people with eating disorders. It will focus on making links between these perspectives.

1.2 Overview

People with eating disorders experience a range of behavioural, cognitive and emotional symptoms. These include characteristic ‘dysfunctional’ styles of cognitive and emotional functioning. These symptoms are manifest in extreme avoidance behaviours (Schmidt, Bone, Hems, Lessem & Treasure, 2002) and high ambivalence to change (Ward, Troop, Todd & Treasure, 1996). Controlled experimental design studies have found high levels of response specificity to type of threat stimuli in people with eating disorders (e.g. Waller, Watkins, Shuck & McManus, 1996; Jones-Chesters, Monsell & Cooper, 1998; Rieger, et al., 1998). Cognitive models of eating disorder psychopathology suggest that this response specificity reflects patterns in the way that information is processed. Processing biases have been identified for stimulus information with themes of weight/shape, food and emotion (e.g. Cooper & Fairburn, 1992; Jones-Chesters, Monsell & Cooper, 1998; Rieger, et al., 1998; Seddon & Waller, 2000).
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An evidence base supports the cognitive model for eating disorders. However, various psychological processes have been proposed to explain the symptoms found in people with eating disorders. The response to an emotional state is found in several of these explanations. From a psychodynamic perspective emotional dysfunction is thought to underly eating disorders. It is thought to act as a protection of the ego from negative affective states. Other psychological processes are suggested in behavioural theory. Operant conditioning, is a mechanism whereby eating disorder symptoms work to block out negative affect and are positively and negatively reinforced by the consequences of their action. Classical conditioning is another behavioural process proposed, such that symptoms block out emotion and are acquired through paired association. Dissociation has been proposed as a mechanism, in that the eating disorder provides an escape from emotion. For example, eating disordered behaviours such as binging, restricting food intake, vomiting and taking excessive exercise are thought to have an effect on the sufferer that is dissociative in quality and therefore provides relief from psychological distress.

There is preliminary evidence to support the use of a motivational approach to working with people with eating disorders. Level of motivation has been shown to predict therapy outcome (Wolk & Devlin, 2001). The concept of motivation has been applied in the transtheoretical stages of change model (Prochaska & DiClemente, 1982; Prochaska & Norcross, 1999) and it has been used to form a therapeutic intervention for people with eating disorders (Treasure, et al., 1999). There is no published information available on how high levels of ambivalence, for example, relate to the established literature on information processing in eating disorders.

This study integrates ideas on motivation and information processing. The aim of the study is to examine the cognitive and emotional processing biases found in people with eating disorders and to determine whether these are associated with their level of motivation to change. For example, people in the action stage who are addressing their symptoms might show more interference in processing compared to people who are in the contemplation stage who are not active. The study builds on the existing literature on information processing and attempts to make links with clinical observations. It is possible that these findings will provide new information on specific interventions to be targeted at the stages of recovery from eating disorders, for example, by suggesting when one type of effect on information processing is greatest.
1.3 Cognitive behavioural models of eating disorder psychopathology

The eating disorders are classified under the DSM-IV (American Psychiatric Association, 1994). The eating disorders include: Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorders Not Otherwise Specified (EDNOS). The behavioural symptomatology for AN are: restrictive eating, excessive exercise and laxative use. In addition to these symptoms, for people with BN the behavioural symptomatology include binge eating and vomiting. People with eating disorders have characteristic ‘dysfunctional’ styles of cognitive and emotional functioning. Examples of these dysfunctional cognitive styles are thought distortions relating to weight and to shape. These are considered to be diagnostic features for the eating disorders.

1.3.1 Cognitive behavioral models

The cognitive behavioural model (CBT) for eating disorders has an evidence base as a causal model and as an effective treatment (e.g. Fairburn, et al., 1995; Agras, et al., 2000;). The model focuses on the role of characteristic behaviours and cognitions in maintaining the disorder (Fairburn, 1997). The central tenet of the model is that specific attentional biases have a role in the causation and maintenance of eating disorders. For example, attention to weight and shape information results in negative self-related evaluations and associated, elevated levels of negative affect and eating disorder behaviours. This in turn influences the allocation of attention to weight and shape information and causes a vicious circle of psychopathology.

The evidence from treatment studies for eating disorders suggests that the effectiveness of the revised, manual-based CBT model is limited (Wilson, 1999). For example, 40-50% of people treated with CBT recover from their symptoms (Wilson, 1999; Wilson, Fairburn, Agras, Walsh & Kraemer, 2002).

The research on eating disorders suggests that difficulties with emotional regulation are experienced across the disorders (Wilson, 1999). Among the several requirements for revisions to the CBT model is a call for a more comprehensive understanding of the role of emotional factors, for example, their role in preventing change. Explanatory models for eating disorders that fall within the broad bio-psychosocial framework, commonly refer to self-related threat and emotion variables. Susceptibility to social pressure to be thin seems to be a theme across eating disorders and may link to underlying mechanisms of self-related threat (Fairburn, 1997; Wilson, 1999). People with AN are reported to have difficulty in self-
regulating and coping with emotions, this is called interoceptive awareness (Miller, Redlich & Steiner, 2003). A recent study provides evidence that starvation in AN functions by disconnecting links between physiological response and affect, thereby avoiding emotionally uncomfortable states (Miller, Redlich & Steiner, 2003). The starvation model of BN suggests that dietary restraint, food craving and binging become a self-maintaining cycle through physiological and cognitive mechanisms (Fairburn & Cooper, 1989). The adapted negative affect model of BN explains evidence for dietary and dietary-depressive subtypes of BN and these behaviours are thought to counteract negative emotion (Grilo, Masheb & Wilson, 2001; Meyer, Leung, Feary & Mann, 2001; Stice & Fairburn, 2003).

1.3.2 Limitations of CBT models for the eating disorders
A number of limitations of the CBT model are described in the literature applied to eating disorders. Several of the limitations are suggested to in the previous section and they are summarized here:

1. The CBT model is primarily a causal and maintenance model and therefore describes the factors associated with these functions rather than being a model primarily designed to explain treatment and recovery.

2. Its application to therapy is based on the assumption that effective therapy works by challenging the dysfunctional thought patterns that maintain the problem in order to treat the symptoms. It does not explain the mechanism of other aspects of treatment.

3. It does not predict all symptoms of the eating disorders.

4. It does not account for the role of emotional factors that behaviours are thought to counteract.

5. The evidence for the efficacy of CBT for eating disorders is thought to represent limited success (e.g. 40-50% of patients recover).

1.3.3 Rationale for studying emotion within CBT models
The original version of CBT designed for depression does not account for emotional regulation as it is viewed in this version as an indirect product of the therapeutic approach
In eating disorders, affect changes to account for eating behaviours, such as binge eating are not emphasized by the CBT model. A recent modification to the original CBT model is the inclusion of an emphasis on referring to changes in affect. For example, a focus on 'hot cognitions' is described by Beck (1995) and Greenberger & Padesky (1995). Hot cognitions are defined as thoughts and beliefs that are flagged up by changes in affect.

1.4 Recovery from eating disorders

This investigation examines the role of cognitive and affective dysfunctional symptoms in relation to peoples' recovery from eating disorders. The study empirically tests hypotheses on the relationship between emotion, cognition and motivation that originate in the literature on clinical observations of psychotherapy (Safran & Segal, 1996).

1.4.1 Rationale for studying recovery from eating disorders

Several reasons for studying the processes of change in an individual's recovery from the eating disorders are cited throughout this introduction. They are summarized here:

1. To explain what is needed for a shift in emotional experience to occur.

2. Evidence provided from randomized controlled trials shows preliminary support for the efficacy of motivational approaches that focus on change.

3. Motivational approaches have been used to inform a treatment approach for eating disorders. This may possibly differ from theories of cause and maintenance and it is in development.

4. The fragmented factors and causal pathways presented in multi-dimensional models of eating disorders form a less than pragmatic approach to studying processes of change.

5. Investigations of recovery are in line with current trends to revise CBT that seem to refer to processes of change (e.g. hot cognitions).

6. To contribute to the continual revision of the CBT model.
7. To help determine where a person is with their recovery to facilitate the therapeutic alliance.

8. Investigations of recovery may complement deconstruction approaches and meta-analytic approaches that aim to identify effective ingredients of therapy.

9. Investigations of recovery reflect meta-cognitive approaches whereby thought processes, rather than content, are emphasized.

Attempts to identify the processes underlying change are a recurrent theme in the psychotherapy literature in general. These processes are described theoretically as "middle level abstraction". That is, they fall between global theories (e.g. behaviourism) and clinical techniques (e.g. progressive muscle relaxation technique) (Prochaska & Norcross, 1999). Empirical methods have yet to be developed to assess these phenomena in vivo (Rachman, 1980; Wilson, 1999). Procedures that evoke a processing response in the person are often used as an approximation but they do not necessarily represent a process of change. The stages of change and the processes of change, such as emotional processing, form the main elements of the transtheoretical model (Prochaska & Norcross, 1999). The model attempts to represent where the person is in terms of their recovery.

No studies have examined emotional processing at the different stages of change among people with eating disorders. This study uses an experimental design and self-report measures to approximate emotional processing and then compares this across different levels of motivation.

1.4.2 Emotional processing

Integrative models describe affect and cognition as sharing a cognitive structure, they relate to meaning and they are automatic (Greenberg & Safran, 1987; Safran & Segal, 1996; Teasdale, 1999). Cognition is thought to link to emotional processing and hence to affect. Complete processing of emotions is thought to result in a shift in an individual's characteristic emotional experience (Greenberg & Safran, 1987). Processing information such as ideas about the self, at a high level of experiencing, is thought to be related to good therapeutic outcome (Safran & Segal, 1996). This processing entails invoked feeling rather than intellectualizing and appraising.
Emotional processing is a non-specific term with different applications in the literature (Rachman, 1980; Greenberg & Safran, 1987; Teasdale, 1999). In a review of eating disorders, Wilson (1999) defined emotional processing as ‘directly experiencing the distress’. He related this to the activation of a schematic level of cognitive organization. Rachman (1980) defined emotional processing, among people with anxiety disorders, as the ‘ability to absorb a disturbance that then declines and then allows the individual to return to undisrupted behaviour’. Teasdale (1999) defined effective emotional processing in a model for depression, as a ‘short lived and self limiting’ response to internally affective stimuli. His interacting cognitive subsystems (ICS) model emphasized the difference between specific meanings at lower levels of the model and a schemata level, mental model of experience that directly produces emotion. The model relates to the persons changing awareness of and relation to their thoughts as opposed to thought content.

An improved understanding of emotional processing is required (Rachman, 1980; Greenberg & Safran, 1987; Safran & Segal, 1996; Teasdale, 1999). Greenberg and Safran (1987) suggested that emotion has a central role in psychological adaptation and that psychological problems are experienced in the blocking or avoiding of emotional experience, that are of relevance to eating disorders. In the modified CBT model for eating disorders, behaviours such as purging and restriction are thought to function partly as compensation and avoidance, because of difficulties in emotional functioning.

Attempts to observe the role of emotional processing in therapy were reported by Pos, Greenberg, Goldman and Korman (2003) from analyses of transcripts from the treatment of depression. They concluded that emotional processing had a role in cognitive appraisal and ultimately in adaptation. The authors speculated that for better outcomes, the improvement was generalized and that low improvers processed on other themes to avoid or divert attention from their core themes.

Summary
The clinical literature on emotional processing is potentially relevant to understanding the action of treatments that aid recovery from the eating disorders (Wilson, 1999). In the eating disorders literature there is particular interest in the avoiding and blocking functions of emotional processing as representing adaptive responses to emotion. Therapeutic techniques to tap into emotion related phenomena are increasingly found in CBT, an example of this is ‘hot cognitions’.
An effective means of assessing emotional processing has yet to be developed, although a range of methods have been adapted for this purpose. This investigation will employ the information processing framework that is commonly used to evaluate processing of threat stimuli combined with self-reports, in order to fully assess emotional processing.

1.5 Empirical studies of information processing

The information-processing framework is an established area of study in cognitive science. It has been applied in clinical studies to inform the cognitive approach to understanding emotional disorders (Williams, Mathews & MacLeod, 1996). These authors report that studies of specific phobias, generalized anxiety and other psychological disorders have found that people attend selectively to information specific to their disorder. These findings have been presented as evidence for biased or dysfunctional processing of selected information in emotional disorders (Beck, Emery & Greenberg, 1985). It is suggested that individuals perceive, attend to, remember and ruminate on information that is specific to the problem (Dalgleish, et al., 2003). The effect found in these studies is called a cognitive processing bias and this term has been used interchangeably with emotional processing bias. In general, this research has demonstrated the specificity of cognitive biases in terms of cognitive processes and stimulus content that is processed preferentially. This is thought to indicate the activation of schema (e.g. Dalgleish, et al., 2003). In the case of eating disorders, a bias in processing is thought to be exacerbated by information related to food, shape, weight and emotion. This is thought to effect mood and in turn enhance mood related biases, resulting in the maintenance of cognitive and behavioural symptoms.

A set of information processing tasks has been designed to assess attention. Other aspects such as memory and rumination will not be covered here. Attention is defined as the 'modulation of processing between competing processing pathways' (Williams, Mathews & MacLeod, 1996). The connectionist-learning model has been used to explain these findings (Cohen, Dunbar & McClelland, 1990). Williams, Mathews and MacLeod (1996) conclude that there is evidence for notions of current concern and danger schema. These are explained in the model in terms of sub-processes of activation and the concept of resting activation levels of different 'input units'. The paper suggests that long-term concerns can be understood as expertise in processing information.
1.5.1 Information processing tasks

The three main task procedures are the ‘stroop task’ (Stroop, 1935), the ‘dot probe task’ (MacLeod, Mathews & Tata, 1986) and the ‘dichonic listening task’. The modified ‘emotional’ stroop task is the most commonly used task (Gotlib & McCann, 1984) and is a measure of task selection. It provides an indication of selective attention for colour naming over word reading operations. The dot probe task measures the spatial allocation of attention between threat and control stimuli by means of latency in response to a neutral probe. The dichonic listening task measures channel selection between competing sources of verbal information. These tasks measure the magnitude of interference of a stimulus on reaction time on a neutral task.

The main findings from stroop task studies of people with eating disorders and people with non-clinical levels of eating disorder symptomatology are summarized below:

1.5.2 Stroop task findings with the eating disorders

The most consistent findings from studies using the stroop task with people with eating disorders are of evidence for selective processing of information related to eating, weight and shape for people with BN (e.g. Fairburn, Cooper, Cooper, McKenna & Anastasiades, 1991; Cooper, Anastasiades and Fairburn, 1992; Cooper & Fairburn 1992). Compared to females with non-clinical levels of symptoms, these people showed significantly greater interference indicated by slower colour naming for these disorder salient words. Cooper and Fairburn (1992) found selective processing of information relating to eating and weight for people with BN and AN, and also with shape words for people with AN. These authors reported that this pattern was associated with severity of purging but not with other psychopathology.

1.5.3 Stroop task sensitivity to therapeutic change

The stroop task has been used to assess for changes in information processing speed after treatment with psychotherapy. It is found to be a sensitive assessment tool in eating disorders (Cooper & Fairburn, 1994) but with some discrepancies among reported studies. These authors and Carter, et al., (2000) reported that people with BN performed significantly faster for naming food and body words after psychotherapy relative to their performance before treatment. However, the latter paper reported that the improvements in processing speed were not specific to word type and were also found for control words. Black, et al., (1997) found that after treatment patients were significantly faster at naming food, control and colour words
but not body words. They reported that improvements were not related to treatment response. Carter, et al., (2000) concluded that the use of the stroop task as a measure of change should be questioned. It might be argued that it is the counterintuitive task of naming colour words that results in interference. It is also a task that does not translate easily to naturalistic situations and so is not a useful comparison. However, counter to this, it is argued that an inadequate analysis is made of the patient’s response to treatment in these studies to warrant a full rejection of the stroop task at this stage. For example, few of these studies specify types of symptoms and how these relate to changes on the stroop task, eating disorders are characterized by an array of symptoms. These authors used a simple dichotomy of abstinent/not abstinent for treatment outcome. There seems to be sufficient evidence for the stroop being associated with improvements in symptoms post treatment to warrant further investigation.

1.5.4 Stroop task with emotion stimuli

Studies of information processing tasks that have included emotion related stimuli show mixed results. Jones-Chesters, Monsell and Cooper, (1998) found interference for naming negative emotion words among patients with BN but not for patients with AN. They found interference for food/eating and weight/shape words across diagnostic groups. They noted that for naming emotion words the difference was found only when similar stimuli were presented consecutively therefore representing an amplification of the processing bias. The authors observed that, people with BN and AN show ‘broadly equivalent disorder-salient stroop effects’. They noted that people with BN in this study were significantly more dissatisfied with their weight and shape than people with AN who were more likely to be near to their slimness ideal. The paper found that the stroop effect correlated with severity of eating disorder symptoms in these people. Sackville, et al. (1998) reported that people with AN showed no interference in processing emotion words compared to control words. They found interference on processing for both thin physique and large physique words and a lesser effect for food words.

1.5.5 Stroop task with non-clinical populations

Studies of people with non-clinical levels of eating disorder symptoms also give evidence in support of information processing biases for threat and emotion stimuli. Non-clinical samples of female dieters and females with bulimic attitudes indicate evidence for biases with different types of self-related threat (Waller, Watkins, Shuck & McManus, 1996; Quinton,
A preliminary study of threat stimuli including: sociotropy threat, autonomy threat, physical threat, ego threat from others and ego threat from self was reported for females with BN (Waller, et al., 1996). The authors suggested that greater interference in response to stimuli invoking 'ego threat' from self (i.e. self-directed criticism) was related to elevated levels of bulimic attitudes. They explained this as a representation of an attentional bias towards threat stimuli and that this was an indication of schema elaboration for self related threat. A study comparing general threat related stimuli (e.g. harm) with neutral information found significant information processing biases that were related to level of bulimic attitudes only among dieters and not controls (Quinton, 1998). Increased latency for negative emotion stimuli was found among a non-clinical sample of older women with bulimic psychopathology compared to younger women with similar symptoms (Seddon & Waller, 2000). They explained this as attentional bias towards the stimuli. The authors also found reduced latency for negative and positive valenced emotion words in younger women. They explained this as cognitive avoidance. They speculated that processing biases may differ depending on the person’s age. This study requires substantiation because of its small number of participants, for example there were seven people in one sub-group.

1.5.6 Dot probe task with the eating disorders

The dot probe task requires that the individual viewing a computer screen makes response, as quick a they can, to a neutral visual probe following a visual presentation of a word pair. The person is instructed to read the upper word of the word pair aloud each time. The response times are collected for each word pair. There are four conditions that relate to the relative positions of the stimulus and probe appearing on the screen. An overall interference index can be derived from response times on the dot probe task (MacLeod, Mathews & Tata, 1986). The interpretation of the interference index used here is based on Dalgleish, et al., (2003) working with a range of emotional disorders. The index score is described as a visual measure of spatial allocation of attention. It indicates the direction and magnitude of interference in response times. A negative interference score on the dot probe task indicates an interference whereby attention is moved away from the position where the stimulus was shown and towards the other word space. A positive interference score indicates a differential influence whereby the individual selectively attends to the part of the screen where the stimulus was shown, maintaining their attention on the word space. A score of zero is a finding of no effect of the stimulus on the latency for detecting the probe and responding (Dalgleish, et al., 2003). This study explores alternative explanations for what the data for
each condition mean. This issue relates to the current status of the attentional bias paradigm that is discussed in the next section.

The dot probe task was used with people with eating disorders in a study by Rieger, et al. (1998). They reported on people with AN, BN and people from the general population who the authors classified for dietary restraint. New to these studies, the authors separated shape, weight and emotion related words into negative (e.g. fat) and positive (e.g. thin). The authors found that large physique words were associated with faster processing, indicated by positive interference scores. They interpreted this as attention directed towards the stimulus. They found thin physique words were associated with slower processing, indicated by negative interference scores. The authors interpreted this as attention directed away from the stimulus. Their explanation was that slower processing indicated avoidance of certain stimuli. They suggested that this pattern of responding has the function of maintaining schema congruent concerns about fear of becoming fat and resisting counter-schematic information, such as words related to thinness. They reported a trend approaching significance for faster detection of probe indices for negatively valenced words and negative emotion words over positively valenced words and positive emotion words. They reported that each of these effects were not found for a sub-group showing high restraint among either BN or AN sufferers and they found no significant differences between the diagnoses. One criticism of this interpretation is that, as with the dot probe literature in general, response times were not examined for individual conditions. For example, interference scores that were close to zero would be found where effects were strong but were counterbalanced in the formula for the interference index. The interference index measures a shift in attention but it does not account for the possible effect of reading the stimulus word aloud. This issue is explored in the study reported here.

1.5.7 Other measures of information processing

A novel design used a categorization task where competing visual stimuli are presented to study participants with non-clinical levels of symptoms of eating disorders (Viken, et al., 2002). The study found that people with high non-clinical levels of symptoms classified images of people by body size rather than by their facial expression. They suggested that attention is organized around classification of weight, shape and eating information. The authors argued that interference in processing indicates elaborate schema. They suggested that among people with these symptoms the schema structure is undifferentiated for emotion information (Vitousek & Hollon, 1990; Viken, et al., 2002).
Summary

On the basis of theory and clinical observations of people with eating disorders, the general findings are of biases for food, weight and shape. There is limited evidence for the correspondence of these biases to different levels of symptom severity and to changes in response to psychological therapies. Several studies report biases for emotion related stimuli among people with eating disorder symptoms. In relation to this, findings from a non-clinical sample of people with eating disorder symptoms suggest preliminary evidence of a role for self directed threat to the ego.

1.5.8 Current status of the attentional bias paradigm

Questions remain as to the utility of the attentional bias paradigm in research on the psychopathology of emotional disorders (Dalgleish, et al., 2003). Several of these questions feature in the eating disorders literature on information processing as well as in the general literature, the following issues remain:

Definition of measured phenomena

Studies reporting on the dot probe task tend to report the interference index score (Mathews, MacLeod & Tata, 1986). The interference index is generally thought by researchers to indicate an attentional bias either towards or away from a stimulus. It has been explained as a response to the activation of cognitive schema. However, this interpretation does not explain the measure fully, for example, a more precise definition may be that the dot probe task assesses location of attention at a point in time, rather that a shift in attention (Dalgleish, et al., 2003). The individual is required to read a word aloud at the beginning of the task as a procedure to locate the person’s attention. A potential criticism of the dot probe task is that the effect of reading the stimulus word aloud is not accounted for. For example, research on the stroop task suggests that the use of verbal processing resources would interfere with the processing of visual word stimuli. This aspect of the dot probe does not appear to be discussed in the literature. One alternative to the task design would be to use a neutral probe at the beginning of the task to anchor attention (e.g. a dot in the middle of the screen). However, this study will follow the usual procedure for the task and the effect of reading the stimulus word when it appears at the top of the presentation will be evaluated.

On the stroop task, interference in processing speed has been interpreted as indicating an impairment in information processing (Fairburn, et al., 1991). The specific biases have been
explained as representing a schema elaboration for specific threat information rather than indicating a general anxiety induction model (Waller, et al., 1996). Faster processing speed found among a non-clinical sample of younger women with bulimic symptoms has been interpreted as cognitive avoidance (Seddon & Waller, 2000). This evidence has been used to argue that bulimic attitudes and behaviours have a specific function to reduce awareness of threat stimuli (Quinton, 1998). This cognitive pattern has been compared among clinical and sub-clinical levels of bulimic symptoms to the concepts of dissociation and escape from awareness (Heatherton and Baumeister, 1991; Waller, et al., 1996; Quinton, 1998).

**Measure of pathology**
The question of whether information processing tasks should be used as sensitive, objective measures of psychopathology and treatment response in people with eating disorders is referred to in literature reviews (e.g. Fairburn, et al., 1991).

**Level of consciousness**
The question of the level of ‘consciousness’ at which components of information processing such as selective attention occur relates to the current status of the information processing model. Studies of people with anxiety disorders have attempted to examine subliminal processing (Mogg, Bradley, Williams & Mathews, 1993) or pre-conscious attentional biases (Williams, Mathews & MacLeod, 1996) using masked stimuli, these are stimuli shown for a few milliseconds and then replaced with a neutral image. In a review report on the emotional stroop task, there was evidence for subliminal biases (Williams, Mathews & MacLeod, 1996). For example, subliminal attention allocated to negative stimuli was found among people with diagnosed anxiety disorders (Mogg, et al., 1993). These findings have not been replicated consistently (Thorpe & Salkovskis, 1997). There seems to be some evidence that state anxiety does not impact on response times and that relevance of threat, rather than the salience of the stimuli in eliciting emotion was being measured on such tasks. In relation to eating disorders, a study of people with AN found no effect for a masked condition (Sackville, et al., 1998). The preliminary evidence suggests that strategic rather than automatic allocation of attention is elicited with the stroop task (Thorpe & Salkovskis, 1997; Sackville, et al., 1998).

Related to this, studies of binge eating that involve inducing eating in response to cues have found that avoidance of affect and cognitive mechanisms involving the activation of representations are implicated (Waters, Hill and Waller, 2001). The cognitive model explains
binge eating as a response to restriction. There is growing evidence to suggest that this behaviour and its physical, cognitive and emotional consequences have a role in the regulation of affect in response to an emotional state.

**Ecological validity**
It has been questioned whether these studies can be taken to be equivalent to or even relate to responses to real stimuli (Thorpe & Salkovskis, 1998). The selection of word stimuli is an issue. For example, emotion stimuli vary between studies and often seem similar to threat specific information. For example emotional words may include 'crash' (Watts, et al., 1986) general threat words such as 'harm' (Waller, et al., 1996; Quinton, 1998). Certain studies request the patient rate the emotionality of the stimulus words as a controlling factor.

**Empirical evaluation**
The scientific evaluation of the most established information processing task, the modified stroop task is incomplete. There is evidence for test-retest reliability (Eide, Kemp, Silberstein, Nathan & Stough, 2002). These authors suggest that its application is based on the theoretically based assumption that mechanisms for emotion resemble cognitive processes. The authors reported that competing models have suggested that emotions are processed under a qualitatively different neural pathway. Counter to this, it might be argued that interest in 'hot cognitions' as intervention techniques in cognitive psychotherapy, indicates links between cognitive focused and emotion focused approaches.

**Summary**
The attentional bias paradigm has been researched for several decades. Its interpretation remains problematic. Its face validity as a potential measure of inaccessible processes is one reason why the interest in it is ongoing. The mechanisms for information processing biases are unknown. Selective attention has been explained as representing the activation of cognitive schema elaborated for a specific threat. In people with eating disorders, avoidance and biases for selecting non-threatening stimuli have been variously interpreted, for example as representing undifferentiated schema for emotion.
1.6 Self-report studies of emotional processing

In this section alexithymia will be described. The research evidence on alexithymia will be summarized and related to the research question.

Alexithymia is defined as a subjective phenomena consisting of self-reported problems, including difficulty in processing emotion (Bagby, Parker & Taylor, 1994). It has origins within psychosomatic medicine (Nemiah, Freygerger & Sifneos, 1976). Alexithymia has a demonstrated three-factor structure that includes: difficulty identifying feelings, difficulty describing feelings and characteristic externally-orientated thinking (Bagby, Parker & Taylor, 1994). It is thought to reflect problems in the adequate development of complex cognitive schema and linguistic forms of representation required in order to appraise states of arousal.

The relationship between alexithymia and emotional processing capacity has been assessed in a study of students using the stroop task (Parker, Taylor & Bagby, 1993). The authors reported that participants with alexithymia showed greater interference for emotional word stimuli (e.g. sad, anger, disgust) than non-alexithymic participants. They hypothesized that the stimuli evoke emotional arousal. They suggested that interference indicates disrupted attention as explained by competition for cognitive processing resources, activated schemata related to the stimulus and the emotion it evoked. They offered the explanation that people with high levels of alexithymic symptoms have poorly differentiated, inflexible or un-integrated schema and hence poor capacity to modulate response to emotional material. The relationship between these phenomena among people with eating disorders has not been assessed as yet.

Alexithymia was reported among people diagnosed with eating disorder symptoms matched to a non-clinical sample of students. Alexithymia was associated with psychological traits of ineffectiveness, interpersonal distrust, interoceptive awareness and maturity fears among people with AN in this study (Taylor, Parker, Bagby & Bourkes, 1996). Alexithymia was not found to be related to cognitive and behavioural symptoms of eating disorders. That is alexithymia was not associated with attitudes and behaviours relating to eating, shape and weight. Therefore among people with eating disorders, alexithymia may indicate aspects of how feelings are worked with that are not accounted for in cognitive and behavioural symptom assessment. Troop, Schmidt & Treasure (1995) also reported that individuals with eating disorders scored significantly higher on alexithymia sub scales for identifying their feelings but did not differ from controls in externally orientated thinking or operational

It has been suggested that alexithymia can predict treatment outcome. People with high levels of alexithymic symptoms respond poorly to interpretive psychotherapies. Alexithymia has been compared to the construct of ‘psychological mindedness’, a predictor of outcomes in interpretive psychotherapy (Bagby, Taylor and Parker, 1994). An alternative explanation is that alexithymia shows similarities with self-awareness and ability to tolerate non-schema consistent processing that are encompassed by the concept of cognitive dissonance (Festinger, 1957). Cognitive dissonance is the psychological state resulting when two cognitions, attitudes, beliefs or emotions, are contradictory.

1.7 Motivation

The therapeutic mechanisms of treatments for eating disorders are an ongoing area of research (Vitousek, 1996). People with eating disorders are particularly characterized by ambivalent attitudes. By examining the processes underlying these attitudes it may be possible to increase the efficacy of existing treatments.

Motivation to change has become a focus for interventions used in the early stages of treatment for eating disorders (Ward, et al., 1996). Motivation is commonly assessed as the person’s behavioural intention or their attitude towards changing specific behaviours.

Theoretical models such as the stages of change model and interventions such as motivational interviewing have their origins in addictions research. Motivational interviewing (Miller & Rollnick, 1991) is a therapeutic intervention that is brief, directive and it focuses on eliciting behaviour change. It uses a series of techniques to explore and resolve ambivalence within the context of a supportive therapeutic alliance. The authors who devised the approach suggested that the motivational discrepancy, between real and idealized self can precipitate behaviour change.

The transtheoretical model, also known as the stages of change model, is an evidence based model of motivation (Prochaska & DiClemente, 1982). It is an explanatory model. The stages described in the model are pre-contemplation, contemplation, preparation, action and maintenance. Different therapeutic approaches are thought to be appropriate for each stage.
The causal constructs in the model are decisional balance and self-efficacy. These causal factors are found in assessments of motivation in people with eating disorders (Rieger, Touyz and Beumont, 2002). In clinical assessments the researcher has observed that discussing readiness to change eating disorder behaviours with clients often elicits responses from the client that are charged with emotion. From this one hypothesis is that increased motivation in the early stages of treatment may act by amongst other things, facilitating emotional processing at some level. Motivational discrepancy (Miller & Rollnick, 1991) is the ability to tolerate non-schema consistent processing, this may be based on cognitive dissonance (Festinger, 1957). Cognitive dissonance can be characterized by heightened self-awareness, emotion and reactivity. It is possible that compared to the pre-contemplation stage, in the action stage a person may exhibit less alexithymic symptoms and more distraction for food, weight, shape and emotion words.

The patient’s stage of change is found to predict behavioural responses to certain forms of psychotherapy for adolescent and adult patients with eating disorders (Wolk & Devlin, 2001; Gusella, Butler, Nichols & Bird, 2003). A process dimension of the stages of change model has been developed to indicate the therapeutic approaches that are appropriate to each stage. For people with eating disorders, in the pre-contemplation and the contemplation stages a cognitive focus is indicated (Marlotte, et al., 2000; Treasure & Ward, 1997). In the action and the maintenance stages a behavioural focus is indicated. ‘Motivational enhancement therapy’ (MET) has been adapted for people with eating disorders. There is reported preliminary evidence of its success in the treatment of eating disorders with outcomes comparable to other treatments (Schmidt & Treasure, 1997; Treasure, et al., 1999). Although, one study comparing treatments reports motivation outcome to be highly related to improvement and the therapeutic alliance, that is, the relationship between therapist and client and not related to a specific treatment type (Treasure, et al., 1999). The effective components of MET are not tested for by these authors. A possible explanation at the level of cognitive and emotional processing is that interventions such as MET may be effective because they change the quality of the schematic representation (whether via elaboration, differentiation or integration) whilst only evoking a tolerable level of emotional content. In this way they may enable non-schema consistent processing. Another explanation is that they modulate the attentional biases directly. The therapeutic alliance may achieve this effect in some treatments.

Individuals with eating disorders have a presentation that includes a range of behavioural symptoms so the available generic measures to assess for motivation have limited application for this population. For example, an individual with bulimia nervosa may show greater variability in motivation to give up binge eating compared to motivation to give up weight
control behaviours (Treasure, et al., 1999). These authors note that appropriate assessment tools to assess the features of these disorders are currently in development. An 'algorithm' for determining stage of change was shown to be sensitive to change among people with eating disorders (Wolk & Devlin, 2001). It was shown to be an outcome predictor for people with BN who complete treatment, although it did not predict those who dropped out of treatment. These authors found an association only for interpersonal psychotherapy but not cognitive behavioural therapy. They speculated that this is due to the prior effect of peoples' expectation for motivation enhancement and symptom change that characterize CBT. However this was a small scale study and these simplified measures should be used with caution (Rieger, Touyz & Beumont, 2002).

A self-report questionnaire to assess motivation in AN is in development, it includes questions that relate to symptoms of BN (ANSOCQ; Rieger, et al., 2000; Rieger, Touyz & Beumont, 2002). In terms of decisional balance, change seems to be found among individuals in action stage. They report significantly lower avoidance coping to minimize negative aspects of life and lower perceived benefits of the eating disorder, such as its providing a sense of control (Rieger, et al., 2000).

There is limited evidence for a direct relationship between measures of symptom severity and stage of change. The ANSOCQ was not associated with clinical measures of severity given as BMI, length of illness or previous admissions or self reported behaviours in general such as binge eating and laxative abuse (Rieger, et al., 2000). The exception was that there were significant, modest association with frequent exercise, purging and general distress. The ANSOCQ has similar associations with eating disorder symptomatology to those reported for alexithymia (Bagby, Parker & Taylor, 1994), although the ANSOCQ is not associated with maturity fears. The ANSOCQ correlates strongly and significantly with drive for thinness, and body dissatisfaction it correlates modestly with asceticism and social insecurity. There is evidence to suggest that longer illness may leave an individual anywhere on the cycle of the stages of change (Towell, Woodford, Reid, Rooney & Towell, 2001).

There is evidence to suggest that the stage of change at the beginning of therapy is related to outcome and is a better predictor than some measures of symptom severity. Treasure et al. (1999) found that people with BN in the action stage benefit from therapy most with no significant difference between CBT or motivational approaches. The stage of change predicted improvement from severity ratings made at baseline by staff where as symptom severity in terms of body image disturbance and eating disordered behaviour on admission were not predictors of improvement (Wolk & Devlin, 2000). Compliance is an indication of
level of motivation on admission that is related to outcome but not to therapeutic change (Towell, et al., 2001).

1.7.1 Link to cognitive behavioural models for the eating disorders

In CBT, emotion is used as a source of information, whilst the focus of the therapy is on modifying thoughts and beliefs. CBT provides an indirect means to altering emotional processing. The deeper cognitive structures are called schema, they are based on early experience resulting in beliefs and thus have a role in the cause and in cognitive and behavioural maintenance mechanisms. The elaborated CBT model suggests that beliefs are triggered by certain stimuli and that they result in 'hot cognitions' (Beck, 1995). Hot cognitions are described as thoughts or images that generate negative affect.

It may be that in the pre-contemplation stage and the contemplation stage, with low motivation a person would display minimal interference in information processing and higher levels of alexithymia. This would explain the use of motivational interventions and monitoring emotion at this stage. In the action stage, with high levels of motivation comes a higher level of emotional processing, demonstrated by greater interference in information processing and lower levels of alexithymia suggesting the use of techniques that include working with hot cognitions. These ideas are represented in simple form in figure 1.

Summary

To summarize, motivation has been shown to be useful in treating eating disorders. Its effect has been considered in relative isolation from cognitive behavioural models and biopsychosocial frameworks to explain the eating disorders. Motivational dissonance may share characteristics with cognitive dissonance. Its effect is thought to be related to schema and emotional processing, although motivational interviewing techniques are described as a cognitive and problem solving based approach. In line with this, the relationship of motivation to affect has not been a focus of study in relation to the cognitive behavioural model until recently, although it is referred to in the clinical literature. Motivation might possibly be viewed as a process variable that can be taken to mean the current status of the person in relation to emotional processing demands.
Figure 1. A simple cognitive model for the eating disorders annotated with italics to suggest the characteristics of processing at high and low levels of motivation.

Early experience

Core beliefs

Trigger e.g. internal cue or external stimulus

Hot cognitions and activation of schema

**High motivation**

*Emotional processing*

*Attentional bias towards stimuli / Low alexithymia*

**Low motivation**

*Intolerance of affect*

*Avoidance of stimuli / High alexithymia*

*Behaviours related to avoidance and blocking of affect*

*Disorder related cognitions for weight, shape and emotion*
1.8 Study rationale

Cognitive theory suggests that, at a schematic level, models of self are affectively charged. Attention to affect has been incorporated as a standard cognitive technique, for example, working with hot cognitions. Innovative methods that are in development for working with the affective system via enactive and exposure therapies have been linked in the literature to a theoretical understanding of emotional processing (Wilson, 1999; Teasdale, 1999). There is evidence to suggest that emotional regulation has a central role in the psychopathology of eating disorders. Separate research on emotional processing and alexithymia in individuals with eating disorders has supported this with finding characteristic patterns.

Whilst the explanatory models for eating disorders have predictive power they have limited therapeutic efficacy. Motivational strategies have been included in treatment procedures to improve engagement in therapy recently. There is evidence for their predictive power over the power of symptom severity as a predictor of outcome. This seems pertinent since clinical observations suggest that ambivalence towards change maybe closely linked to eating disorders symptomatology through various emotional and cognitive mechanisms.

As part of explaining the role of motivation in people with eating disorders, an account of how it links to established cognitive models is required. Empirical research is one avenue for generating evidence from which to build these theoretical links.

This investigation aims to examine the potential for a complex relationship of emotional processing to different levels of motivation across individuals with eating disorders. It may be that those with low levels of motivation, in the pre-contemplation, the contemplation stage and the preparation stage, are detached from their problems. They might display avoidance of emotive information and more alexithymic symptoms. Individuals in the action stage may engage more readily with emotional issues. These individuals with high levels of motivation might display more interference in information processing and less alexithymic symptoms. In the maintenance stage, representing recovery from the eating disorder, individuals may show less interference for emotion related information. In this way, the study may indicate discriminatory markers that could suggest the patterns representing, for example, the experience of the person who is active in addressing their symptoms.
The aims for this study are:

1.) To assess the correspondence between motivational stage of change and processing of emotion related information, measured via the dot probe task and via self-report on the alexithymia scale.

2.) To determine the relationship between naming and experiencing emotions on the alexithymia scale and response to emotion-related stimuli on the dot probe information processing task.

The main hypotheses for this study are:

1.) There will be a significant difference in information processing on the dot probe task between people with eating disorders grouped by stage of change such that: i.) those with low motivation will show less interference on information processing, ii.) those with high motivation will show a greater interference in information processing.

2.) There will be a significant difference in alexithymia symptoms between people with eating disorders grouped by stage of change such that: i.) those with low motivation will show high level of difficulties in emotional functioning on the alexithymia scale, ii.) those with high motivation will show a low level of difficulties in emotional functioning on the alexithymia scale.

3.) Level of emotional functioning on the alexithymia scale will correlate positively with level of interference in information processing on the dot probe task among people with eating disorders.
2. Method

2.1 Design

The study used a between-groups design. The independent variables were the type of threat word, and position of the threat word and the dot probe that follows it. The dependent measures were response time on the dot probe task and alexithymia. The independent variables were the stage of change, eating disorder symptoms, depression and self esteem.

2.2 Participant selection

The sample of 28 participants were recruited via two Specialist Eating Disorders Services. Patients currently attending the eating disorders service who had on admission been diagnosed with an eating disorder meeting DSM-IV criteria were invited to take part. Exclusion criteria were applied. Patients under 17 years of age were excluded from the study. People without English as first language and those with severe visual impairments were excluded. Those participating in other research were excluded.

2.3 Participants’ characteristics

The participants comprised of females aged between 18 years and 61 years. Eleven had a diagnosis of bulimia nervosa and 15 had a diagnosis of anorexia nervosa, two were diagnosed with eating disorders not otherwise specified.

2.4. Materials

2.4.1 ‘Dot Probe’ task

The computerized ‘dot probe’ task (MacLeod, Mathews & Tata, 1986) entailed a series of trials, each consisting of a visual stimuli followed by a neutral task. The participant read from either a pair of ‘neutral’ words or a pair of ‘neutral’ and ‘threat-related’ stimulus words presented on computer screen. They were then required to make a neutral response by pressing a key, in reaction to a neutral stimulus, the dot probe appearing on the computer screen. The stimuli were word pairs of either threat words or control words paired with matched neutral words. The types of threat words were positive emotion, negative emotion, positive weight/shape, negative weight/shape or neutral. The attentional bias effect of a
stimulus display of threat-related words on response times was then calculated. In this study weight/shape and emotion-related words were used as the threat-related cue.

The 80 threat-related words and matching neutral words that were presented were derived from previous research by Rieger, et al. (1998). See appendix one for a full list of the words. These included 20 from each of positive emotion (e.g. happy, cheerful), negative emotion (e.g. sad, upset), positive weight and shape (e.g. athletic, dainty) and negative weight and shape (e.g. flabby, bloated). Each threat word was matched to a neutral word of the same word frequency and length. A further 40 neutral word pairs were made by matching neutral words reported from various studies in the literature to neutral words similar in length and frequency that were derived from British vocabulary frequency lists (Jonhansson and Holland, 1989). Sixty neutral word pairs were presented as filler trials in the study. These were chosen at random from the list of 40 word pairs to avoid repetition of word pairs for any participant. A total of 140 word pairs were presented to each participant.

The experiment ran on a Toshiba Satellite Pro 460 Computer (lap-top) with built in monitor screen. A mouse was attached and used as the response key for the task. E-Prime software (Psychology Software Inc. 2002) was used to present the experiment via a computer programme, written by the researcher for this study using manuals for E-Prime (Schneider, Eschman & Zuccolotto, 2002a; Schneider, Eschman & Zuccolotto, 2002b).

A stimulus display was presented in the form of a word pair (letter-string stimuli), separated on the vertical axis of the screen by 3cm (MacLeod, Mathews and Tata, 1986; Dalgleish et al., 2003). The stimulus was displayed for 500 milli seconds (MacLeod, Mathews and Tata, 1986; Rieger et al., 1998). This was followed by a visual probe, in this case a cross ('+'), appearing in the position of either the top or bottom word, 20 ms after the word pair display ended. Participants were asked to respond as quickly as possible by 'clicking' the mouse key when they detected the visual probe on the screen. The probe display was terminated when the participant responded or 3000 milli seconds after the previous word pair ended. Half the filler trials were presented without visual probes, that is, a blank screen followed the stimulus display for 1000 milli seconds instead of the visual probe. All words were of height 8mm, printed in black capital text on a white background. The participant was presented with a display on the centre of the screen ('ready') until they clicked the mouse key. A 2000ms interval followed before each word pair was presented.

The one hundred word pairs that were followed by dot probes were presented at random. Five word pairs from each type of threat word and five word pairs from the neutral words
were presented for each of the four conditions for the position of the stimulus and probe. The four conditions were: 1.) stimulus up, probe up; 2.) stimulus down, probe up; 3.) stimulus up, probe down; and 4.) stimulus down, probe down. The further 40 filler word pairs without dot probes presented were randomized for position of words in the upper or lower area of the screen. The software was set to ensure that for each participant a full randomization was made for order of presentation across all the lists to eliminate the possibility of order effects.

2.4.2 Measures

**Dependent variables**

The *Dot probe interference index scores* for word stimuli. The properties of this measure are discussed in the introduction.

The *Toronto Alexithymia Scale* (TAS-20; Bagby, Parker & Taylor, 1994) is a 20 item self-report inventory used to measure alexithymia. Factor analysis has derived three subscales: 1.) difficulty in identifying and distinguishing feelings and bodily sensations, 2.) difficulty communicating feelings and 3.) externally orientated thinking. Across clinical and non-clinical populations it has good internal consistency and test-retest reliability (Bagby, Parker & Taylor, 1994). The scale has strong convergent and concurrent validity and 'modest support' was reported for its discriminant validity (Bagby, Taylor, & Parker, 1994).

Among people with eating disorders the TAS-20 is found to have high concurrent validity in relation to the Eating Disorders Inventory (Taylor, Parker, Bagby & Bourkes, 1996).

**Independent variables**

*A general demographic questionnaire* was designed for the study and included a question on ethnicity taken from the 2001 census question. The information collected included age, gender, years in education and age the eating disorder began according to the participant. The participant's weight at the interview and their height were recorded on this questionnaire.

The *Anorexia Nervosa Stages of Change Questionnaire* (ANSOCQ; Rieger, et al., 2000) is a 23 item self-report questionnaire with each item scored from 1 to 5. A total mean score can be used to determine which of the five stages of change the person is reporting on. The items represent different symptoms in AN and BN and they can be grouped to form sub scales. It is a measure in development and psychometric properties of these sub scales are not reported. It
has demonstrated good internal consistency and test-retest reliability, predictive validity and concurrent validity (Rieger, et al., 2000). It has good construct related validity when compared to generic measures to assess constructs related to motivation or readiness to change (Rieger, Touyz & Beumont, 2002). It was used with a bulimic as well as anorexic sample in this study because, given the overlap between these disorders the measure includes items that encompass the range of symptoms for bulimia nervosa.

*The Beck Depression Inventory (BDI-II; Beck, Steer & Brown, 1996)* is a 21 item self report questionnaire to assess the person’s subjective experience of depression symptomatology in the last two weeks. It is a well established measure with excellent psychometric properties in clinical and general populations (Arnau, Meagher, Norris & Bramson, 2001).

*The Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1979)* is a 10 item self report scale that assesses feelings of self worth and competence. There is evidence for the RSE having discriminant validity (Rosenberg, 1979) and convergent validity as it correlates highly with another self-esteem measure (Robson, 1989). It is used as a second indicator of depression in eating disorders as self esteem is thought to be a central feature of the psychopathology (Stice & Agras, 1999; Grilo, Masheb & Wilson, 2001).

*The Eating Disorders Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994)* measures symptoms of eating disorders including related attitudes and behaviours in the last 28 days. It is in evolution as a measure and it has 4 sub-scales these are: restraint, weight concerns, shape concerns and eating concerns.

The EDE-Q has good psychometric properties of reliability including test-retest reliability (Luce & Crowther, 1999, Rizvi, Peterson, Crow & Agras, 2000). Compared to the established investigator interview version of the EDE it shows close agreement except on the ‘difficult to define’ eating disorder behaviours, in particular binge eating (Fairburn & Belgin, 1994). There is a tendency for over-reporting symptoms on this version particularly for binge eating and shape concern (Passi, Bryson & Lock, 2003), although for binge eating disorder studies show either under reporting of binge eating (Wifley, Schwarty, Spurrell & Fairburn, 1997) or significant correlations on binge eating scores (Grilo, Masheb & Wilson, 2001).
2.5 Procedures

2.5.1 Ethical Approval

Approval for the research project was given by the North West Surrey Research and Development manager. Ethical approval for the study was given by the North West Surrey Ethics Committee and the University of Surrey Ethics Committee (see appendix two).

2.5.2 Recruitment procedure

They each received a written invitation to take part in the study (please see appendix three). The information included a statement indicating that choosing not to take part would not affect the normal course of treatment. The invitation came from a clinician at the service with whom they had had some form of contact (e.g. assessment, intervention).

2.5.3 Experiment procedure

Participants were given information about the study and they were given a signed consent form to keep, (please see appendix four for a copy of the information sheet and consent form).

The instructions for the study were based on previous dot probe studies and were presented on the computer screen at the beginning of the experiment. A practice trial with 4 word pairs was given prior to the experiment and the instructions were repeated if the participant wished. It was explained that the experiment would run without a break although if required they could rest when the word ready was on the screen. The experiment was then conducted. The duration of the experiment was approximately 12 minutes. The instructions stated that two words would appear on the screen and asked the participants to read the top word out aloud for each pair of words (Dalgleish, et al., 2003). The instructions stated that some word pairs would be followed by a small cross in either the lower or upper area of the screen and that their task was to respond as quickly as possible when they saw the small cross on the screen by clicking on the mouse (Dalgleish, et al., 2003). Between each word pair the word ‘ready’ would appear on the screen and the participants were required to click the mouse when they were ready to proceed.

Participants sat approximately 50 cm in front of the computer screen, the angle of the screen was adjusted to suit the participant. They were asked to rest their dominant or preferred hand on the mouse key.
The participants were then asked to complete the questionnaire measures described in the measures section. For copies of the questionnaires used, see appendix five. The researcher was present throughout to answer any questions. Each participant took part in the study at a single appointment of approximately 1 hour.

2.6 Analysis

The participants' response times on the dot probe task were recorded by the 'E-Prime' software. This information was merged using the 'E-Merge' and 'E-Data-Aid' programmes in the 'E-Prime' software. The questionnaire scores, the response times and response accuracy data were inputted to a statistical software database (SPSS 11.1 for Windows).

An interference index is a measure of direction and magnitude of interference on a neutral task (i.e. clicking the mouse button) following exposure to a threat stimulus. It was calculated for each of the five word conditions, that is the four threat word conditions. A score was calculated for the difference between a lower and upper probe for the neutral word condition. The interference index was calculated using a formula by MacLeod, Mathews and Tata (1986) as follows:

$$\text{Interference index} = \left\{ \frac{(\text{upper probe/lower threat stimulus} - \text{upper probe/upper threat stimulus})}{2} + \frac{(\text{lower probe/upper threat stimulus} - \text{lower probe/lower threat stimulus})}{2} \right\}$$

The distributions of the data were checked and where necessary or, according to the distribution of the data non-parametric tests were used. Cross tabulations were used to compare categorical information (e.g. demographic information). T-tests were used for between group comparisons (e.g. comparing different stages of change for: BDI-II, RSE, EDE-Q, Dot Probe score and TAS-20). A correlation test was used to examine the relationship between continuous variables, for example between the Dot Probe score and TAS-20. Continuous data were then analysed with analysis of variance or step-wise regression analyses.
3. Results

The psychometric properties of the sampling distributions were examined. A normal distribution was assumed where scores for kurtosis and skewness were not statistically significant and when on visual inspection the distribution curve on a histogram appeared normal. The other graphs inspected were scatter plots for correlations and plots of residuals for regression analyses. Parametric tests were used for data that were interval or above and that met requirements of normal distribution and equal variance for comparisons. Where necessary non-parametric tests were substituted.

3.1 Patient characteristics and stage of change

The numbers of participants in each motivational stage according to the classification (Prochaska & DiClemente, 1982) were as follows: pre-contemplation n=2 (7.1%), contemplation n=4 (14.3%), preparation n=12 (42.9%), action n=9 (32.1%) and maintenance n=1 (3.6%). A cut off of equal or greater than three was used to collapse the five motivation stages to two levels, because of the relatively small number of participants. For the purpose of the study a score of three or more were taken to indicate high motivation. The high motivation group encompassed the action stage and the maintenance stage of the model. A score of less than three was interpreted as low motivation score. The low motivation group encompassed the pre-contemplation, contemplation and preparation stages of the model. This decision was justified on the basis that the mean of the averaged scores was 2.99 (s.d.=0.86) and the median score was 2.85. All participants were female, all were Caucasian except one was Asian. There were no significant differences between the two groups for age or years in education as shown in table 1.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Low motivation (n=18) Mean (s.d.)</th>
<th>High motivation (n=10) Mean (s.d.)</th>
<th>T (df=26)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>30.33 (12.32)</td>
<td>27.00 (5.45)</td>
<td>0.99 *</td>
<td>0.333</td>
</tr>
<tr>
<td>Education (years)</td>
<td>13.77 (2.78)</td>
<td>15.3 (2.79)</td>
<td>-1.39</td>
<td>0.177</td>
</tr>
</tbody>
</table>

* adjusted t value for unequal variances
There was a significant and consistent pattern of difference between participants at low and high levels of motivation on self-reported behavioural markers of symptomatology, markers of psychopathology specific to the clinical group and general psychological adjustment (see Table 2). The low motivation group had greater psychopathology. No significant differences for the body mass index score were expected given that, although it is a marker of severity in anorexia nervosa the BMI is not a measure of disorder severity in bulimia nervosa. People with bulimia nervosa may have severe symptomatology whilst maintaining their weight within health limits.

Table 2. Severity across levels of motivation as indicated by clinical markers, self reported eating disorder and general psychological adjustment.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Level of motivation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low motivation (n=18)</td>
</tr>
<tr>
<td></td>
<td>Mean (s.d.)</td>
</tr>
<tr>
<td>Clinical severity measures</td>
<td>Low motivation (n=18)</td>
</tr>
<tr>
<td>Body Mass Index (kg/m²)</td>
<td>19.11 (4.38)</td>
</tr>
<tr>
<td>Duration of illness (years)</td>
<td>12.56 (12.07)</td>
</tr>
<tr>
<td>Self report eating disorder (EDE-Q) subscales</td>
<td>High motivation (n=10)</td>
</tr>
<tr>
<td>Restraint</td>
<td>3.28 (1.47)</td>
</tr>
<tr>
<td>Weight concerns</td>
<td>4.01 (1.60)</td>
</tr>
<tr>
<td>Shape concerns</td>
<td>4.17 (1.63)</td>
</tr>
<tr>
<td>Eating concerns</td>
<td>3.49 (1.39)</td>
</tr>
<tr>
<td>General psychological adjustment</td>
<td>BDI-II 29.28 (14.94)</td>
</tr>
<tr>
<td>RSE</td>
<td>19.94 (5.54)</td>
</tr>
<tr>
<td></td>
<td>High motivation (n=10)</td>
</tr>
<tr>
<td></td>
<td>Mean (s.d.)</td>
</tr>
<tr>
<td></td>
<td>19.00 (4.71)</td>
</tr>
<tr>
<td></td>
<td>10.50 (6.38)</td>
</tr>
<tr>
<td></td>
<td>1.88 (0.96)</td>
</tr>
<tr>
<td></td>
<td>2.16 (1.29)</td>
</tr>
<tr>
<td></td>
<td>2.91 (1.33)</td>
</tr>
<tr>
<td></td>
<td>2.12 (1.46)</td>
</tr>
<tr>
<td></td>
<td>13.80 (13.97)</td>
</tr>
<tr>
<td></td>
<td>25.20 (6.03)</td>
</tr>
<tr>
<td>T (df=26)</td>
<td>0.07</td>
</tr>
<tr>
<td></td>
<td>0.50</td>
</tr>
<tr>
<td></td>
<td>2.69</td>
</tr>
<tr>
<td></td>
<td>3.13</td>
</tr>
<tr>
<td></td>
<td>2.08</td>
</tr>
<tr>
<td></td>
<td>2.46</td>
</tr>
<tr>
<td></td>
<td>2.68</td>
</tr>
<tr>
<td></td>
<td>-2.33</td>
</tr>
<tr>
<td>p</td>
<td>0.944</td>
</tr>
<tr>
<td></td>
<td>0.623</td>
</tr>
<tr>
<td></td>
<td>0.012*</td>
</tr>
<tr>
<td></td>
<td>0.004**</td>
</tr>
<tr>
<td></td>
<td>0.048*</td>
</tr>
<tr>
<td></td>
<td>0.021*</td>
</tr>
<tr>
<td></td>
<td>0.012*</td>
</tr>
<tr>
<td></td>
<td>0.028*</td>
</tr>
</tbody>
</table>

*significant at p<0.05, ** significant at p<0.01.

Participants in the high motivation group reported normal to mild levels of depression symptoms on the BDI. The low motivation group’s mean score was approaching a level of severe depression, using a BDI cut off score of 30. Cooper and Turner (2000) reported self-
esteem scores similar to those in this study. They found that for female controls the mean score was 33.0 (s.d.=3.7) and for people with AN, the mean score was 18.8 (s.d.=5.4).

An independent t-test, to compare participants diagnosed with AN and BN, found no significant differences on mean scores for ANSOCQ items grouped by theme. The level of motivation to address different aspects of the eating disorder did not differ between diagnostic groups for AN and BN and the mean scores are shown in table 3. An independent t-test to compare high and low motivation groups found significantly different mean scores for each of the ANSOCQ subscales grouped by theme, with t scores ranging from t=-5.68 to t=-2.57 and with significance levels from p=0.0000001 to p=0.016. Those with high motivation scored significantly higher on each themed group of ANSOCQ items.

Table 3. Stage of change subscales and eating disorder diagnosis.

<table>
<thead>
<tr>
<th>ANSOCQ items grouped by theme</th>
<th>Diagnostic category (DSM-IV)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anorexia Nervosa (AN) n=15 mean (sd)</td>
</tr>
<tr>
<td>Weight change / being a healthy weight</td>
<td>2.58 (0.96)</td>
</tr>
<tr>
<td>Body shape, appearance and fat</td>
<td>2.93 (1.09)</td>
</tr>
<tr>
<td>Eating behaviour, feelings and attitudes</td>
<td>3.05 (0.88)</td>
</tr>
<tr>
<td>Use of control strategies</td>
<td>3.47 (1.46)</td>
</tr>
<tr>
<td>Need to work on other psychological problems</td>
<td>3.44 (0.93)</td>
</tr>
<tr>
<td>ANSOCQ total</td>
<td>2.97 (0.85)</td>
</tr>
</tbody>
</table>

Post hoc power analysis

Using the mean on the ANSOCQ as a cut off for high and low motivational groups, a post hoc analysis of observed effect size (d) was made using standard formula (d=mean-mean/population standard deviation). A small to medium effect (Cohen, 1988) was found for negative emotion and for positive emotion with d=0.43 and d=0.45 respectively. No effect was found for either of the weight related stimuli. Post hoc power analysis for one tailed test
was computed using G Power software (Faul & Erdfelder, 1992) on this basis for positive emotion stimuli: power=0.3, critical t(26)=1.71, delta=1.14. For negative emotion stimuli: power=0.28, critical t(26)=1.71, delta=1.09. Using the median of the ANSOCQ scores there was a finding of no effect for any of the types of stimuli, this suggests the measure is not robust.

3.2 Hypothesis 1: Information processing indices and stage of change

The first hypothesis was that there would be a significant difference between the participants in the study with high and low levels of motivation on the dot probe task interference index scores. The interference scores were computed based on Dalgleish, et al., (2003). The interference index score for the four types of threat stimulus word were each calculated from the mean reaction time data for the four positions of stimulus and probe. The scores are given in table 4. Individual t-tests were carried out for each stimulus word type on total interference scores for all participants and on interference scores for low and high motivation groups. No interference score was significantly different from zero.

Table 4. Stage of change and information processing indices.

<table>
<thead>
<tr>
<th>Word category (information processing index in milliseconds)</th>
<th>Low motivation (n=18) Mean (s.d.)</th>
<th>High motivation (n=10) Mean (s.d.)</th>
<th>T (df=26)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative emotion</td>
<td>38.69 (124.56)</td>
<td>-12.82 (106.81)</td>
<td>1.10</td>
<td>0.281</td>
</tr>
<tr>
<td>Positive emotion</td>
<td>9.84 (76.73)</td>
<td>-22.86 (59.49)</td>
<td>1.16</td>
<td>0.255</td>
</tr>
<tr>
<td>Negative weight and shape(^a)</td>
<td>-8.54 (70.72)</td>
<td>9.11 (62.17)</td>
<td>-0.65</td>
<td>0.519</td>
</tr>
<tr>
<td>Positive weight and shape(^a)</td>
<td>13.88 (69.95)</td>
<td>29.37 (70.00)</td>
<td>-0.55</td>
<td>0.583</td>
</tr>
<tr>
<td>Neutral difference</td>
<td>18.39 (102.60)</td>
<td>27.35 (102.38)</td>
<td>-0.22</td>
<td>0.826</td>
</tr>
</tbody>
</table>

\(^a\)Significant kurtosis and skewness scores for negative weight and positive weight indices, z scores ranging from 3.41 to 6.48 for p<0.001 were observed. One outlier case was removed from each of these indices eliminating the significance scores thus meeting requirements for parametric tests. For the remaining analysis reported here on interference indices a full data set was used.
Independent samples t-tests found no significant differences between participants in the low and high motivation groups for each of the stimulus word types. That is, under each word stimulus condition, the difference in variation in response times for word stimuli between groups with high and low levels of motivation was no more than could be expected by chance. Independent samples t-tests found no significant differences comparing combined indices for weight and shape stimulus words to combined indices for emotion stimulus words. Independent samples t-tests found no significant difference for word valence, comparing combined indices for negative stimulus words to indices for positive stimulus words. This does not support Rieger et al. (1998).

The scores for the probe position with neutral words did not differ significantly between participants grouped by level of motivation. This indicated that in general, the information processing task was no more difficult for those with low motivation compared to those with high motivation.

The scores presented in table 5 give the reaction times for the four probe to stimulus positions for each stimulus word type for the two groups of participants. Independent t-tests were carried out to compare low and high motivation groups on the total reaction time and on total reaction times for each stimulus word type. No significant differences were found. For the analysis of the reaction time data a square root transformation was necessary in order for the data to meet the requirements for parametric tests.

On visual inspection of the reaction time scores, there was a consistent pattern for negative and positive emotion stimuli across the two groups. A paired t-test was performed on the transformed reaction time scores for negative emotion stimulus words and positive emotion stimulus words separately, comparing combined reaction times with the stimulus in the upper position to reaction times with the stimulus in the lower position. Reading negative emotion stimulus words was followed by significantly faster probe detection than when a neutral word was read with the stimulus word in the lower position (t(27)=4.76, p=0.00006). It may be speculated that this shows hypervigilence in response to exposure to the negative emotion stimuli. This would explain why the response time was relatively fast when the probe was in the lower area following reading a negative emotion word in the upper area. The observed difference was not significant for positive emotion words.
Table 5. Information processing indices for each probe and stimulus position between levels of motivation.

<table>
<thead>
<tr>
<th>Information processing index (milliseconds)</th>
<th>Probes</th>
<th>Low motivation (n=18)</th>
<th></th>
<th>High motivation (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean (s.d.)</td>
<td>Mean (s.d.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>upper</td>
<td>upper</td>
<td>lower</td>
</tr>
<tr>
<td>Probe position</td>
<td></td>
<td>lower</td>
<td>upper</td>
<td>upper</td>
</tr>
<tr>
<td>Negative emotion</td>
<td></td>
<td>672.48</td>
<td>518.32</td>
<td>554.55</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(324.65)</td>
<td>(137.83)</td>
<td>(175.82)</td>
</tr>
<tr>
<td>Positive emotion</td>
<td></td>
<td>600.96</td>
<td>530.90</td>
<td>591.33</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(200.12)</td>
<td>(164.89)</td>
<td>(243.74)</td>
</tr>
<tr>
<td>Negative weight and shape</td>
<td></td>
<td>516.44</td>
<td>555.16</td>
<td>583.37</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(171.36)</td>
<td>(207.23)</td>
<td>(197.87)</td>
</tr>
<tr>
<td>Positive weight and shape</td>
<td></td>
<td>528.79</td>
<td>509.01</td>
<td>583.69</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(191.64)</td>
<td>(151.02)</td>
<td>(244.10)</td>
</tr>
</tbody>
</table>
A paired t-test was performed for the transformed reaction times for negative weight and shape stimulus words to test for a consistent pattern across groups. Reading the negative weight and shape words was followed by significantly slower reaction times for probe detection than when a neutral word was read \( t(27) = -3.9, p = 0.0006 \). Again, it is speculation to infer from this that a slowed reaction time followed exposure to negative shape words. A paired t-test was performed for the transformed reaction times for positive weight and shape stimulus words for the low motivation group. The low motivation group’s reaction times for positive shape stimuli was faster and approaching significance for the probe in the upper position \( t(17) = 1.979, p = 0.06 \). This is more difficult to interpret, it may represent a trend towards general distractability in response to reading a word, when a positive shape word is shown on the screen, that results in attention being held in the upper position.

A t-test comparison of interference indices was made for alexithymic and non-alexithymic participants given the specificity of alexithymia to the psychopathology of this clinical group. A cut off for high alexithymia \( >.61 \) was used (Taylor, et al., 1996) and no significant differences were found for the interference indices.

To summarize, the trends for differences in interference scores between the low and high motivation groups were not found to be statistically significant. From this study it is speculation that hypervigilence was found in response to exposure to negative emotion word stimuli and that slowed reaction times were found in response to exposure to negative weight and shape word stimuli.

### 3.3 Hypothesis 2: Alexithymia and stage of change

The second hypothesis was that those with high motivation would be less alexithymic than those with low motivation. As predicted, those in the high motivation group reported significantly less alexithymia symptoms on the TAS-20 mean total score and for all TAS-20 sub scales, compared to those in the low motivation group, see table 6. The exception was that the scores for the externally orientated thinking subscale on the TAS-20 did not differ significantly between groups with high or low motivation. A univariate analysis of covariance (ANCOVA) was carried out to partial out general psychopathology scores. Motivation groups were compared, the alexithymia total score was the dependent measure and depression and self-esteem were used as covariates, the effect remained significant \( F(1, 24) = 12.24, \)
p=0.00005, \eta^2=0.61). Alexithymia was important above psychopathology in distinguishing between high and low motivation groups.

The low motivation group’s scores showed clinically significant levels of alexithymia symptoms. Parker, Taylor and Bagby (2003) reported norms for TAS-20 subscales with a general population sample of 1053 American women. The overall mean score was 44.15 (s.d.=11.19) and the norms for subscales were as follows: factor 1 = 14.27 (s.d.=5.20), factor 2 = 11.96 (s.d.=4.21) and factor 3 = 19.93 (s.d. = 4.63).

Table 6. Stage of change and alexithymia scores

<table>
<thead>
<tr>
<th>Measures</th>
<th>Measures</th>
<th>Low motivation (n=18) Mean (s.d.)</th>
<th>High motivation (n=10) Mean (s.d.)</th>
<th>T (df=26)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAS-20 subscales</td>
<td>Difficulty identifying feelings</td>
<td>27.56 (4.33)</td>
<td>20.50 (6.46)</td>
<td>3.46</td>
<td>0.0018*</td>
</tr>
<tr>
<td></td>
<td>Difficulty describing feelings</td>
<td>18.94 (4.08)</td>
<td>12.90 (3.07)</td>
<td>4.07</td>
<td>0.0004**</td>
</tr>
<tr>
<td></td>
<td>Externally-orientated thinking</td>
<td>20.22 (4.47)</td>
<td>17.60 (4.88)</td>
<td>1.44</td>
<td>0.1615</td>
</tr>
<tr>
<td></td>
<td>TAS-20 total</td>
<td>66.72 (9.18)</td>
<td>51.00 (9.25)</td>
<td>4.33</td>
<td>0.0002**</td>
</tr>
</tbody>
</table>

*significant at p<0.05, ** significant at p<0.001.
3.4 Hypothesis 3: Information processing indices and alexithymia

The third hypothesis was that level of emotional functioning on alexithymia would correlate positively with level of interference on the dot probe task among people with eating disorders.

Spearman’s correlations were calculated for correspondence between markers of information processing and measures of psychological adjustment. These correlations are given in table seven and a full table of correlations is given in appendix seven. The positive emotion stimulus indices and negative weight and shape stimulus indices correlated positively and modestly with the externally orientated thinking subscale of alexithymia measure. The index for positive weight and shape stimuli correlated positively and modestly with the difficulty identifying feelings subscale of the alexithymia measure. The positive weight index correlate significantly and negatively with the negative emotion index ($r=-0.43$, $p=0.011$) significantly and positively with age ($r=0.33$, $p=0.045$).

Table 7. Correlation between information processing indices and alexithymia, self-esteem and depression.

<table>
<thead>
<tr>
<th>Information processing index (milliseconds)</th>
<th>Alexithymia (TAS-20) sub scales$^a$</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Identifying feelings</td>
<td>Describing feelings</td>
</tr>
<tr>
<td>Negative emotion</td>
<td>-0.27</td>
<td>-0.05</td>
</tr>
<tr>
<td>Positive emotion</td>
<td>0.11</td>
<td>0.12</td>
</tr>
<tr>
<td>Negative weight and shape</td>
<td>-0.10</td>
<td>-0.11</td>
</tr>
<tr>
<td>Positive weight and shape</td>
<td>0.37*</td>
<td>-0.00</td>
</tr>
<tr>
<td>Psychological adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDI</td>
<td>0.71**</td>
<td>0.57**</td>
</tr>
<tr>
<td>RSE</td>
<td>-0.61**</td>
<td>-0.46**</td>
</tr>
</tbody>
</table>

$^a$Spearman’s rho correlation coefficients given with $^*$ significant at $p<0.05$ $^{**}$ significant at $p<0.01$. 

Spearman’s correlations were calculated between markers of psychological adjustment, eating disorder psychopathology and alexithymia. The alexithymia overall score correlated moderately and significantly with depression (r=0.66, p=0.00005). Alexithymia correlated moderately with number of years of eating disorder (r=-0.32, p=0.048) and the eating disorder subscale for restraint (r=0.41, p=0.016). Alexithymia correlated moderately with the eating disorder subscales for weight concerns r=0.73, p=0.000005, with shape concerns r=0.61, p=0.0003 and with eating concerns r=0.61, p=0.0003. Alexithymia correlated significantly and negatively with self-esteem (r=-0.61, p=0.0003). Depression and self-esteem were strongly and negatively correlated (r=-0.85, p=0.000008). Depression and self-esteem were moderately correlated with the subscales of the eating disorder questionnaire. Spearman’s correlation coefficients ranged from r=-0.521 to r=0.732, with p values between p=0.002 to p=0.000001. The exception was that the restraint subscale of the EDE-Q correlated with depression with r=0.401, p=0.017 and that self-esteem was not significantly correlated with this subscale of the EDE-Q.

A simple linear regression was carried out. The dependent variable was the positive emotion index and the independent variable was the externally orientated thinking subscale of the TAS-20. The linear regression equation estimation for TAS-20 externally orientated thinking on positive emotion was approaching significance overall F(1,24)=3.90, p=0.06, accounting for 14% of the variance in positive emotion interference scores. Externally orientated thinking was a predictor of information processing biases from positive emotion stimuli (β =0.37, t=1.98, p=0.06). Less avoidance and greater selective attention shown on interference scores for positive emotion stimuli was associated with more alexithymia symptoms of externally orientated thinking.

A further simple linear regression was carried out. The dependent variable was TAS-20 externally orientated thinking the independent variable was the negative weight and shape index. The linear regression equation estimation for the effect of negative weight stimuli (with one case removed in order to meet requirements for normality) on TAS-20 externally-orientated thinking score was significant overall (F(1,25) = 5.38, p=0.03) accounting for 18% of the variance in this TAS-20 subscale. Information processing bias for negative weight stimuli was a predictor of TAS-20 externally orientated thinking (β=0.42, t=2.32, p=0.03). Less avoidance and greater attention shown on interference scores for negative weight stimuli was associated with more alexithymia symptoms of externally orientated thinking.
4. Discussion

The discussion consists of a summary of the aims and the findings for the study and their fit to the literature. This is followed by consideration of the implications and limitations of the study.

4.1 Summary of the research problem and findings

4.1.1 The research problem

The study aimed to identify relationships between emotional processing and people’s level of motivation to address their eating disorder symptoms. Information processing and self report symptoms of alexithymia were compared across groups with high and low motivation.

4.1.2 The research findings

People with low levels of motivation reported significantly higher levels of behavioural and attitudinal eating disorder symptoms and significantly lower levels of general psychological adjustment, compared to people with high levels of motivation.

There were no statistically significant differences for the interference indices on the dot probe information processing task using weight/shape word stimuli or emotion word stimuli between participants with high levels of motivation and those with low levels of motivation. This does not support the findings of similar studies of eating disorders (Rieger, et al., 1998) or a range of emotional disorders (Dalgleish, et al., 2003).

The low motivation group reported statistically and clinically significant difficulties in identifying and describing emotions, on the subscales of the alexithymia scale, compared to the high motivation group. A modest association was found between difficulties in emotional processing on some subscales of alexithymia and processing biases for specific emotion and weight/shape stimuli, based on interference scores from the information processing task. Selective attentional biases for positive emotion stimuli and negative weight stimuli were significantly and positively associated with externally orientated thinking on the alexithymia scale. A selective attentional bias for positive weight stimuli was significantly and positively associated with difficulties in identifying feelings on the alexithymia scale. Externally orientated thinking predicted positive emotion interference scores modestly. Negative weight
and shape processing biases predicted externally orientated thinking modestly. Lower interference scores for negative emotion word stimuli were found to be associated with higher interference scores for positive weight and shape word stimuli. This particular finding suggests that these specific cognitive and emotional processing biases have an inverse relationship.

The remaining findings that are reported here are based on observations of the reaction time data from the dot probe task. In some cases they are supported by statistically significant test results. On visual inspection of the data, a consistent pattern of faster reaction times when the negative or positive emotion stimulus words were read was found across low and high motivation groups, compared to reading neutral words. This difference was significant for negative emotion stimulus words. It was speculated that this represented hypervigilence in response to a negative emotion stimulus word. Slower reaction times were found following reading negative shape and weight stimuli across low and high motivation groups, compared to reading neutral words. This difference was significant. Also on visual inspection of the data, the overall reaction times for the low motivation group were slower than for the high motivation group, this difference was not statistically significant.

The difference between high and low motivation groups on interference scores from the dot probe task was not significant and the difference was in the opposite direction to that predicted by the study hypothesis. The low motivation group showed a selective attentional bias for positive and negative emotion word stimuli and the high motivation group showed attention directed away from positive and negative emotion word stimuli. The low and high motivation groups showed a selective attentional bias for weight and shape word stimuli, the exception was that the low motivation group avoided negative weight and shape word stimuli. As noted above, these differences were not significant.

The low and high motivation groups did not differ in terms of their demographic characteristics.

4.2 Findings and clinical literature

Due to the lack of statistical significance, the observed differences on the dot probe task between groups for high and low motivation need to be replicated in order for them to be used to inform the clinical literature.
The whole sample was relatively highly motivated as the participants were recruited from a population of people attending eating disorders services. This has potential to have had an impact on the results. The relatively high level of motivation across the sample means that there was a greater likelihood of finding no significant differences between the groups. This could be investigated in a further study by recruiting people with high and low levels of motivation, possibly by including people on a waiting list and comparing them with those people who are completing treatment. However, access to adequate levels of support would need to be made available for those taking part if they were on a waiting list for treatment and were not receiving other sources of support.

The findings showed that the low and high motivation groups differed on self-reported difficulties in emotional processing, measured on the alexithymia scale. This difference was statistically and clinically significant. In this study, people with low motivation showed clinically significant levels of alexithymia symptoms in their difficulties with identifying and describing emotions. This was not found for externally orientated thinking that is, self reported cognitive operational style in relation to emotion did not differ between the low and high motivation groups. These findings for alexithymia provide evidence to suggest that self-reported emotional processing is related to the processes of change, although a causal relationship was not tested for here. However, the cognitive and emotional processing biases measured on the dot probe interference scores did not show a significant, direct relationship to level of motivation. The findings of this study support Rieger, et al. (2000) who suggested that depression and self-esteem were concurrent with motivation. In addition, in this study alexithymia was found to be important over these aspects of general psychopathology in distinguishing between low and high motivation groups.

A complex set of associations was found between self-reported emotional processing and cognitive and emotional processing biases from the dot probe interference scores. Self reported cognitive processing of emotions (i.e. difficulty identifying and describing emotions) was associated with attention towards positive weight words (e.g. thin). Self reported cognitive operational style (i.e. externally orientated thinking) was associated with attention towards positive emotion words (e.g. happy) and negative weight words (e.g. fat). These differences show that cognitive processing biases (e.g. threat specific to the disorder such as weight and shape) and emotional processing biases may have different effects within the eating disorders.
This study found that the ANSOCQ distinguishes between individuals with different levels of eating disorder symptomatology on the EDE-Q, but not between the diagnoses of eating disorders. The finding that the participants in the diagnostic groups of AN and BN did not differ in their levels of motivation suggests that motivation may be a valid measure to supplement a trans-diagnostic approach to eating disorders (Fairburn, Cooper & Shafran, 2003; Fairburn and Harrison, 2003).

Only anecdotal observations can be made on the information processing biases across all five stages of change because of the small group sizes. The biases appear to differ across the stages with a non-linear relationship, this would suggest that cognitive and emotional processing biases are instrumental at specific stages of behavioural change. This would support the argument for examining a discontinuity pattern for stages in the transtheoretical model, as described in the literature (Armitage & Arden, 2002; Sutton, 2000).

4.3 Findings and information processing literature

This study provided some detail on the nature of interference effects in information processing among people with eating disorders. There were no main findings for information processing on motivation. The findings also suggested that there may be an inverse relationship between certain emotional and cognitive processing biases. For example, attentional bias away from negative emotion (e.g. sad) was associated with attentional bias towards positive weight (e.g. slim).

Patterns of hypervigilence in response to negative and positive emotion stimuli in people with eating disorders have not been assessed for on the stroop or dot probe tasks as reported in the literature. Previous stroop task studies have rejected a general anxiety induction model (Waller, et al., 1996). The study examined how a variety of response patterns on the dot probe task can be assessed. This study speculates that patterns in response to reading word stimuli, such as hypervigilence, slowing of processing and general distractibility, may exist. It provides statistical support for hypervigilence in response to negative emotion word stimuli and slowed response following negative weight and shape word stimuli. These are effects in addition to the cognitive and emotional processing biases for eating disorders that are reported in the information processing literature. In this study, statistically significant interference effects were not found on the basis of the index score as predicted from the literature review. This study found that reading the word out loud in the dot probe task had an effect. These
observations lead to the question whether the interference index formula, commonly used with the dot probe task, is a meaningful measure.

Visual inspection of the data for the individual conditions suggested that, overall the high motivation group responded quicker than the low motivation group. However, comparing high and low motivation groups, the difference between their total scores was not significant and the differences between total scores for each word stimulus were not significant.

It is possible to speculate on the pattern in the response times on the dot probe task generally. It seemed that hypervigilence in response to reading negative emotion word stimuli was found consistently across groups for level of motivation. For reading positive emotion word stimuli, a similar pattern was observed but it was not significant. General slowing of processing in response to reading negative weight word stimuli also appeared to be significant and consistent across groups for level of motivation. Positive weight stimulus resulted in the only apparently differing responses across motivational groups although this was not statistically significant. This may represent the presence of an adaptive response in information processing accompanying an increased motivation to address symptoms of eating disorders. It seemed that the overall pattern was robust to some extent when a median split for the groups was used. One test of these ideas would be to examine whether improved processing of positive weight stimuli relates a shift in motivational levels. The main area for a follow up investigation would be to test whether hypervigilence, activated by emotion word stimuli, and slowed responses following negative shape word stimuli are enduring characteristics of the eating disorders as implied by the findings of this study.

Associations between certain dimensions of alexithymia and specific information processing patterns on the interference indices were found. These associations can be interpreted tentatively, given the question regarding the use of interference scores that is highlighted by this study. Attentional bias towards positive weight words shown on interference scores was found to be significantly associated with increased difficulty in identifying feelings in alexithymia. Attentional biases towards positive emotion stimuli and negative weight stimuli on the interference scores were found to be associated with self-reported externally orientated thinking in alexithymia. This supports a previous study with a student population, where alexithymia was found to be associated with increased latency on the stroop task for naming threat word stimuli (Parker, Taylor & Bagby, 1993). It supports the view that alexithymia reflects discrepancies in cognitive and emotional information processing.
The explanation given in the literature on the dot probe task with emotional disorders is that these processing biases represent preferential encoding of mood congruent information as indicated by an attentional shift (MacLeod, Mathews & Tata, 1986). The evidence from this study may possibly reflect the organising and simplifying function of the eating disorder in response to threat e.g. in AN the symptoms represent a drive for thinness and control (Vitousek, 1996). It can be argued that in this study the emotional processing biases previously reported in eating disorders, namely selective attention towards and avoidance or attention away from specific stimuli, were fully assessed by combining self-reports with an experimental design. The study found evidence for additional, different information processing effects in eating disorders, namely hypervigilence in response to emotion word stimuli and slowed processing in response to weight and shape word stimuli. Further studies could aim to replicate and test for these differential information processing effects. It seems that they have potential to help to explain aspects of eating disorder symptomatology, such as preoccupation with weight and shape and difficulties in emotional regulation.

4.4 Relating emotional processing and motivation to cognitive behaviour therapy

There is a need to articulate how differences in emotional processing and motivation might fit with the cognitive behavioural model that is commonly used to treat the eating disorders. Evidence for a relationship between level of motivation and emotional processing was found. A relationship between motivation and information processing biases on interference indices for weight and shape stimuli, as would be predicted by the cognitive model, was not found in this study. The association between alexithymia and specific biases in processing for positive and negative weight word stimuli and positive emotion word stimuli was also modest.

The findings support the suggestion that the current cognitive behavioural model is not sufficiently elaborated to explain emotional processing in eating disorders. For example Taylor, Parker, Bagby & Bourkes (1996) find that symptoms of alexithymia in people with eating disorders do not correspond to their cognitive and behavioural symptoms. The authors argue for a need to understand the role of emotional processing in the disorder. The findings of this study suggest that level of motivation is associated with self-reported difficulties in emotional processing. It is speculation that information processing is also effected differently by negative emotional stimuli and negative weight stimuli and that these effects are found consistently across levels of motivation. Given that the groups differed on depression scores
and on the subscales of the eating disorder questionnaire, an alternative explanation is that these variables rather than motivation explain the differences. However, when depression was controlled for, the differences between the motivational groups remained. If the study was repeated with a much larger sample this could be teased out with a two stage regression analysis.

In the cognitive behavioural model, hot cognitions are indicated by raised affect and are thought to represent activation of disorder relevant schema. The study finds specific patterns of emotional and cognitive processing. The findings may be used to imply that emotional processing may relate to the clinical use of motivational approaches. Cognitive/motivational dissonance is a mechanism that may explain the links found between emotional processing and motivation. It may be reflected in that people reported fewer difficulties with self-awareness and emotion in the high level of motivation group than in the low motivation group. It may also relate to the speculation from this study that reactivity in the form of hypervigilence in response to emotion stimuli also has a role in the eating disorders, although this was found across levels of motivation.

4.5 Limitations of the study

The small sample size and weak power of the study have potential to reduce its argument. Furthermore, small to moderate correlations are reported here. In this study design, greater sensitivity could be achieved with a larger sample size and reducing error, with a more homogenous sample (e.g. for illness duration) or by using repeated measures for people at different stages of recovery. In addition, the ANSOCQ questionnaire is in development. Its use with people with bulimia nervosa appears to be valid, however it needs to be fully evaluated for this group.

The study replicated the dot probe task and met the research aims with limited success. This may be due to the dot probe experiment itself. A range of different visuo-spatial operations are required of a person in order to complete the dot probe task. This increases the potential for confounding variables to influence the measure (Williams, Mathews & MacLeod, 1996; Dalgleish, et al., 2003). Attempts were made to control for these variables by using consistent instructions and setting conditions. Further control could possibly be introduced to the experiment itself for example, by measuring the distance and angle of the participant to the computer screen. However, the significant and meaningful findings of the study suggest that
different effects of the dot probe task were found. Similarly large standard deviations for dot probe mean scores and indices as found in this study, are reported from studies across disorders including: people with eating disorders (Rieger, et al., 2000), children with emotional disorders (Dalgleish, et al., 2003) and adults with anxiety disorders (MacLeod, Mathews & Tata, 1986).

The study sample represents people with a long duration of eating disorder symptoms, although those with high and low levels of motivation did not differ in the duration of their condition. It is possible that a distinct pattern of information processing in people who are newly diagnosed with eating disorders may be found and this was not investigated here. For example, an anecdotal observation is that for people with enduring eating disorders with low motivation, their answers to the questions on the ANSOCQ sometimes seem highly complicated.

A strength of the study is that it uses both self report and experimental measures to assess for emotional processing. At a practical level, a strength of the study is that there were no missing data from the data set.

4.6 Clinical implications

A heterogeneous sample was achieved in this study given the broad inclusion criteria used. The participants did not differ significantly in the two motivation groups when compared on demographic information. Therefore the findings may represent people from a general clinical population attending an eating disorders service, as opposed to a highly selected sample, as found in research studies. The study findings are generalizable to people undergoing treatment for eating disorders. Since the participants were engaged in treatment, it may be expected that the study sample reflects higher levels of motivation to people beginning treatment or to people not currently undergoing treatment. The reported levels of motivation in other studies are wide ranging for example, reports of incidence for clients with BN being in the action stage range from 10% (Treasure, et al., 1999) to 80% (Blake, et al., 1997).

The study provides limited evidence to support the argument that motivational change represents a shift in aspects of emotional processing. This indicates the relevance to eating disorders of clinical techniques that attend to emotional processing. These techniques have
recently been articulated in revisions to standard cognitive and behavioural approaches for the emotional disorders with the aim of improving their efficacy.

4.7 The potential future work

These findings contribute to a case for the explanatory potential of understanding interactions between emotional processing and motivation in eating disorders. They also suggest that self reported symptoms of difficulties in emotional processing are of clinical significance in eating disorders. Following from this, a potential avenue of work would be to replicate the range of different patterns found in this study on the dot probe task and also to examine each of the five stages of motivational change. This may help to delineate the mechanisms underlying the relationship between emotional processing and motivation variables. An alternative approach would be to examine how these factors fit with the aims and gains from effective treatments.
5. References


Appendices
Appendix 1. Word Pairs

Word Pairs Containing Positive Shape and Weight Target Words

(reproduced with permission from E. Rieger)

<table>
<thead>
<tr>
<th>Target Word</th>
<th>Neutral Word</th>
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<td>Athletic</td>
<td>cupboard</td>
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<td>Fit</td>
<td>cup</td>
</tr>
<tr>
<td>Dainty</td>
<td>kettle</td>
</tr>
<tr>
<td>Small</td>
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</tr>
<tr>
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<td>table</td>
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<td>lamp</td>
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<td>vase</td>
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<td>comb</td>
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<td>Narrow</td>
<td>bottle</td>
</tr>
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<td>calendar</td>
</tr>
<tr>
<td>Slender</td>
<td>lantern</td>
</tr>
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<td>Slight</td>
<td>stairs</td>
</tr>
<tr>
<td>Tiny</td>
<td>bowl</td>
</tr>
<tr>
<td>Toned</td>
<td>broom</td>
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<tr>
<td>Firm</td>
<td>book</td>
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Word Pairs Containing Negative Shape and Weight Target Words

(reproduced with permission from E. Rieger)

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<td>car</td>
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<td>Tubby</td>
<td>ruler</td>
</tr>
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<td>Heavy</td>
<td>plant</td>
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Word Pairs Containing Positive Emotion Target Words

(reproduced with permission from E. Rieger)

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<td>Ecstatic</td>
<td>gardener</td>
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<td>Pleasant</td>
<td>contains</td>
</tr>
<tr>
<td>Glad</td>
<td>copy</td>
</tr>
<tr>
<td>Joyful</td>
<td>aerate</td>
</tr>
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<td>Satisfied</td>
<td>assistant</td>
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<td>Affectionate</td>
<td>methodically</td>
</tr>
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<td>Merry</td>
<td>alley</td>
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<td>Delighted</td>
<td>afterward</td>
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<td>Blissful</td>
<td>altitude</td>
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<td>Tender</td>
<td>finite</td>
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**Word Pairs Containing Negative Emotion Target Words**

(reproduced with permission from E. Rieger)

<table>
<thead>
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<td>Ashamed</td>
<td>collect</td>
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<td>Lonely</td>
<td>aboard</td>
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<td>Rejected</td>
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<td>brain</td>
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<td>Aggressive</td>
<td>allocation</td>
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Appendix 2. Ethical approval
Dear Martin

Re: Information Processing and motivational change in patients with eating disorders.

Thank you for a copy of your research proposal. I have signed the appropriate section.

As discussed previously, it would be useful to share some basic information about the project in the National Research Register (NRR). I trust you are happy for me to do so.

Yours sincerely

Tom Chan RMN, RGN, MSc, PhD
Associate Nursing Director
R & D Programme Manager

Enc
7th April 2004

Emma Harrold
Trainee Clinical Psychologist
University of Surrey

Dear Emma

LREC Ref: PRO/06/03
INFORMATION PROCESSING AND MOTIVATIONAL CHANGE IN PATIENTS WITH EATING DISORDERS

The Chairman, acting under delegated authority, is satisfied that your response has fulfilled the requirements of the Committee. You are therefore given approval for your research on ethical grounds providing you comply with the conditions set out below:

Conditions of Approval:

- You do not undertake this research in any NHS organisation until the relevant NHS management approval has been received.

- You do not deviate from, or make changes to, the protocol without the prior written approval of the LREC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases, the LREC should be informed within seven days of the implementation of the change. Likewise, you should also seek the relevant NHS management approval for the amendment, or inform NHS organisation of any logistical or administrative changes.

- You complete and return the standard progress report form to the LREC one year from the date of this letter and thereafter on an annual basis. This form should also be used to notify the Committee when your research is completed and should be sent to the REC within three months of completion. For a copy of the progress report please see www.corec.org.uk.

Page 1 of 2

March 2004 Letters/PRO 86 03 Approval (LREC) Harrold

An advisory committee to Surrey and Sussex Strategic Health Authority
LREC Ref: PRO/86/03
INFORMATION PROCESSING AND MOTIVATIONAL CHANGE IN PATIENTS WITH EATING DISORDERS

Approval Letter dated 7th April 2004
Page 2 of 2

- If you decide to terminate this research prematurely, a progress report form should be sent to the LREC within 15 days, indicating the reason for the early termination. For a copy of the progress report please see www.corec.org.uk.

- You must advise the LREC of all suspected Serious Adverse Reactions (SARRS) and all Suspected Unexpected Serious Adverse Reactions (SUSARS).

- You advise the LREC of any unusual or unexpected results that raise questions about the safety of the research.

The project must be started within three years of the date of this letter.

NHS LRECs are compliant with the International Conference on Harmonisation/Good Clinical Practice (ICH GCP) Guidelines for the conduct of trials involving participation of human subjects.

Your application has been given a unique reference number, please use it on all correspondence with the LREC

Yours sincerely

[Signature]

Mrs Anne Damerell
CHAIR
(signed by Sarah-Jane Richards in Mrs Damerell's absence)
15 April 2004

Ms Emma Harrold
Trainee Clinical Psychologist
Department of Psychology
School of Human Sciences

Dear Ms Harrold

**Information processing and motivational change in patients with eating disorders (EC/2004/05/Psych)**

I am writing to inform you that the Ethics Committee has considered the above protocol and, on receipt of the letter from the North West Surrey LREC, has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, the Guidelines can be downloaded from the Committee’s website at [http://www.surrey.ac.uk/Surrey/ACE/](http://www.surrey.ac.uk/Surrey/ACE/).

This letter of approval relates only to the study specified in your research protocol (EC/2004/05/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Ethics Committee: 15 April 2004
Date of expiry of approval by the Ethics Committee: 14 April 2009

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, EC
    Dr V Senior, Supervisor, Psychology
Appendix 3. Invitation to the participants
Research Study on Motivation and Information Processing

We are currently looking at motivation and information processing and would like to invite you to take part in a study.

The way people take in information effects how they see themselves, others and the world in general. This study aims to find out how motivation can impact on the way people with an eating disorder respond to information and deal with emotions. This study is not to judge you in any way. The objective is to understand the range of people’s experiences and the effects that eating disorders can have. The findings of this study will be used to promote a greater understanding and hopefully more effective treatments.

Participants in this study will be asked to complete some questionnaires and take part in an easy computer task during an appointment lasting 1 hour approx.

- You will not be asked to disclose any identifiable personal details.
- Your taking part is confidential and your answers will be kept anonymous and stored securely.
- Participants are free to withdraw from the study at anytime without giving a reason why.
- The study has passed the Local Medical Ethics Committee study registration: PRO/86/03. It is being carried out at the Eating Disorders Service as a clinical psychology trainee research project by Emma Harrold, under the supervision of Dr Martin Carroll, Clinical Psychologist.

If you would be interested in taking part or to know more about the study please fill in your name and a contact number below and hand this in at reception. If you require further information call Emma Harrold at the Eating Disorders Service (reception tel: ).

I would be pleased to receive information about the study and for Emma to call me to make an appointment to take part.

Name: ........................................................................................................................................

Telephone number or address: ....................................................................................................

...................................................................................................................................................

(please complete this and hand it in at the secretary’s office)
Appendix 4. Participant information sheet and consent form
You are invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives and your GP if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Consumers for Ethics in Research (CERES) publish a leaflet entitled ‘Medical Research and You’. This leaflet gives more information about medical research and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London, N16 0BW.

1. **What is the purpose of the study?**
   People tend to respond to information based on what is important to them. This study aims to find out how an eating disorder can impact on the way they respond to new information and their attitudes towards emotions. This is hoped to help with understanding the range of effects that eating disorders can have. It is anticipated that the results of this study will provide a greater understanding and hopefully more effective treatments. If you decide to take part, any information you provide will be kept anonymous. This study does not ask you to disclose about any identifiable personal details, events or people in your life. The objective is to understand the range of people’s experiences.

2. **Why have I been chosen?**
   You have been invited to take part as a matter of routine. All patients attending the service will be invited to take part in the study.

3. **Do I have to take part?**
   It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You are free to withdraw at any time and without giving a reason. If you choose not to participate or to withdraw at any time this will not affect the care you receive.

4. **What will happen to me if I take part?**
   If you decide to take part in this study you will be asked to attend for one appointment only. This will usually last between 45 minutes and one hour.

   At the appointment you will be asked to complete a simple task on a computer and set of easy to read questionnaires.

5. **What are the possible benefits of taking part?**
   There is no intended immediate benefit to you in taking part in this study. The information we get from this study may help us to treat patients with eating disorders better in the future.

6. **What if something goes wrong?**
If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanism is available to you.

7. **Will my taking part in this study be kept confidential?**
   All information which is collected about you during the course of the research will be kept strictly confidential. All information will be handled in accordance with the Data Protection Act 1998.

8. **What will happen to the results of the research study?**
   The results of the research will be presented as part of a thesis and to the local service. They are also likely to be published in a relevant clinical journal within two years and details will be available at the service. You will not be identified in any report/publication.

9. **Who is organising and funding the research?**
   This study is organised by Emma Harrold, Trainee Clinical Psychologist. It is supervised by Dr Carroll, Clinical Psychologist of the Eating Disorders Service and by tutors on the Clinical Psychology Doctorate course at University of Surrey.

   No payment is being made to the researcher or the staff who care for you for your involvement in this study.

10. **Who has reviewed the study?**
    This study was reviewed by the North West Surrey Research Ethics Committee.

11. **Contact for further information**
    Emma Harrold, Trainee Clinical Psychologist, Landsdown Unit, Famham Hospital and Centre for Health, Hale Road, Famham, Surrey.
    Telephone number: 01483 782018.

    Thank you for taking part in this study!

    You will be given a copy of this Information Sheet and a signed Consent Form to keep.
CONSENT FORM

Title of Project: Information processing and eating disorders

Name of Researcher: Emma Harrold, Trainee Clinical Psychologist.

Please initial box

1. I confirm that I have read and understood the information sheet dated 5th December 2003 (version 3) for the above study and have had the opportunity to ask questions.

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

3. I understand that the diagnosis of my eating disorder will be obtained from the Eating Disorders Service database by Clinical staff from the Eating Disorders Service. I give permission for these individuals to have access to this information.

4. I agree to take part in the above study

Name of Participant ______________________ Date ____________ Signature ____________

Name of Person taking consent ______________________ Date ____________ Signature ____________
(if different from researcher)

Researcher ______________________ Date ____________ Signature ____________

1 for participant; 1 for researcher; 1 to be kept with hospital notes

Participant Information Sheet (version 3-05/12/03)
Appendix 5. Questionnaires
General Questionnaire

1. Date of birth  ____ / ____ / ____
   (day) (month) (year)

2. Age  ____ years

3. Gender  Male / Female  (delete one)

4. How would you describe your ethnic origins?  
   White British □
   Irish □
   Any other white background □
   Mixed White and Black Caribbean □
   White and Black African □
   White and Asian □
   Any other mixed background □
   Asian or Asian British □
   Indian □
   Pakistani □
   Bangladeshi □
   Any other Asian background □
   Black or British Black □
   Caribbean □
   African □
   Any other black background □
   Chinese or other ethnic group □
   Chinese □
   Any other, please write below □

(Please tick one box. This question format is taken from the 2001 UK Census)

5. Age left school  ____

6. Years in education  ____

7. At what time did you last eat a meal today?  ____ am/pm
   (Please fill in the time of your meal and delete am/pm as appropriate. We ask this because some tasks at this appointment require you to concentrate)

(The final two questions, 8. and 9., can be completed with the researcher)

8. a) Height  ____ cm  
   b) Weight  ____ kg

9. At what age did your Eating Disorder symptoms begin?  ____ years
Anorexia Nervosa Stages of Change Questionnaire

Directions: Each of the items below is made up of five statements. For each item, please read the five statements carefully. Then select the statement (or statements) which best describe/s your current attitude or behaviour (not how you have been in the past or how you would like to be). If you have any problems, please ask for assistance. Your answers are completely confidential.

1. The following statements refer to gaining weight:
   a) As far as I am concerned, I do not need to gain weight.
   b) In some ways I think that I might be better off if I gained weight.
   c) I have decided that I will attempt to gain weight.
   d) At the moment I am putting in a lot of effort into gaining weight.
   e) I am working to maintain the weight gains I have made.

2. The following statements refer to body weight:
   a) As far as I am concerned, I do not need to weigh at least ____ kg (insert your minimal normal weight)
   b) In some ways I think that I might be better off if I weighed at least ____ kg.
   c) I have decided that I will attempt to reach at least ____ kg.
   d) At the moment I am putting in a lot of effort to reach at least ____ kg.
   e) I am working to maintain a weight of at least ____ kg.

3. The following statements refer to parts of your body which may particularly concern you in terms of weight gain (such as hips, thighs, stomach, or buttocks):
   a) There is no way I would be prepared to gain weight on these body parts.
   b) Sometimes I think I would be prepared to gain weight on these body parts.
   c) I have decided that I am prepared to gain weight on these body parts.
   d) I am presently trying to gain weight on these body parts.
   e) I am working to maintain the weight I gained on these body parts.

4. The following statements refer to your appearance:
   a) I do not want to be a normal weight because I would be less satisfied with my appearance at a weight of at least ____ kg (insert your minimum normal weight)
   b) I have occasionally thought about being a normal weight because in some ways I would be more satisfied with my appearance at a weight of at least ____ kg.
   c) I have decided to reach a normal weight because I would be more satisfied with my appearance at a weight of at least ____ kg.
   d) I am presently trying to reach a normal weight because I will be more satisfied with my appearance at a weight of at least ____ kg.
   e) I am working to maintain a normal weight because I am more satisfied with my appearance at a weight of at least ____ kg.

5. The following statements refer to your health:
   a) I do not need to be a normal weight because there are no risks to my health when I weigh below ____ kg. (insert your minimal normal weight)
   b) I have occasionally thought about being a normal weight because of the risks to my health when I weigh below ____ kg.
   c) I have decided to reach a normal weight because of the risks to my health when I weigh below ____ kg.
   d) I am presently trying to reach a normal weight because of the risks to my health when I weigh below ____ kg.
e) I am working to maintain a normal weight because of the risks to my health when I weigh below ____ kg.

6. The following statements refer to the importance of body shape and weight:
   a) I do not exaggerate the importance of my body shape or weight in determining my happiness and success.
   b) Sometimes I think that I exaggerate the importance of my body shape or weight in determining my happiness and success.
   c) I have decided that I need to reduce the importance that I place on my body shape or weight in determining my happiness and success.
   d) I often try to challenge the importance that I place on my body shape or weight in determining my happiness and success.
   e) I have succeeded in reducing my tendency to place too much importance on my body shape or weight in determining my happiness and success and want to stay this way.

7. The following statements refer to a fear of fatness:
   a) My fear of becoming fat is not excessive.
   b) I occasionally think that my fear of becoming fat is excessive.
   c) I have decided that I need to do something about the fear I have of becoming fat because it is controlling me.
   d) I know that my fear of becoming fat has caused problems and I am now trying to correct this.
   e) I have succeeded in reducing my fear of becoming fat and want it to stay this way.

8. The following statements refer to weight loss:
   a) I would prefer to lose more weight.
   b) Sometimes I think that it might be time to stop losing weight.
   c) I have decided that it is time to stop losing weight.
   d) I am trying to stop losing weight.
   e) I have managed to stop losing weight and hope to stay this way.

9. The following statements refer to body fat versus muscle:
   a) I might think about gaining muscle on purpose, but I would never think of gaining fat on purpose.
   b) Sometimes I think that I may need to gain some fat even though I would prefer to have only muscle.
   c) I have decided that to be healthy I need to have some fat on my body.
   d) I realize that I need to have some fat on my body and am working to achieve this.
   e) I have managed to increase the level of fat on my body which I am trying to maintain.

10. The following statements refer to the rate of weight gain:
    a) There is no way I would be prepared to gain at least 1 kg a week.
    b) Sometimes I think I would be prepared to gain at least 1 kg a week.
    c) I have decided that in general it would be best for me to gain at least 1 kg a week.
    d) I am putting in a lot of effort to gain at least 1 kg a week.
    e) I am working to maintain my weight but would be prepared to gain at least 1 kg a week if necessary.

11. The following statements refer to certain shape and weight standards which you may have for evaluating your body (such as only being satisfied with your body when your stomach is flat or when you are below a certain weight):
a) The standards I use to evaluate my body are not too strict.
b) Sometimes I think that the standards I use to evaluate my body may be too strict.
c) I have decided that the standards I use to evaluate my body are too strict and need to be changed.
d) I am putting in a lot of effort to change the strict standards which I use to evaluate my body.
e) I have managed to let go of the strict standards which I used in the past to evaluate my body and am hoping to keep it this way.

12. The following statements refer to certain foods which you may avoid eating (such as food high in calories or fat, red meat or dairy products):
   a) There are certain foods which I strictly avoid and would not even consider eating.
   b) There are certain foods which I try to avoid, although sometimes I think that it might be okay to eat them occasionally.
   c) I think that I am too strict in the foods which I allow myself to eat and have decided that I will attempt to eat foods which I usually avoid.
   d) I am putting in a lot of effort to regularly eat foods which I usually avoid.
   e) I used to avoid eating certain foods which I now eat regularly.

13. The following statements refer to daily food consumption:
   a) There is no need for me to eat 3 standard-size meals and a snack each day.
   b) Sometimes I think that I should eat 3 standard-size meals and a snack each day.
   c) I have decided that I need to eat 3 standard-size meals and a snack each day.
   d) I am putting in a lot of effort to eat 3 standard-size meals and a snack each day.
   e) I am working to maintain a current eating pattern which includes 3 standard-size meals and a snack each day.

14. The following statements refer to time spent thinking about food and your weight (such as thoughts about becoming fat, counting the calories or fat content of food, or calculating the amount of energy used when exercising):
   a) There is nothing wrong with the amount of time I spend thinking about food and my weight.
   b) The amount of time I spend thinking about food and my weight is a problem sometimes.
   c) I have decided that I need to use strategies to help me reduce the amount of time I spend thinking about food and my weight.
   d) I am using strategies to help me reduce the amount of time I spend thinking about food and my weight.
   e) I used to spend too much time thinking about food and my weight which I have managed to reduce and am working to keep it this way.

15. The following statements refer to certain eating behaviours (such as needing to eat food at a specific rate or time, moving food around on the plate, being unable to eat all food on a plate, taking longer than others to eat meals, having difficulty eating with others, needing to chew food a certain number of times or needing to stick to the same food plan each day):
   a) There is nothing that I need to change about the way I eat my meals.
   b) I sometimes think that I need to change aspects of the way I eat my meals.
   c) I have decided that I will try to change aspects of the way I eat my meals.
   d) I am putting in a lot of effort to change aspects of the way I eat my meals.
   e) I have succeeded in changing aspects of the way I eat my meals and want it to stay this way.
16. The following statements refer to feelings associated with eating (such as feeling guilty) and not eating (such as feeling in control):
   a) There is no need for me to change the feelings I associate with eating and not eating.
   b) I sometimes think that I need to change the feelings I associate with eating and not eating.
   c) I have decided that I will try to change the feelings I associate with eating and not eating.
   d) I am putting in a lot of effort to change the feelings I associate with eating and not eating.
   e) I have succeeded in changing the feelings I associate with eating and not eating and want it to stay this way.

17. The following statements refer to methods which you may use to control your weight (such as restricting your eating, exercising, vomiting, taking laxatives or other pills). You may select more than one statement for the different methods you use to control your weight. Please indicate which weight control method/s you are referring to in the blank space/s provided:
   a) There is nothing seriously wrong with the methods (______________________) I use to control my weight.
   b) I have been thinking that there may be problems associated with the methods (______________________) I use to control my weight.
   c) I have decided that I will attempt to stop using certain methods (______________________) to control my weight.
   d) I am putting in a lot of effort to stop using certain methods (______________________) to control my weight.
   e) I have managed to stop using certain methods (______________________) to control my weight and I would like to keep it this way.

18. The following statements refer to certain emotional problems (such as feeling depressed, anxious or irritable):
   a) I do not have any emotional problems which I need to work on.
   b) I sometimes think that I may have certain emotional problems which I need to work on.
   c) I have certain emotional problems which I have decided to work on.
   d) I am actively working on my emotional problems.
   e) My emotional problems have improved and I am trying to keep it this way.

19. The following statements refer to certain characteristics (such as perfectionism, low self esteem or feeling a need for control):
   a) I do not have any problems in the way I approach life which I need to work on.
   b) I sometimes think that I may have certain problems in the way I approach life which I need to work on.
   c) I have certain problems in the way I approach life which I have decided to work on.
   d) I am actively working on problems in the way I approach life.
   e) The problems in the way I approach life have improved and I am trying to keep it this way.

20. The following statements refer to relationship problems (such as relationships with family and friends):
   a) I do not have any problems in my relationships with others which I need to work on.
   b) I sometimes think that I may have certain problems in my relationships with others which I need to work on.
   c) I have certain problems in my relationships with others which I have decided to work on.
   d) I am actively working on problems in my relationships with others.
   e) The problems in my relationships with others have improved and I am trying to keep it this way.
**TAS – 20**

Using the scale provided as a guide, indicate how much you agree or disagree with each of the following statements by circling the corresponding number. Give only one answer for each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Moderately Disagree</th>
<th>Neither Nor Agree</th>
<th>Moderately Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am often confused about what emotion I am feeling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. It is difficult for me to find the right words for my feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I have physical sensations that even doctors don’t understand.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I am able to describe my feelings easily.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I prefer to analyze problems rather than just describe them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. When I am upset, I don’t know if I am sad, frightened, or angry.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I am often puzzled by sensations in my body.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I prefer to just let things happen rather than to understand why they turned out that way.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I have feelings that I can’t quite identify.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Being in touch with emotions is essential.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I find it hard to describe how I feel about people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. People tell me to describe my feelings more.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I don’t know what’s going on inside me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I often don’t know why I am angry.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I prefer talking to people about their daily activities rather than their feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. I prefer to watch “light” entertainment shows rather than psychological dramas</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. It is difficult for me to reveal my innermost feelings, even to close friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. I can feel close to someone, even in moments of silence.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. I find examination of my feelings useful in solving personal problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. Looking for hidden meanings in movies or plays distracts from their enjoyment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

© (Taylor, Bagby & Parker, 1992)
Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

### 1. Sadness
- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can’t stand it.

### 2. Pessimism
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

### 3. Past Failure
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

### 4. Loss of Pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don’t enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can’t get any pleasure from the things I used to enjoy.

### 5. Guilty Feelings
- 0 I don’t feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

### 6. Punishment Feelings
- 0 I don’t feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

### 7. Self-Dislike
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

### 8. Self-Criticalness
- 0 I don’t criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

### 9. Suicidal Thoughts or Wishes
- 0 I don’t have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

### 10. Crying
- 0 I don’t cry anymore than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can’t.

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Subtotal Page 1

Continued on Back
<table>
<thead>
<tr>
<th>11. Agitation</th>
<th>17. Irritability</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I am no more restless or wound up than usual.</td>
<td>I am no more irritable than usual.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I feel more restless or wound up than usual.</td>
<td>I am more irritable than usual.</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>I am so restless or agitated that it's hard to stay still.</td>
<td>I am much more irritable than usual.</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>I am so restless or agitated that I have to keep moving or doing something.</td>
<td>I am irritable all the time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. Loss of Interest</th>
<th>18. Changes in Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have not lost interest in other people or activities.</td>
<td>I have not experienced any change in my appetite.</td>
</tr>
<tr>
<td>1</td>
<td>1a</td>
</tr>
<tr>
<td>I am less interested in other people or things than before.</td>
<td>My appetite is somewhat less than usual.</td>
</tr>
<tr>
<td>2</td>
<td>1b</td>
</tr>
<tr>
<td>I have lost most of my interest in other people or things.</td>
<td>My appetite is somewhat greater than usual.</td>
</tr>
<tr>
<td>3</td>
<td>2a</td>
</tr>
<tr>
<td>It's hard to get interested in anything.</td>
<td>My appetite is much less than before.</td>
</tr>
<tr>
<td></td>
<td>2b</td>
</tr>
<tr>
<td></td>
<td>My appetite is much greater than usual.</td>
</tr>
<tr>
<td></td>
<td>3a</td>
</tr>
<tr>
<td></td>
<td>I have no appetite at all.</td>
</tr>
<tr>
<td></td>
<td>3b</td>
</tr>
<tr>
<td></td>
<td>I crave food all the time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. Indecisiveness</th>
<th>19. Concentration Difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I make decisions about as well as ever.</td>
<td>I can concentrate as well as ever.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I find it more difficult to make decisions than usual.</td>
<td>I can't concentrate as well as usual.</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>I have much greater difficulty in making decisions than I used to.</td>
<td>It's hard to keep my mind on anything for very long.</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>I have trouble making any decisions.</td>
<td>I find I can't concentrate on anything.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14. Worthlessness</th>
<th>20. Tiredness or Fatigue</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I do not feel I am worthless.</td>
<td>I am no more tired or fatigued than usual.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I don't consider myself as worthwhile and useful as I used to.</td>
<td>I get more tired or fatigued more easily than usual.</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>I feel more worthless as compared to other people.</td>
<td>I am too tired or fatigued to do a lot of the things I used to do.</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>I feel utterly worthless.</td>
<td>I am too tired or fatigued to do most of the things I used to do.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have as much energy as ever.</td>
<td>I have not noticed any recent change in my interest in sex.</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I have less energy than I used to have.</td>
<td>I am less interested in sex than I used to be.</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>I don't have enough energy to do very much.</td>
<td>I am much less interested in sex now.</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>I don't have enough energy to do anything.</td>
<td>I have lost interest in sex completely.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have not experienced any change in my sleeping pattern.</td>
<td>I am no more irritable than usual.</td>
</tr>
<tr>
<td>1a</td>
<td>1</td>
</tr>
<tr>
<td>I sleep somewhat more than usual.</td>
<td>I am more irritable than usual.</td>
</tr>
<tr>
<td>1b</td>
<td>2</td>
</tr>
<tr>
<td>I sleep somewhat less than usual.</td>
<td>I am much more irritable than usual.</td>
</tr>
<tr>
<td>2a</td>
<td>3</td>
</tr>
<tr>
<td>I sleep a lot more than usual.</td>
<td>I am irritable all the time.</td>
</tr>
<tr>
<td>2b</td>
<td></td>
</tr>
<tr>
<td>I sleep a lot less than usual.</td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td></td>
</tr>
<tr>
<td>I sleep most of the day.</td>
<td></td>
</tr>
<tr>
<td>3b</td>
<td></td>
</tr>
<tr>
<td>I wake up 1-2 hours early and can't get back to sleep.</td>
<td></td>
</tr>
</tbody>
</table>

NOTICE: This form is printed with both blue and black ink. If your copy does not appear this way, it has been photocopied in violation of copyright laws.
**EATING QUESTIONNAIRE**

**Instructions**

The following questions are concerned with the PAST FOUR WEEKS ONLY (28 days). Please read each question carefully and circle the appropriate number on the right. Please answer all the questions.

<table>
<thead>
<tr>
<th>On how many days out of the past 28 days ......</th>
<th>No</th>
<th>1-5</th>
<th>6-12</th>
<th>13-15</th>
<th>16-22</th>
<th>23-27</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2 Have you gone for long periods of time (8 hours or more) without eating anything in order to influence your shape weight?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>3 Have you tried to avoid eating any foods which you like in order to influence your shape or weight?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4 Have you tried to follow definite rules regarding your eating in order to influence your shape or weight; for example, a calorie limit, a set amount of food, or rules about what or when you should eat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5 Have you wanted your stomach to be empty?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6 Has thinking about food or its calorie content made it much more difficult to concentrate on things you are interested in; for example, read, watch TV, or follow a conversation?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7 Have you been afraid of losing control over eating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Question</td>
<td>No</td>
<td>1-5</td>
<td>6-12</td>
<td>13-15</td>
<td>16-22</td>
<td>23-27</td>
<td>Everyday</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----</td>
<td>-----</td>
<td>------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td>Have you had episodes of binge eating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Have you eaten in secret? (Do not count binges.)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Have you definitely wanted your stomach to be flat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Has thinking about shape or weight made it more difficult to concentrate on things you are interested in; for example read, watch TV or follow a conversation?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Have you had a definite fear that you might gain weight or become fat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Have you felt fat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Have you had a strong desire to lose weight?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>On what proportion of times that you have eaten have you felt guilty because the effect on your shape or weight? (Do not count binges.)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
16 Over the past four weeks (28 days), have there been any times when you have felt that you have eaten what other people would regard as an unusually large amount of food given the circumstances? (Please put appropriate number in box.)

0 - No
1 - Yes

17 How many such episodes have you had over the past four weeks?

[ ][ ][ ]

18 During how many of these episodes of overeating did you have a sense of having lost control over your eating?

[ ][ ][ ]

19 Have you had other episodes of eating in which you have had a sense of having lost control and eaten too much, but have not eaten an unusually large amount of food given the circumstances?

0 - No
1 - Yes

20 How many such episodes have you had over the past four weeks?

[ ][ ][ ]

21 Over the past four weeks have you made yourself sick (vomit) as a means of controlling your shape or weight?

0 - No
1 - Yes

22 How many times have you done this over the past four weeks?

[ ][ ][ ]

23 Have you taken laxatives as a means of controlling your shape or weight?

0 - No
1 - Yes

24 How many times have you done this over the past four weeks?

[ ][ ][ ]

25 Have you taken diuretics (water tablets) as a means of controlling your shape or weight?

0 - No
1 - Yes

26 How many times have you done this over the past four weeks?

[ ][ ][ ]

27 Have you exercised hard as a means of controlling your shape or weight?

0 - No
1 - Yes

28 How many times have you done this over the past four weeks?

[ ][ ][ ]
OVER THE PAST FOUR WEEKS (28 DAYS) (Please circle the number which best describes your behaviour.)

<table>
<thead>
<tr>
<th>Question</th>
<th>NOT AT ALL</th>
<th>SLIGHTLY</th>
<th>MODERATELY</th>
<th>MARKEDLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 Has your weight influenced how you think about (judge) yourself as a person?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Has your shape influenced how you think about (judge) yourself as a person?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 How much would it upset you if you had to weigh yourself once a week for the next four weeks?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 How dissatisfied have you felt about your weight?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33 How dissatisfied have you felt about your shape?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34 How concerned have you been about other people seeing you eat?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 How uncomfortable have you felt seeing your body; for example, in the mirror, in shop window reflections, while undressing or taking a bath or shower?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36 How uncomfortable have you felt about others seeing your body; for example, in communal changing rooms, when swimming or wearing tight clothes?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**New York State Self Esteem Scale**

These statements refer to how you feel about yourself in general. Please circle a response to indicate whether you Strongly Agree, Agree, Disagree or Strongly Disagree with the following items:

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

THANK YOU FOR COMPLETEING THESE QUESTIONNAIRES.
Appendix 6. Participant debrief information
PARTICIPANT DEBRIEF INFORMATION

Study: Information processing and eating disorders

Your participation in the study is now complete. We appreciate you time and effort in taking part. Thank you.

About the study

The study involved completing several questionnaires and a computer task. The questionnaires asked how you feel about challenging your eating disorder at present. Other questionnaires asked you to report on symptoms of eating disorders, depression, self-esteem and your sense of ease at identifying and expressing emotions.

The computer task (the 'Dot Probe' task) tested the idea that it takes a person longer to respond to a neutral task (pressing a button when a dot appears on the screen) after threatening words are presented than after neutral words. Eating disorders are thought to vary the attitudes that people have regarding their emotions, weight/shape and food. The task was that you were presented neutral words and threat-related words (emotional and weight/shape words). You were then asked to click a button when a dot appeared on the screen.

The study's aim is to find out whether people who are currently challenging their eating disorder are quicker to respond to threat words than people who are less active in addressing the disorder at present. It also asks whether this is related to how easy these people find identifying and express their emotions.

What happens next?

This study is not to judge you in any way. The objective is to understand the range of people's experiences and the effects that eating disorders can have. The findings of this study will be used to promote a greater understanding and hopefully more effective treatments. The findings will be reported and possibly will be published. Please be assured that your participation in the study is confidential. Your information will be made anonymous and will not be identifiable in any report or publication.

If you are interested to know about the outcome of the study a brief summary of the findings will be available later in the year from the administration office at the Eating Disorders Service.

Thank you.

If you would be interested in taking part in similar studies in the future please complete the form below and hand it into the office.

I would be pleased to receive information about studies at the Eating Disorders Service in the future. I would like to be invited to consider whether to take part.

Name: ..............................................................................................................................

Telephone number or address: ..............................................................................
..............................................................................................................................
..............................................................................................................................

(please complete this and hand it in at the secretary's office)
Appendix 7. Correlation tables
Table 8. Spearman’s rho and p values for associations between measures of emotional processing, psychological adjustment and eating disorder symptoms.

<table>
<thead>
<tr>
<th></th>
<th>TAS-20 difficulty identifying feelings</th>
<th>TAS-20 difficulty describing feelings</th>
<th>TAS-20 externally orientated thinking</th>
<th>TAS-20 Total</th>
<th>Negative emotion index</th>
<th>Positive emotion index</th>
<th>Negative weight &amp; shape index</th>
<th>Positive weight &amp; shape index</th>
<th>Beck depression inventory</th>
<th>Rosenberg self esteem scale</th>
<th>EDE-Q restraint</th>
<th>EDE-Q weight concerns</th>
<th>EDE-Q shape concerns</th>
<th>EDE-Q eating concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAS-20 difficulty identifying feelings</td>
<td>1.000</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAS-20 difficulty describing feelings</td>
<td>0.532**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAS-20 externally orientated thinking</td>
<td>0.196</td>
<td>0.362*</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAS-20 total score</td>
<td>0.775**</td>
<td>0.783**</td>
<td>0.642**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative emotion index</td>
<td>-0.272</td>
<td>-0.049</td>
<td>-0.143</td>
<td>-0.194</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive emotion index</td>
<td>0.081</td>
<td>0.403</td>
<td>0.234</td>
<td>0.161</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative weight &amp; shape index</td>
<td>-0.102</td>
<td>-0.110</td>
<td>0.352*</td>
<td>0.033</td>
<td>-0.024</td>
<td>0.002</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive weight &amp; shape index</td>
<td>0.303</td>
<td>0.288</td>
<td>0.033</td>
<td>0.433</td>
<td>0.452</td>
<td>0.496</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beck depression inventory</td>
<td>0.711**</td>
<td>0.566**</td>
<td>0.160</td>
<td>0.664**</td>
<td>0.069</td>
<td>-0.067</td>
<td>-0.196</td>
<td>0.252</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rosenberg self esteem scale</td>
<td>-0.605**</td>
<td>-0.464**</td>
<td>-0.224</td>
<td>-0.607**</td>
<td>-0.180</td>
<td>-0.145</td>
<td>0.151</td>
<td>-0.080</td>
<td>-0.846**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDE-Q restraint</td>
<td>0.454**</td>
<td>0.480**</td>
<td>-0.015</td>
<td>0.405*</td>
<td>-0.062</td>
<td>0.037</td>
<td>-0.191</td>
<td>0.209</td>
<td>0.401*</td>
<td>-0.212</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDE-Q weight concerns</td>
<td>0.704**</td>
<td>0.633**</td>
<td>0.195</td>
<td>0.732**</td>
<td>-0.074</td>
<td>0.063</td>
<td>-0.132</td>
<td>0.256</td>
<td>0.760**</td>
<td>-0.613**</td>
<td>0.670**</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDE-Q shape concerns</td>
<td>0.685**</td>
<td>0.604**</td>
<td>0.113</td>
<td>0.670**</td>
<td>-0.101</td>
<td>0.025</td>
<td>-0.168</td>
<td>0.211</td>
<td>0.617**</td>
<td>-0.521**</td>
<td>0.720**</td>
<td>0.927**</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>EDE-Q eating concerns</td>
<td>0.803**</td>
<td>0.513**</td>
<td>0.059</td>
<td>0.608**</td>
<td>-0.108</td>
<td>-0.019</td>
<td>-0.175</td>
<td>0.235</td>
<td>0.652**</td>
<td>-0.546**</td>
<td>0.650**</td>
<td>0.810**</td>
<td>0.727**</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Note 1. TAS-20=Toronto Alexithymia Scale. EDE-Q=Eating Disorders Examination Questionnaire.
Note 2. * Spearman’s rho correlations significant at p<0.05.  ** Spearman’s rho correlations significant at p<0.001.
Log of Research Experience
LOG OF RESEARCH EXPERIENCE

This research log provides information to demonstrate the research skills and experiences acquired during my training. Under each category heading, a description of my relevant research activity and experience is given. In some cases this is experience in addition to that shown in the reports within the research dossier.

<table>
<thead>
<tr>
<th>Research Skill/Experience</th>
<th>Description of how research skill/experience acquired</th>
<th>Date research skill acquired</th>
</tr>
</thead>
</table>
| Conduct a literature search | During my clinical training I conducted literature searches using computerized search engines and databases these included: Medline, BIDS, PsychInfo and Ebsco, the research database of the psychology and behavioural sciences collection. Literature searches were completed for all case reports, essays and research projects. I also searched the literature as part of my regular preparations for clinical practice on clinical placements and I brought this to supervision. I used the library extensively to access key texts and for information to support my studies during the course. A selection of the literature searches are recorded below:

On the adult placement, search topics included: simple phobias; attention deficit hyperactivity disorder and Asperger's. On the people with learning disabilities placement, topics included: psychodynamic psychotherapy; staff attributions; difficulties expressing affect and bereavement. On the older adult placement, topics included: obsessive compulsive disorder; marital difficulties using a psychodynamic perspective; Dyogenes Syndrome and carers of older people with functional disorders. On the eating disorders placement, the topics related to eating disorders included: attachment, alcohol, attachment and self-harm, cultural issues and multidisciplinary teams. On the pain management placement topics included: depression in patients on cardiology rehabilitation programmes; attention and mindfulness techniques.

For work with psychotherapy groups, topics included: relaxation training, social skills training; group treatments for anxiety in older adults in in-patients; gender, life span and body image in people with eating disorders.

For presentations given, organisational work and mini-projects carried out the search topics included: social communication in older adults; policy on care plans in eating disorders; multidisciplinary teams and eating disorders; psychology and physical rehabilitation.                                                                 | Sept. 2001 - July 2004                      |
<table>
<thead>
<tr>
<th>Research Skill/Experience</th>
<th>Description of how research skill/experience acquired</th>
<th>Date research skill acquired</th>
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| Critically review the literature                             | I critically reviewed the literature and reported this as part of all essays and research projects. In the process I gained skills in critical evaluation of literatures on for example, the evidence base for clinical treatments and the development of models and theories.                                                                                                               | Oct. – Nov. 2001
|                                                                |                                                                                                                                                                                                                                                                                                                                                                                             | March – Oct. 2003              |
| Formulate a specific research question                       | I formulated a specific research question for my service related research project (SRRP) and for two proposals for major research project proposals (MRPs). I also contributed to formulating a research question as part of a group for my qualitative research project.                                                                                                                | Oct. – Nov. 2001
|                                                                |                                                                                                                                                                                                                                                                                                                                                                                             | March – Oct. 2003              |
| Write a brief research proposal                              | I wrote a brief research proposal for my SRRP and for two MRPs. In the process I learned skills in communicating complex information concisely and to other health professionals.                                                                                                                                                                                                  | Oct. – Dec. 2001
|                                                                |                                                                                                                                                                                                                                                                                                                                                                                             | March – Oct. 2003              |
| Write a detailed proposal/protocol                           | I wrote a detailed research proposal for my two MRPs. I learned through this new skills writing comprehensively and accurately. I consulted my research supervisor and learned about theory and how to conduct a power calculation.                                                                                                                                                                                  | August - Oct. 2003             |
| Obtain appropriate supervision/collaboration for research    | I consulted with my clinical placement supervisor and the heads of the adult and psychology services in the process of developing the outline proposal for my SRRP. For my first MRP, on worry in postpartum women, I gained input from clinical specialists at the University and from an external supervisor, a research psychologist based at a teaching hospital. For my second MRP I gained much from supervision from a clinical psychologist working in eating disorders and from my research tutor. I also contacted a research psychologist with experience of using the Stroop task for advice. I contacted the clinician’s who had developed the three main clinical measures that I used, to ask for permission to use their measure and for their advice on their use. | Oct. 2001
|                                                                |                                                                                                                                                                                                                                                                                                                                                                                             | April 2003                     |
|                                                                |                                                                                                                                                                                                                                                                                                                                                                                             | Aug. 2004                      |
| Write a participant information sheet and consent form       | I wrote a participation information sheet for my MRPI according to St George’s Healthcare NHS Trust Ethics Committee format and for my MRPII for the North West Surrey Ethics Committee                                                                                                                                                                                                                       | May 2003
<p>|                                                                |                                                                                                                                                                                                                                                                                                                                                                                             | Sept. 2003                     |</p>
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<tr>
<td>Judge ethical issues in research and amend plans accordingly</td>
<td>I considered ethical issues related to my SRRP and included this in the proposal forms submitted to university and to the Trust’s audit department. I included considerations to ethics issues in each stage of research planning and at the proposal stage for my MRP I and II. At the request of the North West Surrey Ethics committee, I modified the patient information sheet to specify that information would be kept in accordance with the data protection act 1989. I kept all information about research participants in locked filing cabinets, all questionnaires were anonymized. The study was passed with the Trust Research and Development manager and the Data Protection officer.</td>
<td>Oct. – Dec. 2003</td>
</tr>
<tr>
<td>Obtain approval from a research ethics committee</td>
<td>I obtained approval from the Trust audit department for my SRRP. I obtained approval from Ethics Committee for my MRP I, with requirements for major changes to the design. My field supervisor left to work for another NHS trust and at this stage I decided to abandon the project and I began work on my MRPII. I submitted to North West Surrey Medical Ethics Committee and University’s Ethics Committee. I presented my project at the meeting of North West Surrey Medical Ethics Committee. After small modifications to the proposal noted above, approval was obtained from the committee.</td>
<td>Dec. 2001 – June 2003</td>
</tr>
<tr>
<td>Collect data from research participants</td>
<td>For my SRRP I collected data from retrospective departmental records. On MRP II I provided information to prospective participants about the study, I used the Trust’s procedures to gain informed consent and I conducted interviews with the research participants to collect data.</td>
<td>Nov. 2001 - March 2002</td>
</tr>
<tr>
<td>Set up a data file</td>
<td>For the SRRP I used Access set up ‘form’ format for data entry. I then transferred the data to Excel and SPSS-X. For the MRPII I set up a database in SPSS-X. I designed the data input format by consulting with the literature for common categorisations (e.g. norms and cut off points) used in reporting on the research topic. I entered data to SPSS-X from questionnaires. I transferred data into a single file in E Prime using a ‘data merge’ programme and I carried out preliminary analysis using ‘data aid’. I converted this data to an Excel file and then to SPSS-X.</td>
<td>Nov. 2001 - April 2004</td>
</tr>
<tr>
<td>Set up a psychological experiment using a computer package</td>
<td>I set up a psychological experiment using the E Prime computer software package. Using the manual for the software and the developer’s website for advice, I first learned to write a detailed protocol for the experiment and then to translate this into the form of a computer programme. I tested and piloted the programme to ensure that the data was collected and recorded correctly and that it was reliable.</td>
<td>Jan. - March 2004</td>
</tr>
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<tr>
<td>Analyse quantitative data</td>
<td>I completed analyses of data for my SRRP and MRP II using SPSS-X. The procedure for the analysis was described in the reports for these projects.</td>
<td>June 2004</td>
</tr>
<tr>
<td>Analyse qualitative data</td>
<td>I analysed qualitative data for the qualitative research project in a collaborative research group. The final report of the analysis was written by each researcher separately.</td>
<td>April - May 2003</td>
</tr>
<tr>
<td>Summarise results in figures/graphs</td>
<td>I summarised results in figures and graphs for the SRRP and MRP II.</td>
<td>May 2002 June 2004</td>
</tr>
<tr>
<td>Interpret results from data analysis</td>
<td>I interpreted data from the analysis for my SRRP and MRP II. I presented this in the text to each research report. I interpreted qualitative data analysis for the qualitative project and reported on this in the report on the project.</td>
<td>May 2002 May 2003 June 2004</td>
</tr>
<tr>
<td>Present research findings/plans to an audience</td>
<td>For SRRP I informally discussed the research plans in an Adult Psychology department meeting, this was recorded in the minutes at the meeting. I presented research findings to Adult Psychology department. I presented the proposal for MRP II to the eating disorders team at two services. I plan to present the findings of the study to the staff at both services.</td>
<td>Nov. 2002 Feb. – March 2004</td>
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<tr>
<td>Produce a written report on a research project</td>
<td>I produced a written report for my SRRP and qualitative project.</td>
<td>May - June 2002 March - April 2003</td>
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<tr>
<td>Defend research project at an oral examination</td>
<td>I intend to defend my MRP at the viva for the PsychD. in Clinical Psychology in September 2004.</td>
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<tr>
<td>Submit research report for publication in a journal/book</td>
<td>I have contributed to a report on the qualitative project to be submitted for publication to the clinical psychology forum during 2004. I plan to write up my MRP for publication by the end of 2004.</td>
<td>--</td>
</tr>
<tr>
<td>Apply research findings to clinical practice (give examples of 3 papers published during your training which influenced your practice).</td>
<td>A paper by Brown (2002) on the validity of psychiatric diagnoses has helped me maintain a critical approach to my clinical practice in the course of training.</td>
<td>Sept. 2001 – July 2004</td>
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<td></td>
<td>My clinical practice in assessments and reflection on clinical work during training has been informed by several recently published papers on models of post traumatic stress. A paper reporting a meta analysis on predictors and the development of the disorder by Ozer, et al. (2003) formed part of my reading. (continued over..)</td>
<td></td>
</tr>
</tbody>
</table>
| **Apply research findings to clinical practice (give examples of 3 papers published during your training which influenced your practice).** (continued) | On my older adult placement, under supervision from my placement supervisor, an evidence-based text by Young, et al. (2003) on schema therapy was used to inform a brief intervention with a person with a long-term medical condition who was experiencing panic attacks. This intervention followed on from cognitive behaviour therapy with the client. This book has informed my practice across my subsequent clinical placements.

