A PORTFOLIO OF ACADEMIC STUDY, CLINICAL PRACTICE & RESEARCH

Volume I

including

“Cigarette Smoking in Women with Eating Disorders”

by

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Introduction to the Portfolio

This volume of the portfolio contains a separate dossier for each of the three main components (academic, clinical and research) of the three year clinical psychology doctorate course (PSYCH D). The academic dossier comprises five selected essays, which cover core and specialist topics.

The clinical dossier includes a brief summary of the clinical experience gained on each of the six placements, a copy of the placement contract and a summary of the five clinical case reports.

The research dossier includes a service-related research project completed while on clinical placement in Year I, a literature review completed in Year II and a large scale research project completed in Year III.

A separate confidential clinical volume has been submitted containing the full versions of the five clinical case reports and all placement documentation including clinical activity log books and evaluations forms.

The work in each section reflects the variety of clients, presenting problems and approaches covered during the course. In each section the work is presented in the order in which it was completed to demonstrate how my thinking and interests have developed during the course.
Academic Dossier
Adult Mental Health Essay

“Compare the Treatment Roles of Psychological Therapies and Psychotropic Medication for Depression”

Year I

December 1997
Introduction

Pharmacological intervention has long since been established as the standard treatment for clinical depression. However in the last two decades there has been emerging evidence that psychosocial treatment may also be effective, particularly cognitive therapy. Recently however, the American Psychiatric Association, (1993) stated that cognitive therapy may be no more effective than pill-placebo controls. This widely publicised statement was all the more damaging, as it was based on the findings of one of the most controlled trials to date.

This essay will briefly define depression, and describe the theory behind the intervention approaches used in pharmacotherapy and cognitive therapy to clarify the differences in their treatment roles. Since there is already extensive literature proving superiority of both treatment approaches used singly in treating depression compared to no treatment at all, or wait-list controls, this debate is not revisited. Instead, a more topical issue is focused on; a review of the current literature evaluating the effectiveness of cognitive therapy compared to pharmacotherapy in i) the reduction of symptoms of depression, and ii) prevention of reoccurrence of symptoms following successful treatment. The effectiveness of combining the two modalities in the treatment of depression will also be discussed.

What is depression?

While depression, at least in the form of a sad mood, is almost a universal experience, clinically significant depression is defined as...
along with a set of additional symptoms, (including; diminished interest or pleasure in all or most activities, significant weight loss or gain, sleep disturbances, and fatigue or loss of energy) persisting over time (at least two weeks) and causing disruption and impairment of functioning. 12 per cent of the population experience depression severe enough to require treatment at some point in their lives. A more detailed description of depression can be found in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM -IV).

Clinical depression as a diagnostic category has been sub classified in a number of ways, but as there is still much confusion over the status of various subtypes of the depressive illness, only the most widely accepted subdivision of unipolar and bipolar depression need be discussed at this stage. A bipolar disorder can be characterised by periods of both mania and depression, although some individuals experience mania alone. Mania, or manic episodes are periods of extremely elevated moods and unipolar disorders are depressions in which there is no indication of any form of mania or manic episodes.

At present, there is no single factor to explain the occurrence of depression, but rather it occurs from an interaction between many different factors. Its onset and course have been shown to relate to a variety of biological, historical, environmental and psychosocial variables (Boyd & Weissman, 1982). Despite the confusion over what depression is, it is agreed that depression can vary in terms of the relative degree and severity of its symptoms, their duration and frequency. Hence individuals can vary as to whether their depression is mild, moderate or severe and they may have one episode or many. Depression can have an acute onset or come on gradually and be chronic or short lived.
Psychotropic treatments of depression

One of the most popular theories behind the use of antidepressants for the treatment of depression is known as the monoamine hypothesis of depression (Coppen & Shaw, 1963). The role of the brain is seen as a communication circuit, consisting of neurotransmitter networks, that control sleep, sex, appetite, cognition and other processes in which many of the symptoms of depression appear. Many of these networks are separate "systems" that maintain their chemical balance via an intricate process of transmission of neurotransmitters. The monoamine hypothesis holds that depression results from chemical imbalance in one or more of these systems in which monoamines functions as neurotransmitters.

The monoamines, include two neurotransmitters believed to play an important role in depression; noradrenaline and 5-HT (serotonin). A widely accepted hypothesis is that depression is associated with a deficiency of one or both of these neurotransmitters and that mania is associated with an excess of one or both of them.

Antidepressants are thus divided into two categories that act in different ways to increase the availability of noradrenaline and 5-HT in the nervous system. These include:

1) Monoamine oxidase inhibitors (MAOI) which block the activity of an enzyme that can destroy both noradrenaline and 5-HT thereby increasing the concentration of those two neurotransmitters in the brain.

2) non-MAIO (tricyclic) drugs, which prevent reuptake of those two neurotransmitters thereby prolonging the duration of their activity. Imipramine, was the first drug of this type to be synthesised and is still one of the most widely used antidepressants to date. Recently, non-tricyclic
drugs have been introduced and are thought to have an entirely different mode of action.

Tricyclics and MAOI's take from 1 to 3 weeks before they begin to relieve the symptoms of depression and are particularly useful when they are chosen after careful examination of efficacy for a particular depressed patient. However they are widely used and commonly without this consideration. This is all the more significant given the number of side effects of antidepressants. These include; rapid heartbeat, dry mouth, blurred vision, constipation and urinary retention, sleep disturbances, and sexual dysfunctions, (Noll, Davis and Deleon-Jones, 1985). Antidepressants also interact negatively with other substances, including alcohol, barbiturates, certain food substances and other medications, which can cause additional side effects.

**Psychological treatments of depression**

The past ten years have seen the rapid development of a range of short-term psychological treatments for depression,(Rush 1982). However cognitive-behavioural treatment for depression (Beck, Rush, Shaw, & Emery, 1979) was selected for the purposes of this review as, at its best it comprises a complex interweaving of cognitive and behavioural techniques and is presently one of the most widely adopted, extensively evaluated, and influential of the psychological theories.
Cognitive theory:

Beck's cognitive model of depression (Beck 1967, 1976) is represented in Figure 1.

**Figure 1. The cognitive model of depression.**

- **Early experience**
  - Formation of dysfunctional assumptions
  - Critical incident
  - Assumptions activated
  - Negative Automatic thoughts

  *consists of the cognitive triad;*
  *i.e. negative views of the self, current experience, and the future*

  **Symptoms of depression**

  *consist of:*
  - Behavioural symptoms: e.g. withdrawal, decreased activity levels.
  - Motivational symptoms: e.g. loss of interest, inertia.
  - Emotional symptoms: e.g. anxiety, guilt.
  - Cognitive Symptoms: e.g. poor concentration, indecisiveness, suicidal thoughts
  - Physical symptoms: e.g. loss of sleep, loss of appetite.

The model suggests that experience leads people to form assumptions or schemata about themselves, and the world, which are subsequently used to organise perception and to govern and evaluate behaviour. Some assumptions are extreme, resistant to change and hence dysfunctional, however this alone does not account for the development of clinical depression. Problems arise when critical incidents occur which coincide with the individuals own personal belief system.
Treatment breaks into this vicious circle (shown in Figure 1.) by teaching the patients to question negative automatic thoughts, and to challenge the assumptions on which they are based. However, individuals present with a number of problems including the depression itself and depressive thinking prevents them from solving these.

Therefore, although symptom relief is the immediate target, cognitive-behavioural therapy aims in the longer term to solve life problems, and to prevent, or at least reduce the likelihood of future episodes of depression, by dealing with the dysfunctional beliefs that underlie the negative automatic thoughts. Beck, Hollon, Young, Bedroisan and Budenz (1985) have grouped them into three central areas of concern: achievement, acceptance, and control. Once identified, challenged and new beliefs tested out, there follows a decreased vulnerability to future relapse by undermining the fundamental assumptions on which depressive thinking is based.

**Cognitive therapy versus pharmacotherapy**

Current research has focused mainly on patients with acute depressions who are non-psychotic, nonbipolar and treated on an outpatient basis. Dobson (1989) reviewed eight studies comparing cognitive therapy versus tricyclic pharmacotherapy in the treatment of depressed outpatients and found evidence suggesting the effectiveness of the former. The average patient treated with cognitive therapy did better than 70% of the drug treated patients.

Dobson concluded that cognitive therapy is at least comparable to tricyclic pharmacotherapy, but could not state superiority given the small number of studies and generally limited sample sizes. His findings were however consistent with conclusions drawn in both earlier quantitative (Miller & Berman, 1983) and qualitative reviews (Hollon & Najavits, 1988).
Two studies have shown cognitive therapy to outperform pharmacotherapy; Rush, Beck, Kovacks, & Hollon, (1977) and Blackburn, Bishop, Glen, Whalley & Christie, (1981) However, results from these studies are equivocal as both appear methodologically flawed. In Rush et al's, (1977) trial, withdrawal of medication began two weeks before the end of treatment, accounting for pharmacotherapy's apparent poorer performance at post treatment since levels of depressive symptoms had actually increased in the two week interval.

Blackburn et al's study found cognitive therapy to outperform tricyclic pharmacotherapy only in the general practice group of patients, but not in the outpatient sample. This raises concerns as medication is commonly under prescribed by general practitioners and furthermore no effort was made to monitor patient compliance or plasma medication levels; suggesting the inadequate implementation of the medication.

Therefore, although the literature appears to suggest that cognitive therapy is at least as effective as antidepressant medication in the treatment of depression, methodological issues undermine the certainty with which any conclusion can be drawn. More so given that most of the direct comparison trials have tended not to use pill-placebo controls (including the two mentioned above). In their absence it is not possible to determine whether the sample selected was indeed pharmacologically responsive (Klein, 1989) or whether the drug was adequately administered.

The study causing the recent controversy over the efficacy of cognitive therapy was conducted by The National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Project (Elkin, Parloff, Hadley, & Autry, 1985). It was one of the most ambitious cognitive therapy-psychotherapy comparisons to date removing unnecessary uncertainty in
conclusions by including pill-placebo controls. In their study, 250 unipolar depressed outpatients at three different sites were randomly assigned to one of four treatment conditions: cognitive therapy, imipramine plus clinical management (ICM); interpersonal psychotherapy, and a pill-placebo control. A total of 162 patients (65% of those assigned) completed treatment.

Treatment outcome was evaluated on both self-report and clinician rated measures. Post treatment scores on initial analysis indicated few differences among the four conditions in the full sample. (Elkin et al, 1989). However patients judged to be more severely depressed or dysfunctional on clinician ratings at pre treatment displayed evidence that pharmacotherapy was superior to the pill-placebo control condition, some evidence for the relative superiority of interpersonal psychotherapy, and little or none for cognitive therapy.

These findings are inconsistent with other studies, as no other suggests any advantage for pharmacotherapy over cognitive therapy. Klein however dismisses these other studies by noting that none included pill-placebo controls, something he argues is necessary to establish that pharmacotherapy was adequately implemented and that the specific samples were truly responsive.

However, in the same way one could argue the importance of establishing the adequate implementation of pharmacotherapy; it is equally important to establish the adequacy with which cognitive therapy or any other psychological therapy was implemented. Hollon, Shelton & Davis, (1993) suggest that since pharmacotherapy outperformed cognitive therapy at only one of three participating sites, the competency with which cognitive therapy was executed across the three sites was inconsistent and most likely inadequately implemented. Particularly when considering the cognitive therapists participating in the study were inexperienced, and supervision
received during the study was minimal (one contact per month relative to the once or twice weekly supervision used in comparable trials).

Comparable trials that do appear to have established adequate implementation of pharmacotherapy and cognitive therapy in their comparison study of depressed outpatients, were conducted by Hollon, Derubeis, Evans, Weimer, Garvey, Grove & Tuason (1992) and Murphy, Simons, Wetzel & Lustman (1984). Both trials found little indication of superiority for either modality over the other. Although they again did not use placebo-pill controls the studies were overseen by experienced research pharmacologists. Drug dosages were consistent with current practice and compliance and absorption was monitored through plasma medication levels. Therefore it is unlikely that the medication was inadequately implemented.

The existing literature therefore appears to suggest that cognitive therapy is neither more nor less effective than antidepressant medication in the average non-psychotic, nonbipolar, depressed outpatient. Furthermore the one trial including pill-placebo controls (Elkin et al, 1989) that renewed the controversy over the efficacy of cognitive therapy did not prove to be as methodologically coherent as it first appeared.

The prevention of relapse using cognitive therapy

Cognitive therapy claims that it protects patients against symptomatic relapse or reoccurrence following treatment termination, a claim that is rarely made on behalf of pharmacotherapies. This is an ambitious claim, but if evidenced cognitive therapy has the potential to surpass the clinical use of pharmacotherapies since it would have greater efficacy in the long term.

Indeed the studies do appear more promising for cognitive therapy in terms of preventing symptom return following successful treatment. Across four
different studies, patients previously treated with cognitive therapy either alone or in combination with medication, evidenced a marked lower rate of symptom return than did patients receiving pharmacotherapy alone: 26% versus 64% respectively (Hollon, 1990).

A two-year follow up study conducted by Ellen and colleagues (1989) found that patients previously treated with cognitive therapy evidenced a significant lower rate of relapse (21% in cognitive therapy) than patients treated pharmacologically from whom medications were withdrawn (50% relapse). Relapse was considered to be two weekly BDI scores of 16 or more. When return to treatment was taken into account, differences became even more pronounced and patients continued on medication for the first year of the 2 year follow up also evidenced a higher rate of relapse (32%) than cognitive therapy.

The literature therefore, suggests that cognitive therapy does indeed provide protection against symptomatic reoccurrence following treatment termination. However, it is still not possible to conclude that cognitive therapy reduces risk as studies are few and sample sizes have been small. Furthermore, although these follow up studies have been informative none were designed to look specifically at long term treatment. Clearly what is needed are studies with larger sample sizes designed to look specifically at relapse after successful treatment.

**Combining cognitive therapy and pharmacotherapy**

The existing literature on combining cognitive therapy and pharmacotherapy indicates no clear advantage for the combination over either single modality alone.
Covi and Lipman (1987) compared combined cognitive pharmacotherapy with cognitive therapy alone found no significant differences between combined treatment and cognitive therapy alone, although differences that were evident favoured the combined treatment. Miller and colleagues (1989) in the only controlled comparison to date of depressed inpatients found no differences at discharge in depressed inpatients with either standard treatment (including pharmacotherapy, in most, but not in all cases), standard treatment plus cognitive therapy or standard treatment plus skills training. Differences favouring the combined treatments (particularly the one involving skills training) did emerge, however in a four month follow up period. Thus, although there are some indications that combined treatment may possibly be superior to one or both single modalities, these indications are neither large or statistically significant.

Conclusion

The existing literature indicates that cognitive therapy is no more or less effective than pharmacological treatment of non-psychotic, non bipolar acutely depressed outpatients. However it is not possible to conclude that the effectiveness of both modalities are comparable since most of the studies have not included pill-placebo controls. Such trials undermine the certainty with which any conclusions can be drawn since questions arise concerning the adequacy with which medication was implemented in these trials.

There are clearer indications that cognitive therapy may prevent relapse following successful treatment. However, studies with larger samples and specifically designed to look at reoccurrence of symptoms following successful treatment are necessary, before firmer conclusions can be made.

There is no significant evidence to suggest that the combination of cognitive therapy and antidepressant pharmacotherapy provides any superiority to
either modality alone. However small differences have been found to favour combined treatments, which justify the need for additional studies with larger sample sizes than before.

It is apparent that there are treatment roles for both psychological therapies and antidepressant medication. Each modality reduces depressive symptoms and individuals with medical conditions that contraindicate antidepressant or those who cannot tolerate the side effects, or those who are unwilling to use medication have other psychotherapeutic options available. However, in each case, matching the individuals personal and clinical characteristics would most likely improve the performance rate of both types of treatment. The indication that cognitive therapy may prevent relapse is another crucial factor when selecting treatment options, more so considering the 'value for money' climate we are currently pertaining to.

However, there is clearly a need for more research into the treatment of depression. Firstly studies with larger sample sizes, and designs ensuring adequate implementation of both pharmacotherapy and cognitive therapy. These studies will hopefully reduce the uncertainty that remains on drawing conclusions about the effectiveness of cognitive therapy compared to pharmacotherapy.

Secondly, there is little research into the treatment of the different subtypes of depression. Only one of the studies involved depressed inpatients, and another general practice patients. Thus, generalising current findings to other subtypes of depression other than non-psychotic, non bipolar, acutely depressed out patients would be unwise. However, given that the two modalities tackle depression using two very different approaches it seems justifiable that studies involving patients with other subtypes of depression need to be implemented to shed light on which subtypes of depression if any,
may be more effectively treated with pharmacotherapy and which with cognitive therapy.

Finally, none of the studies reviewed reported a 100% success rate in the reduction of depressive symptoms for either pharmacotherapy or cognitive therapy alone or combined. This evidence should not be dismissed and future studies should also focus on other models of treatment such Interpersonal Psychotherapy (IPT) developed by Klerman & colleagues (1984), which as yet have not received as much empirical and theoretical attention as the two modalities discussed here, but clearly warrant such attention.
References


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therapy, pharmacotherapy, and combined cognitive-pharmacotherapy for depression Manuscript submitted for publication.


Learning Disabilities Essay

"Discuss the Relevance of Genetic Anomalies to Day-to-Day Clinical Psychology Work with People who have Learning Disabilities"

Year I

June 1998
Learning Disabilities Essay: Discuss the Relevance of Genetic Anomalies to Day to Day Clinical Psychology Work with People who have Learning Disabilities

Introduction

Despite an increasing number of genetic anomalies shown to be associated with learning disabilities, there has been considerable reluctance to consider the psychological implications of aetiology. Historically an emphasis on an organic involvement in learning disabilities carried the implication of being untreatable; creating low expectations and subsequently an atmosphere of pessimism. Consequently the tendency was to classify and intervene according to level of impairment rather than genetic aetiology.

Presently, it is acknowledged that awareness of aetiology and diagnosis is of increasing importance both practically and psychologically. Clements (1987) for instance claims that knowledge of aetiology will help to “refine psychological interventions and develop rational broad-spectrum interventions incorporating both biological and psychological components”.

This paper will discuss whether or not this claim is justified for clinical psychologists working with people who have learning disabilities (PLD). To clarify this discussion it seems necessary to firstly mention some of the genetic causes of learning disabilities (using examples) and subsequently the relevance of behavioural phenotypes in the daily practice of a clinical psychologist. Problems inherent with an excessive emphasis on genetic aetiology in PLD will also be discussed.

Genetic causes of learning disabilities

There are a large number of organic causes attributed to learning disabilities and these can be structured according to what time they operate in the
pregnancy. For the purposes of this paper we are interested in the genetic causes of learning disabilities which occur at the prenatal stage and are the single most common causes of learning disabilities. Examples include Down syndrome where there is usually a complete extra chromosome at the 21st pair of chromosomes; Fragile X syndrome where the condition is transmitted in a sex linked fashion due to a fragility (where the chromosome appears to be restricted and can show clear breakage) present on the X-chromosome and Lesch-Nyhan Disease found only in males, involving an abnormal gene on the X chromosome which is associated with the absence of a particular enzyme necessary for purine metabolism.

**Behavioural phenotypes**

It is often unclear what researchers mean by the term behavioural phenotype and different workers in the field seem to have a different understanding of the concept.

Flint and Yule (1994) have taken a restrictive view and require two conditions to be met before a distinct behavioural phenotype can be established. "There must be distinctive behaviour that occurs in almost every case of the condition and rarely in other conditions. Also a direct and specific relationship to the genetic anomaly causing the condition's physical manifestations must be demonstrated".

With these requirements in mind, only three syndromes show a clear behavioural phenotype. The syndromes include; Lesch-Nyhan syndrome, Prader-Willi syndrome and Rett's syndrome. Severe self-mutilation (e.g. biting of lips, the inside of the mouth and fingers and thumping of the ears and face) is exhibited by 85% of children affected with Lesch-Nyhan syndrome (Deb, 1998). Overeating and abnormal food seeking behaviour characterise children with the Prader-Willi syndrome and abnormal hand movements are found in the rare condition of Rett's syndrome.
Turk and Sales (1996) however, argue for a broader more helpful definition. Their justification being that much of the research findings of behavioural phenotypes have arisen from poorly controlled studies of small numbers. Thus behavioural associations with specific syndromes may not have been demonstrated even though they exist.

For the purposes of this paper the following definition will be implied when referring to behavioural phenotypes. 'A behavioural phenotype is defined as those aspects of behaviour attributable to an underlying biological (including genetic) abnormality which has occurred early on in development and found at a heightened probability in individuals with a given syndrome relative to those without the syndrome'. (Turk & Sales, 1996), (Dykenes, 1995). This broader definition permits many more syndromes to exhibit behavioural phenotypes and thus maximises the potential relevance of genetic anomalies to clinical psychologists.

Examples of syndromes that exhibit behavioural phenotypes subject to this definition include; the conversational tendencies labelled 'cocktail-party chatter' (sophisticated but lacking depth or meaning) found in Williams Syndrome as well as hyperactivity, social isolation, anxiety and eating and sleeping difficulties. The structurally sophisticated speech but more limited comprehension, in Infantile Hypercalcaemia as well as problems with gross and fine motor skills and spatial orientation, poor peer relations but excessive friendliness to adults, high levels of anxiety, sleep difficulties and hypersensitivity to particular noises.

**Relevance of behavioural phenotypes to clinical psychologists**

Implications for clinical psychologists from the research on behavioural phenotypes does appear convincing. It seems that there are a number of areas in the daily practice of a clinical psychologist working with PLD which could benefit from a general knowledge of genetic aetiology. However, since much of the work undertaken with PLD is multidisciplinary it is recognised that
some, if not all of these opportunities may be equally available to many other professionals.

General awareness

Clinicians such as Turk & Sales (1996) argue that a “clear understanding of the nature, aetiology and implications of behavioural phenotypes by child mental health professionals is essential if they are to be of real benefit to clients with such problems and their families”. Not all professionals are expected to be experts in gene interaction, but knowledge of important warning signs could help indicate the need for a referral to a specialist.

Furthermore, although it seems natural for psychologists to look for psychological and social contributors to a behavioural disturbance, awareness of genetic aetiology would broaden formulations by indicating possible biological contributors.

This awareness is clearly warranted in the condition of phenylketonuria (PKU) since environmental treatment has such a striking effect. Treatment involves dietary restriction of phenylalanine that must begin in early life since untreated individuals have been shown by Hackney and colleagues (1968) to have severe learning disability and autism. However, a clinical psychologist’s awareness that dietary restrictions discontinued in middle childhood can lead to a decline in intellectual performance and increased behavioural disturbances, such as hyperactivity, and unresponsiveness can help direct initial psychological treatment to dietary control methods rather than (perhaps, ineffective) long behavioural programmes.

Helping the individual and the families come to terms with the disability

A common reason for referral of an individual with a learning disability to a psychologist is the coexistence of the person’s learning disability with a psychological difficulty. One common problem is the individuals low self
esteem and sense of worth which can lead to problems interacting with peers and depression. Working through the loss of the idealised perfect self and the associated guilt and anger at having a genetic defect is an essential component of any psychological treatment. The psychologists knowledge and understanding of the syndrome can help by clearing uncertainty, relieving blame and guilt, and steering discussions to focus on the strengths of the individual whilst acknowledging developmental and behavioural difficulties common for that syndrome.

Requiring similar attention is the effect and significance of loss for the parents of the individual. Perhaps more so, since any successful assessment and intervention of a clinical psychologists relies on the input and co-operation of the main carers of the individual with the problem. For parents the loss is of the idealised child which has been reported as an enduring grief rather than a time bound grief (Wikler Wasow & Hatfield, 1981).

Knowing the aetiology of the syndrome can help the clinical psychologist establish the families acceptance of the individual and their syndrome in two ways. Initially, by putting the individual and family in touch with support groups (with other families with individuals of the same syndrome). This is seen as an invaluable means of support for the family which offers helpful advice and assistance which services cannot. Additionally, filling in gaps in their knowledge of the cause of the condition, its likely effects developmentally and the possible links with behaviours can relieve the guilt and distress found in many parents caring for individuals with learning disabilities. Rather than feeling their child's challenging behaviours are a result of a lack of parental care and neglect they are more prepared when presented with certain behaviours associated with the syndrome, generating a sense of control rather than anger, guilt and helplessness.

An example of this can be seen with carers of those with the Lesch-Nyhan syndrome. The severe self-injurious behaviour (SIB) in Lesch-Nyhan syndrome is not under the control of the affected individual and most
individuals do try to avoid the behaviour but do not seem to be able to (Deb, 1998). Awareness of this helps the carers to understand that the SIB is qualitatively different from that found in most others with a learning disability, facilitating a more empathic response.

**Assessment and intervention**

Knowledge of behavioural phenotypes may also help tailor a clinical psychologist's assessment and intervention.

Firstly, awareness of the aetiology, the behavioural phenotypes and the developmental path of a given syndrome can help highlight other potential causes of the behaviour than those identified by the referrer, which should be addressed at assessment. For instance in later adult life, people with Down syndrome appear to be at serious risk of developing Alzheimer's disease. Its clinical symptoms in Down syndrome can however go frequently undetected until the disease is advanced and deterioration is severe. More often the expression of its symptoms may be labelled as a challenging behaviour or depression.

Once Alzheimer's has been correctly identified in the individual the psychologist can then help enhance the services for these individuals. Carers should be made aware that individuals may require more structured and supervised residential programmes and vocational and recreational activities may need to be modified for decreased memory and social skills as well as shortened attention spans. Bauer & Shea (1986) argue that efforts should be made from the start to inform caregivers of the relationship between Alzheimer's and Down's syndrome and offer training into the identification and treatment of affected persons. In this way intervention can be proactive rather than reactive.

Knowing that the behaviour may have a genetic cause can also help direct the psychologists interventions. A common reason for referring PLD to clinical
psychologists is for help with their challenging behaviour e.g. SIB, aggression and so on. Behavioural interventions however, have been reported as inconsistent and even harmful in some cases of SIB in individuals with Lesch-Nyhan syndrome (Anderson, Dancis, Alpert & Hermann, 1977). In such cases, emphasising the importance of environmental causes in SIB may prove more effective in managing the behaviour. For instance, Deb (1998) recommends shifting carers attentions towards looking at what factors in the environment (such as stimulation, over stimulation, rejection and so on) maybe increasing the likelihood of the behaviour.

Treatment approaches addressing psychological problems have also been developed specifically for individuals having a common syndrome. Such treatments have been developed with specific reference to Fragile-X Syndrome. An example is cited in Turk's (1992) paper, where Hagerman & Sobesky (1989) have developed a cognitive-behavioural package specifically for emotional and social difficulties experienced by female carriers.

Behavioural phenotypes are also helpful when working directly with the individual. For example it has been reported that males with Fragile X syndrome find eye contact distinctly aversive and will actively avoid meeting another persons gaze. Attentional deficits, restlessness, fidgetiness, distractibility and impulsiveness are also common. Knowing these behaviours are likely, clinical psychologists can modify their seating arrangements, shorten sessions, repeat information, verify understanding and allow more time for responses to encourage the participation of the individual in the session.

Furthermore, knowing individuals of a certain syndrome exhibit certain interests and strengths e.g. most individuals with Fragile X syndrome exhibit strengths in daily living skills such as cooking, cleaning and so on rather than community skills (Bregman & Hodapp, 1991) can help in increasing the probability of a successful treatment programme by utilising favourable
incentives. Also by suggesting and encouraging the active participation in activities that they are more likely to be good at.

**Education**

Despite the biological basis of much learning disability, early interventions of appropriate education have a significant role in determining the nature and severity of learning disability and associated problems (Turk, 1996). Clinical psychologists should be aware of the potential of early education. Knowing the behavioural phenotypes of a syndrome may help direct attention towards the most suitable level of education at the earliest possible age.

Many studies have explored aetiology specific profiles to develop more refined educational packages for specific aetiological groups. Hoddap, Leckman, Dykens, Sparrow, Zelinsky, & Ort (1992) compared the aetiology-specific profiles of intellectual abilities across three groups of males with learning disability using the Kauffman Assessment battery (K- ABC). Subjects included 10 males with Fragile X syndrome, 10 with Down's syndrome and 10 with non specific learning disability who were equated for both mental and chronological age. They found both general effects of learning disability and specific profiles of strengths and weakness within separate aetiological groups.

The several patterns that appear to be aetiology specific appear to have useful implications for education with particular learning disabled groups. It seems Down's syndrome children appear especially proficient at imitating sequences of hand movements. This finding suggests that interventions that emphasise sign language should be helpful in the early training of children with Down's syndrome. In contrast, males with Fragile X syndrome appear to be unable to imitate series of hand movements suggesting they would benefit little from training in sign language.
Udwin, Yule & Martin (1987) carried out the largest psychological study of children with Idiopathic Infantile Hypercalcaemia (IIH). They found that all 44 children exhibited superior verbal skills compared to visuo-spatial and motor abilities. From these findings they suggested that specific educational attention should be given in most cases to areas of visual perception, spatial orientation, numeracy and pencil control. Training such skills may be facilitated by using procedures which utilise their strengths (i.e. their superior spoken language) e.g. by talking through relevant exercises. For other activities such as writing it was thought more advantageous to bypass these difficulties with fine motor skills and use tape recorders and computers. Furthermore findings that children with IIH have superior auditory processing skills to visual has implications for the teaching of reading. Emphasising the use of approaches which rely on phonetic skills may be more effective than approaches which emphasise visual skills.

However although these findings suggest that professionals maybe able to tailor interventions towards a specific aetiological group, replications are necessary since the studies involved small group sizes. Additionally general findings across PLD, such as the strength of simultaneous processing (ability to integrate stimuli in a spatial gestalt like manner) relative to sequential processing (ability to recall stimuli presented in temporal or serial order) are as useful for intervention purposes as knowledge of specific-aetiological profiles.

Problems with aetiological classification

From these studies and what has been highlighted so far it does seem that there is a strong argument for clinical psychologists to have some knowledge of genetic aetiology and behavioural phenotypes in PLD. Hodapp (1997) goes on to argue that there are theoretical, research and intervention advantages to considering aetiological approaches. This suggests that perhaps aetiology based classification systems may be more useful than the current focus on level of impairment.
However this view is not shared by everyone in the field of learning disabilities. Goodman (1990) stated that “it is unhelpful and possibly detrimental to make aetiology the cornerstone of a diagnostic system”. She argues for intellectual level to be the basis of any classification system since knowing an individual’s IQ as well as their chronological age, provides information on level of instruction, social expectations and likely rates of progress; aetiology she believes gives no such information.

There are some inherent problems in using aetiology as a basis for classification. A major one being that a large percentage of PLD do not have an identified aetiology. It also simplifies the complex relationship between cause and outcome; sometimes ignoring the importance and interplay of environmental factors. More over it seems rather premature to contemplate a move towards an aetiological based classification system when researchers in the field are still debating over the correct definition of behavioural phenotypes as well as whether or not the effects of genetics on behaviour are direct or partial.

Classification by genetic aetiology also fosters the misconception that all people with the same syndrome have the same appearance or behaviour. This is clearly not the case since there is often a great deal of variety in the physical and behavioural manifestations of a syndrome. 40% of Down syndrome babies do not have the characteristic folds around the eyes and not all boys with Fragile X syndrome have gaze aversion.

Genetic aetiology also struggles to explain the wide variation of intelligence seen within syndromes. For instance, the range in IQ in Down syndrome extends from mildly disabled to IQ in the normal range and individuals with Fragile X syndrome are equally prevalent in the mildly learning disabled group as the severely disabled group. Therefore given the variation of intelligence it would be misleading to group all individuals with the same syndrome together,
for they will be less like each other in terms of functional levels and outcomes than a group of individuals with different genetic syndromes but similar IQ's.

**Conclusion**

This paper highlights the range of areas in a clinical psychologist's practice where ideally knowledge of genetic anomalies could prove useful. However with a stricter definition of 'behavioural phenotypes', the relevance of genetic anomalies is more limited. Further research into genetic syndromes and its influence on behaviour, (e.g. using larger samples) is required before the extent of its importance with PLD can be established.

The author believes that knowledge of genetic aetiology seems most helpful to clinical psychologists in its premise that biology does not always cause behaviours but that biological vulnerabilities predispose the individual to certain behaviours. Therefore a clinical psychologists intervention (as always) should ultimately be individualised and based on each persons specific profile, but awareness of the genetic cause (if known) can provide general guidelines that may tailor intervention approaches.
References


Child and Adolescents Essay

"Childhood Bereavement has a less deleterious effect upon children's psychological outcome than does marital discord and divorce. Discuss"

Year II

December 1998
Child and Adolescent Essay: Childhood Bereavement Has a Less Deleterious Effect Upon Children's Psychological Outcome Than Does Marital Discord and Divorce. Discuss

Introduction

The effect on a child of separation from its parents has proved to be one of the key issues in child psychiatry and developmental psychology. Bowlby (1969) believed that early separations cause a variety of psychiatric disorders ranging from anxiety and depression to psychopathic personality that persist into or appear for the first in adult life. This belief still largely stands and this suggestion of permanent sequelae following separations in early childhood raises particular attention to the needs of children experiencing parental bereavement and divorce.

This paper aims to review the recent literature on the long term effects of childhood bereavement, marital discord and divorce in children. Before doing so however, it presents a brief overview of attachment theory to help the reader understand the theoretical context in which the clinical research is set. It also suggests a number of possible reasons for the inconsistencies in the data, from methodological limitations to moderating variables which make it impossible to justify the above statement unequivocally.

Although the main aim of the paper is to question the long term impact of three separate life events on an individual, the reader must be aware that the author does not make any efforts to compare each with the other. Marital discord is defined to include conflict, disharmony and lack of parental agreement between married parents of children, including separated (but not divorced) patents. However, Block, Block & Gjerde (1986) had the opportunity to obtain detailed observations about children and parents in families that came to divorce many years later and found that ‘by the time the marriage breaks down, many children have spent years feeling relatively unsupported...
by their parents in a home that they regard as ill tended or conflict ridden'. Therefore, this raises the possibility that many responses that are associated with divorce may equally be due to the experience of living amongst marital discord for many years. Given this overlap, this paper chooses only to compare the long term effects of childhood bereavement with marital discord and divorce collectively. It thus uses studies of marital discord and divorce interchangeably with the assumption that divorced children have lived in a high conflict environment for many years.

**Attachment Theory**

Underlying both types of life events is the common aspect of separation from a parent. Although this seems less evident in divorce, the most negative aspect of divorce reported by children across studies was loss of contact with a parent. Fustenberger & Nord (1985) cited in Wallerstein (1991) reported that 23% of the fathers in post divorce families had had no contact with their sons or daughters in the previous 5 years and another 20% had not seen their children during the entire preceding year.

Therefore, given that both life events involve a break of an affectional bond, a brief overview of a typical attachment relationship that develops between a child and a parent seems necessary, before it can be fully appreciated how early separations can potentially have such detrimental effects in later life.

Social relationships begin in the first months of life, and it is during this time that a child's preferential reaction to their parents originate and gradually increase. During the second half of the first year, infants come to develop specific attachments to particular people. At 6-8 months they become upset if the person to whom they are attached leaves them. Similarly, if they are faced with an unfamiliar or frightening situation they seek physical closeness and comfort with their attachment figure, but are secure enough when with that figure to play and explore their environment.
Between 1 and 3 years children continue to show selective attachments and wariness of strangers, but most children now have multiple attachments (usually three to four). All of these attachments have a similar function in providing comfort and security and if separated from the persons to whom they are attached they show characteristic emotional distress/protest reactions. However, the tendency to develop selective attachments is a strong one, and thus if looked after by other responsible adults will soon form other selective attachments with their new caregivers.

Over the pre-school years children gain an increasing sense of security with their parents without the need for the same extent of physical proximity. Despite this developing ability to move away from their attachment figures they continue to need close contact when ill, tired or upset and particularly following separation experiences. At around 4 years, the manner in which children respond to separations change. If they are able to understand the reasons for their parents leaving they show little emotional upset, but if the separation is sudden, unexpected, and unexplained the separation anxiety will manifest.

As children grow older, attachments to parents continue to be primary, and possibly even stronger. Findings have shown adolescents are more likely to show prolonged grief after a bereavement and become less able to transfer affection to a new parent following divorce.

Therefore, attachment can be defined as the life long tendency of human beings under conditions of stress to seek some form of proximity (physical or emotional) with specific persons who are perceived as protective or comforting. The experience of secure specific attachments (as described) is believed to foster self esteem, self-efficacy, and autonomy that makes later social functioning more likely to be adaptive. Contrarily, breaking the affectional bond or rendering it less secure in childhood predispose individuals to react adversely to later stressful experiences as they lack the protective function of a secure attachment. Given the developmental history and power
of a secure attachment relationship, it is understandable that on a physiological, cognitive or emotional level, loss or thwarted access to an attachment figure becomes a universal stressor throughout the life span.

Theoretically, given that both childhood bereavement and divorce involve a crucial separation from a significant attachment relationship, the impact of these life events should produce equivalent reactions. Separation experiences however are heterogeneous and children’s short and long term reactions differ depending on the type and circumstances of the separation. To illustrate the variety of effects seen, children’s long term reactions are considered with respect to bereavement initially, followed by marital discord and divorce. Factors that influence the severity of the impact of the separations are also discussed.

The long term effects of childhood bereavement

In the 60’s the impact of a parent’s death on the individual child and the manner in which he attempted to cope with it was thought to be of crucial importance in shaping the course of his future personality development. Arthur & Kemme, (1964) investigated 83 emotionally disturbed children and their families following the death of a parent. From their findings they concluded that ‘bereavement may produce feelings of insecurity, inadequacy, emptiness, worthlessness and/or guilt of such magnitude as to threaten the entire personality’. Psychoanalytic literature supported this finding suggesting that an adult depressive illness was the most likely outcome following parental loss.

Since then however, the causal relationship between parental loss in childhood and adult psychological illness, has been substantially weakened. Tennant, Bebbington and Hurry (1980) reviewed the evidence that parental death in childhood predisposes to depressive disorders in later life and found most studies showing a significant finding to have substantial methodological flaws. For instance, studies such as Arthur & Kemme (1964) used samples of
psychiatric patients. The use of such groups means that findings primarily relate to psychiatric illness behaviour. Tennant et al, (1980) also argue that it is necessary to exclude those cases where parental death is by suicide since a genetic risk of depression may be indicated. They found no studies had excluded parental suicides from consideration. In general, their findings were largely inconsistent and where experimental and control samples were most rigorously matched, no association was found between childhood bereavement and depression in later life.

A similar review was carried out by Finkelstein (1988). He supported the inconsistency of findings in the existing literature, but felt conclusions should be drawn from the greater bulk of studies presenting similar findings. On that basis, the relatively strongest evidence supported an association between early mother death and later depression - in particular severe forms of depression. The relationship of early parent death and later alcoholism was also suggested.

Van Eerdewegh, Bieri, Parrilla, and Clayton (1982) carried out a one year retrospective study of 105, 2 to 17 year old children of a sample of widows and widowers assessed in the community and of the children of controls. The children’s reactions to the death were recorded at one month and thirteen months after the event in a structured interview with the surviving parent. Compared with a control group, psychological disturbance was extremely common at one month. Seventy-seven percent of the bereaved children showed symptoms of depressive mood as opposed to 34% in the control group. The most severely depressed bereaved children seemed to be mostly adolescent boys who had lost their fathers. In addition to symptoms of depression, poor school performance and bed wetting were also associated with the bereavement. There was a considerable lessening of symptomatology and difficulties one year later, the only exception being, disinterest in school becoming more common over that period. Interestingly 49 % of parents also reported that their bereaved children had become more helpful and took more responsibilities since the death.
However, as the authors note this study can be criticised because the interviews were not carried out with the children themselves. Dyregrov (1994) amongst others, noted that many parents are unaware of children's feelings and thoughts following a bereavement and furthermore underestimate the intensity, longevity and depth of children's reactions. Therefore this raises the possibility that the parents interviewed were so overwhelmed with their own grief that little attention was given to other members of the family and thus the bereaved children appeared (overly) well adjusted.

Therefore, in summary the literature on the long term impact of childhood bereavement is inconsistent and lacking in clarity. It does however, tend to suggest that despite severe emotional disturbance immediately after the bereavement their is a considerable lessening of symptomatology and difficulties after the first year.

Perhaps the most crucial methodological limitation of the studies reviewed (particularly from an attachment theory perspective) however, is the lack of control of the subject's age at the time of loss. Given that specific attachments can be created more easily at certain ages, it stands to reason that the nature of the relationship between parental death in childhood and adult morbidity may well be concealed if the subject's age at the time of loss is not controlled for. As cited in Tennant et al (1980), Birtchnell (1970a) found no difference in patients and controls, when parental death was assessed from birth through 19 years of age yet, when age categories 0-9 years and 10-19 years were separately assessed, significant differences emerged in the first group.

The long term effects of marital discord/divorce on children

Research in the area of marital discord and divorce has led to substantially more consistent findings than that of childhood bereavement. More over, the studies appear to be more methodologically sound, controlling for variables such as age at separation and sample selection.
One such prominent study was carried out by Hetherington, Cox and Cox (1985). They used 144, well educated, middle-class white parents and their children. Half of the children were from divorced, mother-custody families, and the other half were from a matched group of non-divorced families. The target child within the divorced group was four years old at the time of the divorce. Children of divorce showed more antisocial, acting out, and impulsive behaviours, more non-compliance and aggression with authority figures and peers, more depression, more difficulty in peer relationships, and more problem behaviours in school. These findings were found to more severe for boys than for girls and persisted at a second follow up, up to 2 years after final divorce.

A national survey carried out by Guibaldi, Cleminshaw, Perry, & McLaughlin (1983) corroborated this finding. They selected a random sample of 341 boys and girls aged 6-11, who had lived an average of 4 years in a single parent family, 90% mother custody, at the time of first data collection and 358 children from two-parent families. Information was gathered from parents, children, psychologists and teachers, controlling for potential bias in parents' reports alone. Children of divorced families performed more poorly than children of intact families in two major arenas - social behavioural and academic competence. Boys from mother custody homes were consistently rated most poorly by teachers and psychologists, showing less appropriate behaviour in school, less work effort, less happiness, more difficult peer relations and a higher frequency of behaviour problems than other children.

Hetherington et al's (1985) study at the 6 year follow up largely found that girls in the divorced families were similar in adjustment to girls in non-divorced families but as before, boys in the divorced families showed more aggressive and acting out behaviours and less social competence than boys in non-divorced families.

Similar results have been found in terms of marital discord. Reid & Crisafulli (1990) carried out a meta analysis of all published data from 1988 onwards
examining the relation of marital discord to the behaviour problems of children. The child behaviour problems included in the analysis were limited to problems of "under control" defined as conduct problems such as aggressive or disruptive behaviour. The analysis presented clear cut evidence that the relationship between marital discord and child behaviour problems existed for boys, but offered little support of its existence for girls. Although carrying out a meta analysis avoids the inevitable researcher bias found in conceptual reviews. Reid & Crisafulli (1990) have ignored sex differences in children's response to parental divorce, since girls show less externalising or under control measures when adjusting to divorce than boys but more internalising over control measures such as anxiety. Nevertheless the most consistent finding to date maintains that negative long term effects exist for boys experiencing marital discord and divorce remaining in single mother custody homes.

Contrarily, Wallerstein & Kelly (1980) found no differences in psychological adjustment between boys and girls aged 7 ½ -12 years, 5 years after separation. Instead, relationships within the post divorce family and the extent to which the family functioned as a whole were salient regardless of the sex of the child. Furthermore, they have found evidence for a long term "sleeper" effect in adolescent girls and young adult women.

Wallerstein & Kelly (1980); Wallerstein (1985) carried out what is renowned as the most enduring investigation of the long term effects of divorce on children and their parents. It provides the only 10 year and 15 year data available and includes observations of children as they have entered adulthood. They noted at the 10 year follow up that a significant number of young women who had done well during their early adolescent years experienced a sleeper effect as they moved into late adolescence and became frightened of failure. Almost all confronted issues of love, commitment, and marriage with anxiety, sometimes with very great concern about betrayal and abandonment, and not being loved.
However, Zuk (1991) argued that evidence from Wallerstein’s research was limited because it lacked a control group and thus her conclusions were concerning as they may not apply to the problem of divorce alone. However, Wallerstein argues that a control group was not relevant to the questions she pursued or the clinical methods employed. Rather her efforts had been directed at illuminating the inner experience of the child and the changing relationships within that family. As such, comparisons with intact families would not have added to the discussion.

Indeed, Hetherington and others have also found evidence for a sleeper effect. She suggested that this sleeper effect occurs since girls without fathers in the home during their childhood lack the opportunity to interact appropriately with men. She speculates that this results in high anxiety about heterosexual relationships which result in promiscuous behaviour in girls living with a divorced custodial mother and withdrawn inhibited behaviour in girls of widows. The effect being more notable in divorce since daughters may view men negatively as a result of prior marital conflict or their mothers persistent belittling of their father.

From these findings it would seem that the body of research addressing the longer term adjustment of children following divorce is considerable and with methodological rigour. The findings suggest that divorce is not short lived, moreover a significant number of children suffer long term, with boys showing increased behavioural problems after the divorce and up to 5 years after the crisis and women experiencing submerged effects that may appear more than 10-15 years later.

**Specific variables associated with post divorce outcome**

Therefore, contrary to what attachment theory would suggest, the reviewed literature proposes that it takes children longer to recover from divorce than from bereavement. However, it is misleading to see divorce as basically the loss for the child of one parent, usually the father. The studies show that
divorce has a longer history; usually following years of marital strife and with lasting consequences. For instance, discord or conflict may escalate after the marital separation, with the child experiencing a bitter custody battle; and in many cases there is the further event of parental remarriage with all its consequences. Kelly (1988) has identified a number of variables that significantly differentiated the experiences of those children who cope successfully in the years after divorce from those identified to be at risk. The specific effects of conflict and remarriage are discussed.

**Conflict**

Perhaps the most salient variable (and that which explains the difference in prolonged effects between bereavement and divorce) is the potential custody battles and disputes that (more often than not) follow divorce. Johnston and Campell, (1988) investigated a total sample of 100 children ages 1 to 12 and their parents. All of the families had instigated legal proceedings to obtain custody and/or were disputing arrangements over access. Disputes continued despite mediation efforts and attorney negotiations. A striking finding was that more than 95% of the children had witnessed some form of parental verbal or physical abuse. The period subsequent to the decisive separation displayed highly distressed and frightened children, showing a wide range of acute symptoms. As a group they showed very little overt aggression, and those who had witnessed physical abuse were particularly inhibited and withdrawn. At 2 ½ year follow up, the children seemed even more clinically disturbed. Overt aggressive behaviour was newly visible and clinical depression more consolidated. Furthermore, troubling configurations of defensive and coping behaviours were now visible.

Four and a half years post separation, the children who were in court ordered shared custody (greater access to both homes overriding the objections of one or sometimes even both parents) were significantly more depressed and withdrawn compared to their peers in sole custody regardless of mother or
father. Parent child relationships, including the more resilient mother-daughter relationships had deteriorated strikingly in the shared custody homes.

On this occasion, the girl's emotional and behavioural adjustment appeared to be more negatively affected by frequent access to both homes than boys, perhaps more notable as a result of their reacting to the custody dispute in such different ways. Girls tended to form close, emotionally dependent relationships with their father and to display hostility and ambivalence towards their mothers. Boys on the other hand tended to become more involved in the parental disputes.

Buchanan et al (1991) cited in Wallerstein (1991) showed that feeling caught in the middle was an experience also found in adolescents, associated with higher levels of depression, anxiety and deviance. Nevertheless 40% of their sample whose parents had showed high levels of disputes had been able to remain emotionally distanced from the parental conflict. This appeared most likely in cases where the youngster had maintained close relationships with both parents especially the mother.

Remarriage

The most critical new relationship following divorce comes of course, with the parental remarriage which is more likely to follow divorce than bereavement. Hetherington et al (1985) found that preadolescent boys and girls who had lived in remarried families for less than 2 years showed increased externalising behaviours and all parent-son/ parent-daughter relationships in the newly remarried families were problematic. By contrast however mothers and daughters in the non-remarried families continued to enjoy satisfying and close relationships. This seems to suggest that initially, remarriage brings the need for considerable adjustments by the children.

After two years of marriage however, the boys in re-married families seemed to benefit from having a step-father, and no longer differed from non-divorced
boys, as compared with the divorced boys who continued to have problems. In contrast the girls living in remarried families for more than 2 years had more externalising and internalising behaviours than those living in either the non divorced or the divorced families. Similar difficulties are also thought to persist over the long term for both boys and girls if the remarriage occurs during adolescence. This seems fitting with attachment theory which suggests that by adolescence, attachment figures are less easily replaced with new caregivers.

Therefore, given that parental conflict, custody battles and remarriage are associated more with divorce than bereavement it is possible that it is not the divorce per se that has the greater detrimental effect, but rather the conditions and agreements that are created during and after the divorce.

**Variables effecting the long term reactions to loss**

Finkelstein (1988) and Kelly (1988) have suggested that aside from the methodological flaws associated with bereavement and divorce studies, divergent findings may also be reflective of the varying impact of loss on the experiencing children. They identified a number of similar salient factors that may influence the severity of the long term reaction to the loss for children of both bereavement and divorce. The most similar of these are discussed.

**Adjustment of the surviving/custodial parent**

The psychological adjustment of either the bereaved parent or custodial parent is crucial in determining the eventual outcome of the child. Kranzler, Shaffer, Wasserman & Davies (1989) showed that depression in surviving parents was the most powerful predictor of childhood disturbance. Furthermore, VanEerdewegh et al (1982) found 83% of the surviving mothers of depressed bereaved children were suffering from a primary or secondary depression themselves. In the divorce literature, Wallerstein & Kelly (1980) reported that 'being in the custody of a psychologically disturbed parent, or a
parent who was neglectful or minimally invested in parenting responsibilities, was significantly linked to serious deterioration in the behavioural, social and academic functioning of children 5 years after separation'. These findings show the importance of ongoing adversity in the family following bereavement or divorce, especially depression in the parent.

**Child rearing practices**

In a related vein, a home climate of consistent care and support seems to be a protective factor attenuating the impact of bereavement and divorce. Custodial mothers are considered to have difficulties in disciplining their children after divorce. This inconsistent discipline and diminished controls with children may be a factor contributing to the increased aggression and conduct disturbances noted in divorced children. A common finding in bereavement studies is that parents often feel unable to meet the children's needs, consequently children become enmeshed in the family dynamics, taking active roles in 'saving' the family, caring for younger siblings or worrying about the welfare of the surviving parent. In this way children grow up to fast, take on too much responsibility and their need for independence is stifled.

**Financial consequences**

Both bereavement and divorce may have adverse financial consequences for the family. Tennant et al (1988) found early parental death may cause a decline in social class during childhood leading to changes in leisure and social activities and pressure on parents to fulfil two roles. Divorce almost always leads to an erosion of material security especially for women and Guibaldi et al (1988) found that much of the academic difference between children and divorced families and children in intact families were associated with significantly lower incomes in the divorced families.

Clulow (1990) however, argues that the financial consequences of divorce can be more severe than those following bereavement. He reported that families and friends are more likely to gather round sympathetically after a death,
offering vital extra-familial support. They can offer important economic aid and emotional assistance to the bereaved family and children often learn to use extra-familial figures as substitutes for the lost parent so that the effect of the continued absence of the parent is minimised. Divorce, on the other hand, may not only cost children one of their parents but also one set of grandparents -even all the relatives of the noncustodial parent.

Only a few of the variables that alter the reaction following divorce and bereavement have been presented, and others such as nature of the pre-existing relationship, meaning attached to the loss of a parent, and custody arrangements are as crucial to the subsequent reaction as those discussed here. Despite this shortcoming, it highlights that although loss of a parent (either via bereavement or divorce) creates a vulnerability it is additional ongoing provoking agents, particularly inadequacy of parenting after the loss, that mediates the child's risk.

Conclusion

There has been a large expansion in our understanding of bereavement during the last decade, (Dyregrov, 1994) and findings on long term reactions are largely inconsistent. This is due in part to methodological limitations of most studies, principally that of inadequate control of potentially confounding variables. Research regarding the long term effects of marital discord and divorce on children on the contrary, yields a growing consensus that significant numbers of children suffer for many years from psychological and social difficulties associated with continuing and/or new stresses within the postdivorce family, (Wallerstein, 1991).

Yet the evidence presented shows that it is difficult to ascertain unequivocally whether or not bereavement has a less deleterious effect upon children's psychological outcome than divorce. In both types of separation, the reactions of children are heterogeneous depending on the circumstances prior to and following the stressful life event. Nevertheless, it does appear that children
take longer to recover from divorce than bereavement. This does not seem surprising given that divorced children are more likely to live in a high conflict environment for many years prior to and following the divorce. Therefore, it can be argued that the impact of divorce has a more psychologically detrimental outcome for children than bereavement due to the increased risk of experiencing additional hardships such as parental conflict, custody battles, remarriage and having to come to terms with the fact that one parent chose to leave voluntarily.

Lastly, a word of caution identified by Wallerstein (1991) when reviewing these studies seems notable and worth emphasising. "Little is known about subgroups within divorced and married populations. Consequently, current group-aggregated comparisons between divorced and intact cohorts are of dubious validity and potentially seriously misleading".
References


Older Adults Essay

"Discuss the Issues and Concerns in the Provision of Group Therapy for Older People"

Year II

June 1999
Older Adults Essay: Discuss the Issues and Concerns in the Provision of Group Therapy for Older People

Introduction

The population of persons over the age of 65 is growing in the 1990's at a more rapid rate than most other age groups in our society (Toseland, 1990). This is made significant for health professionals by the escalating rates of psychological and medical disturbances that frequently accompany the ageing process. Consequently, there has been a dramatic increase in programmes and services for older persons and their families; group therapy being particularly prominent and effective. Yost, Bentler, Corbishley, & Allender, (1986) go further and add "not only is the group situation effective for older adults, it is often preferable to individual therapy, because the group offers unique opportunities that are important but often unavailable to the population."

This essay considers the issues and concerns in the provision of group therapy for older adults. It aims to do this by highlighting the common themes that emerge when working with older adults and subsequently, describing the various types of group therapy designed to meet these needs. The 'unique opportunities' that groups provide will also be discussed as well as key issues that may impede the effectiveness of the group. To conclude, empirical studies examining the efficacy of group psychotherapy are reviewed and directions for future research identified.

The definition of an 'Older Adult'

When discussing any work with older adults it is important to define 'Who the older adults are?' as it is a population that has changed and will continue to change considerably. Britton & Woods (1999) report "the usual arbitrary cut off point for many purposes, including psychological research and practice to
define when old age begins is 65 (or sometimes 60)". However, because people age at different rates Gurfein & Stutman (1993) suggest that the population is more usefully dived into two categories. Active elders or the young-old, i.e. those in their fifties, sixties and early seventies who are not notably affected by age-related changes (such as slowed reaction time, reduced visual acuity and so on) and the frail elders or old-old, those over seventy five who experience increasing limitations of their everyday functioning.

Moreover not only are we thinking about a diverse population in terms of physical health and ability, we are also discussing a population of individuals that have had a life time of unique experiences. Consequently, Toseland (1990) believes that old age could be the most diverse time of life as each older adult draws upon their unique backgrounds and their unique sets of coping strategies they have developed to cope with and adapt to the process of ageing.

Therefore, although it is helpful to understand as much as possible about the experience of old age when working with older adults, stereotypes of individuals based on chronological age, or preconceived notions of what it means to grow old are unhelpful. The variety of qualities and characteristics older members bring to groups (e.g. health, social networks, financial status) are at least, if not more, important than chronological age. Thus it is readily acknowledged that important individual difference in older adults exist that limit the interpretations and generalisations that can be made from the literature.

**Common Themes**

Despite the diversity of the ageing experience there are some common issues and themes that typify the major concerns of older adults. Many of these are generated by age-induced losses and changes, and by the individual's difficulty in negotiating the late-life developmental challenge of maintaining a
sense of self that is acceptable and tolerable to that of their past (Leczcz, 1991).

Pre-occupation with the past

Toseland (1990) noted that in peer groups, older adults often spend much time talking about their past accomplishments and swapping stories about what life has been like for them. He suggested that older adults are not preoccupied with the past merely for the sake of it, but rather, because their sense of self was developed in earlier years, they relied on their past to maintain a sense of self and to help soothe them through the difficult times. One of the most common insight orientated groups employed with older adults, life review group therapy draws on this principle and is based on Butler's (1975: cited in Tross & Blum, 1988) theory that “decreasing practical demands and proximity to death press for dramatic personal growth in late adulthood”.

Life review therapy has been described “as a developmentally appropriate and natural process of review through which elderly persons organise and evaluate their lives” (Leszcz, 1991). It consists of reminiscence about one’s own life, working through past feelings of guilt, clarifying positive personal values and resolving conflicts. By combining reminiscence, longitudinal perspective and an appreciation of the present, it is regarded as a process that facilitates or even restores a person’s feelings of self worth, stature, and competence through the articulation of past successes and the recollection of prior credentials. Butler (1975) applied the life review method to both group and individual settings and felt that group members would add to its success by modelling, supplementing and supporting the life review process.

Life review and reminiscence therapy are often used interchangeably, but Haight & Burnside (1993: cited in Woods, 1999) suggest that life review be used solely to describe an intervention where the therapist is seeking to assist the person in achieving a sense of integrity. Reminiscence therapy on the other hand is seen as having a variety of goals, including increased
communication and socialisation, and providing pleasure and entertainment. It is used extensively with people with depression and dementia, but Britton & Woods (1999) suggest some caution is required as large individual differences have been noted in older adults’ attitudes towards reminiscence and its potential to invade a person's privacy. Leszcz (1991) also warns against its use with profoundly depressed or withdrawn patients. He suggests that reminiscing may result in a “further preoccupation with the past; guilt over irreparable errors; and a heightened, morbid self absorption that results in social alienation”, and in such cases would no longer be serving the desired purpose.

**Loss**

Themes of loss are consistently reported to emerge when older people gather in groups. Toseland, (1990) reports that older people experience the death of other family members and close friends more frequently than do younger persons and retirement can often cause the loss of economic status and the loss of a satisfying and meaningful role. Gurfein & Stutman (1993) add that older adults may also express the loss of mental and physical functioning, loss of independence and fears of loneliness and alienation from loved ones’. Needless to say, these concerns are not unique to late life, but are more likely to occur in the latter third of life (Knight, 1999).

Psychodynamic group therapies for the cognitively intact elderly emphasise and try to understand the subjective experience of the elderly individual. They offer the opportunity for clients to share their emotional reactions with peers who are understanding and empathic. Examining the processes of relationships, interactions, and resistances in the group, helps the therapist and subsequently the clients to understand some of their behaviours as attempts to protect or stabilise the vulnerable sense of self. With greater understanding, opportunities for interpersonal learning are thereby enhanced (Leszcz, 1991).
One of the potential consequences of the loss of family, friends and social and work related roles is social isolation. The feelings of belonging and affiliation that comes from participating in groups help older adults to counter the social isolation and loneliness that can accompany loss (Toseland, 1990). Through group participation, older adults can expand their social networks and 'remotivation groups' are particularly successful at arousing the interest of older persons in other members and the environment, the effects of which can sometimes last long after the end of the group (Burnside & Schmidt, 1994).

**Depression**

Although most of those over the age of 65 adjust to the changes that accompany the ageing process, depression is still a chief psychiatric complaint of older patients (Tross & Blum, 1988). Yost et al, (1986) argue that a significant number of older people manifest both depression and loss of self esteem, but deny or fail to recognise it. This is supported by Eisdorfer, Cohen & Veith's (1980: cited in Yost et al, 1986) finding that men over 65 are four times more likely to commit suicide than men under 25, (the next highest peak period), but major depression is diagnosed only twice as often among older people.

Cognitive therapy was originally developed to treat depression and Yost et al, (1986) suggest that cognitive therapy is often the most logical way to deal with problems arising from the reality of old age. They claim that since many older adults have more time on their hands for thinking, “cognitive therapy is particularly appropriate for older adults, in that it provides them with the means to control their cognitive processes at a time of life when these processes have assumed greater prominence”.

The advantage of group cognitive therapy in dealing particularly with exaggerated and personified cognitive distortions is that participation in a group offers the older adults the opportunity to see the universality of their problem and helps to validate and affirm the experiences of older persons.
This sense of universality not only applies to specific common problems, but to the life stage that group members share. Thus, the group provides them with the opportunity to “share and compare” which is considered a natural medium for examining and changing attributions (Parham et al, 1982: cited in Tross & Blum, 1988).

**Satisfying and meaningful roles**

Following retirement, some older adults report feeling frustrated that they are being forced to live what they view as “relatively useless and unproductive lives” (Yost et al, 1986). In group therapy, especially in the context of a cognitive behavioural approach, members have ample opportunity to help each other and to realise that although their contribution may not be made in the familiar work setting, they can still have a valuable role in helping others. When talking about both the positive and negative aspects of ageing, group members can function as additional therapists, identifying problem cognitions and behaviours and developing corrective strategies for others, (Tross & Blum, 1988). All of these opportunities allow older people to demonstrate their capabilities, to exercise their talents and to assure themselves and others of their continued usefulness. Not only does this renewed self confidence in their role emerge in the group, it also provides older adults with unique opportunities for interpersonal learning, so that they are able to develop new roles outside of the group.

Despite the overwhelming benefits of groups for older adults it is important to remain aware that the vast majority of older adults cope well with the changes that ageing brings and consequently are less likely to need what group therapy can offer. For instance, while there are some older adults that live in poverty, the great majority are financially secure and are looking forward to pursuing leisure activities that were not possible in the very hectic early years of their life. Furthermore, the widespread belief that older people become increasingly isolated with age is not supported by the available evidence (Antonucci, 1985: cited in Toseland, 1990). Although some older adults are
isolated, the overwhelming majority of older people are surrounded by a support network of family and friends.

**Cognitive impairments**

Therapeutic groups have been developed for specific populations of older adults that have severe cognitive impairments. For instance, reality orientation is a widely used procedure that has been used with older people with dementia for over 30 years (Woods, 1999). The goal of the procedure is to reduce confusion and help older persons remain as orientated as possible by providing them with basic information about their environment. Reality orientation tends to occur as part of a 24 hour milieu approach to provide consistent and persistent orientation of the individual. Staff members remind the patients of time, place, and person in every interaction and reality reminders such as clocks and calendars are strategically placed.

Holden & Woods (1995: cited in Woods, 1999) reviewed 21 studies that evaluated the effects of reality orientation in comparison with either no treatment or an alternative treatment. However, because the studies were so different (e.g. in location, duration and so on), drawing conclusions from the data became problematic. Nevertheless, strong support for reality orientation sessions being associated with increased scores on measures of verbal orientation as compared with no-treatment control groups did emerge.

**Caregiver burden**

Caregiver groups have also developed in response to the increasing number of cognitively impaired and dementing individuals cared for at home by their families (Johnson & Catalano, 1983: cited in Gallegger-Thompson, Lovett & Rose, 1991). The rationale for the groups stem from the fact that many of the caregivers are themselves older, physically frail and are highly stressed, isolated and depressed (Leszcz, 1991). Gallagher-Thompson et al, (1991) describe various caregiver groups that utilise a psychoeducational approach. Objectives of the group are multiple and include an education of the
dementing process, and learning new ways of interacting and caring for the patient. A central psychological feature of support groups on the other hand, is to help carers work through some of the painful issues of having to deal with loved ones who are no longer able to express gratitude, show little signs of recognition of the caregiver and frustratingly few periods of coherent behaviour. Overall, carers group can help carers work through some of the guilt and resentment over their current situation and encourage practices of self care and access of other sources of support.

The advantages of care giver groups over individual treatment is that the homogeneity of the problems tends to foster rapid group cohesiveness, and thus greater self disclosure. Hearing other very similar experiences relieves some of the feelings of loneliness, frustration and guilt that is overwhelming for many carers. Groups also have several practical advantages. Members are encouraged to have extra group contact to provide crucial support outside of the group and share useful practical information such as information on respite, day care and so on. Outcome studies on caregiver groups indicate that participants in these groups show improved subjective feelings of self-control, self-direction, an increased ability to consider separation from the person being cared for and perhaps most importantly an increased capacity to care for themselves (Lazarus, Stafford, Cooper et al, 1981: cited in Leszcz, 1991).

In summary, it seems that there are certain older adults for whom groups are particularly well suited. Older adults who are socially isolated, shy, and inhibited, need accepting interpersonal relationships that groups can provide (Toseland, 1990). Groups provide opportunities for peer feedback and reality testing and partners to participate in role plays to increase learning of new interpersonal behaviours. They are also particularly appropriate for older adults who need assistance in identifying and participating in new social roles. They can learn about new roles from peers, to stay active, and involved, and to use the skills, expertise, and wisdom they have accumulated over a lifetime.
Impediments to the effectiveness of group work

Despite the apparent benefits of group work for the older person, there are also a number of issues that in practice can make group work less efficient and effective. Several authors, such as Toseland, (1990) and Waters (1984: cited in Burnside (1994) have gone so far as to say that there are certain contraindications for group therapy for older persons.

Selection of group members

Waters (1984) suggests that it is inappropriate for persons who are so "preoccupied with and overwhelmed by their own problems that they are unable to listen or respond to other people". Also that some people are so concerned about their privacy that they will not be able to discuss personal matters in a group meeting. Yalom, (1985) noted that individuals with severe hearing loss who would not be able to adequately hear and thus participate in group discussions should also be excluded as difficulties in engagement and group cohesiveness are a likely result. Toseland, (1990) adds that older adults with certain personality attributes or those displaying deviant and bizarre behaviour patterns may elicit negative interactions in groups that decrease feelings of self-esteem and well being.

In general, groups that are homogenous for degree of cognitive functioning are more likely to become cohesive quickly and generally are more supportive (Leszcz, 1991). Feelings of universality are enhanced, but excessive homogeneity runs the risk of a lack of contrasting perspective. Some groups have found that mixing the age of the members helps to preserve this quality in the group. Ba (1991) on the other hand, observed that mixing elderly patients with younger ones often made the patients assume the role of "relative" figures. This raises concerns over the members' ability to express their wishes freely, uneasiness and emotions. Therefore in general, Finkel (1991) suggests that members should be heterogeneous in terms of their problem, but homogenous in the degree of impairment. For all types of groups
however, the greater the impairment of the group members, the more homogenous the group should be. This practice encourages optimal opportunities for members to identify positively with one another.

The role of the group leader

Regardless of the amount of time and preparation that may have gone into selecting the appropriate members of the group, it is acknowledged that facilitation of the group may still prove problematic. There are a number of subsequent issues that may impede the effectiveness of the group, and the role of the professional in managing these obstacles is paramount to its success.

Attitudes towards psychotherapy

Yost et al, (1986) observed that many older adults have little experience or understanding of therapy and consequently are rarely enthusiastic at the outset of group therapy. In general, they have been raised in an era that encouraged and relied on independent problem solving and avoiding airing concerns in a public setting. Pearlman (1993) concluded from numerous conversations with older adults that feelings were knowingly repressed so that tasks of daily importance could be accomplished. Thus, rather than having a history of dealing with problems from a standpoint of emotional or psychological insight, many older adults often have a lifetime of practical, realistic problem solving.

Unfortunately these values can often be another potent source of negative cognitions during the ageing process. Yost et al, (1986) regard beliefs such as 'you have to work to be of value to society, or I should be able to handle problems myself, it's weak to ask for help", as serving well during the working years but fostering negative attitudes and beliefs about old age, and increasing the shame in admitting and seeking help for emotional problems.
Toseland (1991) suggests overcoming this obstacle to therapeutic commitment by discussing with the older person, what to expect in the group. This helps establish a therapeutic alliance and set group norms regarding regular attendance, confidentiality and extra group socialisation. Explaining the rationale of psychotherapy demystifies an otherwise anxiety provoking situation and introduces the concept of active management of their own lives. This is important as older adults may have recent experiences of receiving expert advice and assistance, regardless of their own input (Yost et al, 1986).

Groups that have employed effective pre-training have resulted in enhanced group cohesiveness, task adherence, increased hopefulness, reduced anxiety, and increased interaction and self disclosure, thereby increasing the chances of successful treatment (Leszcz, 1991).

**Young leadership**

The single most obvious difference between group members and leaders is usually their ages. Therapists can be up to 50 years younger than some of their clients and this alone can raise concerns regarding credibility and empathy (Yost et al, 1986). The group leader may find themselves being accused of not understanding the concerns of older people and therefore not being able to help. Although these are legitimate concerns, members who were reluctant to engage in therapy may use it as an excuse to discount any therapeutic interventions offered. Others may spend the majority of group time trying to convince the young person how difficult it is to be old.

Beliefs such as these could potentially sabotage the therapy, and thus Pearlman, (1993) suggests that group leaders pre-empt these concerns and discuss them in the first session. These discussions allow the therapist to explore the clients' expectations of them as a leader and the possibilities of learning and benefiting from someone younger.
Older Adults Essay

Transference Reactions

Finkel, (1991) suggests that groups offer the opportunity for older people to become “part of a family unit with a nurturing supportive system...” Consequently, transference reactions may be particularly intense within older adult groups and together with group pressures, the group leader is more vulnerable to developing their own negative cognitions when clients talk about their physical health. Group leaders in this situation may begin to doubt the use of psychotherapy in the face of such overwhelming medical problems. Additionally, given the tendency for older adults to discuss loss, degeneration and death in groups, group leaders are more likely to focus on their own mortality and the likelihood of being in a similar position to their clients in old age. These cognitions frequently lead to feelings of hopelessness and helplessness, that interfere with the therapists effectiveness in the group. Leszcz, (1991) has observed this position of hopelessness in the following ways; the therapists own boredom, lateness, or cancellation of meetings with the rationalisation that the group members will not miss the meeting.

Conversely, the therapist may become an idealised object. The group leader is in an ideal position to be the target of patients’ projections of lost youth, successes, health, employment and competence. Gurfein & Stutman, (1993) stress that ‘idealising transferences that develop should neither be confronted as defensive or rejected as unreal; both are real to the client and when validated aid in the development of self esteem’. However, it is appreciated that if the idealisation fails to strengthen and comfort group members and only leaves them feeling bereft of any of their own power or efficacy, it needs to be actively confronted. Discussing these issues however can be productive, and permits the members to explore these topics as they relate to them personally (i.e. how they view their own life and ageing).

Consultation, supervision and co-therapy serve to diminish these potential counter transferential difficulties. The use of cotherapists is widely regarded as helpful (Yalom, 1985) and has several significant advantages for older
adult groups. Firstly, cotherapy dilutes the disproportionate amount of attention focused by the older adults on the group leaders as opposed to other group members. Splitting the transference amends the tendency to see the therapist as the sole focus of interaction and authority. Secondly, it enables group dynamics to be more easily observed (as at any one time one of the therapists acts as an observer) so that warning signs of, boredom, frustration and so on can be addressed at any earlier stage in the group process. Thirdly, having a cotherapist provides mutual support and helps share some of the burdens of activating the group and engaging resistant members. Lastly, it ensures that the group meets regularly, despite therapists' holidays or illness, and thus reduces the threat to group cohesiveness.

The efficacy of groups

Despite a vast literature suggesting the utility of psychotherapy with older adults there are few empirical studies assessing treatment efficacy in older adults. Small sample sizes, patients receiving more than one treatment at one time and ethical difficulties in maintaining a non treatment control group, have hampered the evaluation of group treatments. Consequently most of the outcome data from group therapy investigations are from analogue studies but with non patient samples, or from studies with institutionalised patients in groups of diverse diagnostic composition (Steuer, Mintz, Hammen, Hill, Jarvik, McCarley, Motoike, & Rosen, 1984)

A few empirical studies however, have examined the comparative effectiveness of different types of group therapies for older adults. Steuer et al, (1984) assessed whether or not depressed geriatric patients would respond to group therapy and, if so, would they respond differently to psychodynamic and cognitive-behavioural group psychotherapy.

Subjects were 33 community volunteers who were 55 years or older and met the Diagnostic and Statistical Manual of Mental Disorders Third Edition (DSM-III: American Psychiatric Association, 1980) criteria for a diagnosis of
major depressive disorder and had minimum cut off scores on observer rated depression scales. Only 20 of the subjects, 10 per group completed the 9 month course of treatment.

The results revealed that both psychotherapy groups demonstrated statistically significant decrements in depression and anxiety as measured by observer and self rating scales. However the lack of a control group in the design of the study makes it technically impossible to conclude that the treatments were responsible for the reduction of symptoms observed. Nevertheless, the researchers maintain that the study did not aim to demonstrate the effects of treatment versus no treatment, but rather to learn whether or not older depressed patients could benefit from group psychotherapy.

An examination of comparative efficacy of the two types of treatment revealed no clinically significant differences, but a statistically significant difference between the types of groups was found for the Beck Depression Inventory (BDI: Beck, Rush, Shaw, & Emery, 1979) that favoured the cognitive-behavioural treatment. The BDI however, is heavily loaded with subjective depressive items such as hopelessness and self criticism, which is directly targeted in cognitive-behavioural treatment and thus more likely to exhibit significant gains on this measure. Therefore, the authors felt that both therapies were equally effective in producing meaningful symptom relief. This finding is consistent with Tross & Blum's (1988) review of geriatric group psychotherapies. They found that "all consistent and rational group psychotherapies are equally as effective as long as the patient remains in the treatment for the prescribed period of time and does not suffer from physical illness". They explain this finding as a function of the non specific ingredients that these therapies share, including therapist attention, interpersonal contact and empathy.

Other studies such as Beutler, Scogin, Kirkish, Schretlen, Corbishley, Hamblin, Meredith, Potter, Bramford & Levinson (1987) have compared the
relative and combined effectiveness of medication, in this case alprazolam (Xanax) and group cognitive therapy. Subjects for the study were 56 individuals who were 65 or older and met the DSM-III criteria for a diagnosis of major depression, and a score of above 28 on the Hamilton Rating Scale for Depression (HRSD: Hamilton, 1967).

Subjects were treated over a 20 week period in one of four groups: alprazolam support, placebo support, cognitive therapy plus placebo support, and cognitive therapy plus alprazolam support. The results revealed that individuals assigned to the group cognitive therapy showed consistent improvements in subjective state and sleep efficiency relative to non-group therapy subjects. There was also a much lower drop out rate and dissatisfaction ratings for group cognitive therapy than for medication only conditions.

However, no differences were found between the alprazolom and placebo conditions, regardless of whether individuals received group cognitive therapy or not. These results suggest that either inadequate dosage levels were used or alprazolam is ineffective in modifying symptoms of depression, which may explain why these results are inconsistent with other studies such as Steur, Mintz and Jarvik's (1982: cited in Tross & Blum, 1988) study. They compared the effects of tricyclic antidepressants (either imipramine or doxepin), placebo drug treatment and group psychotherapy in older depressed outpatients (either cognitive behavioural therapy or psychodynamic group therapy).

Both antidepressant and group therapy resulted in greater symptomatic improvement than the placebo drug condition. They also reported that group therapy outcome appeared to be as effective as the antidepressants on scores on the BDI, but this was not the case when the HDRS scores were analysed. The researchers concluded that the BDI is concerned with cognition and feelings which respond to psychotherapy, while the HRSD is highly influenced by the presence of somatic symptoms that respond better to drug treatment. This conclusion would also explain why Beutler et al, (1987) only
found improvements in the self report measures of depression in the cognitive therapy group condition, but no significant improvement in HRSD scores for any of their treatment conditions. Steur et al's (1982) results also suggest that the different types of intervention may be treating different aspects of depression in which case the intervention of choice with older adults might be a combination of the two. Future studies would benefit from pursuing this further.

More research into the efficacy of groups, not directly focused on older people has been carried out and findings appear encouraging. For instance, Toseland and Spiron, (1986) carried out a review that used only rigorously controlled studies comparing group work to individual treatment. They found that group work was a more effective modality in 25 percent of the studies and in the remaining studies reviewed they found no differences. Thus the review suggested that group work was at least as effective as individual treatment. Consistent with Steur et al's, (1984) study, they also found that group treatment was associated with lower rates of discontinuance from treatment. That is group treatment produced fewer dropouts than individual treatment. However not all studies examined this question. The authors speculated that the mutual support, mutual aid, and cohesion found among group members tended to keep them participating longer than individuals who participated in individual treatment.

Toseland and Sipiron (1986) also demonstrated some empirical support of the popular belief that group treatment is more efficient than individual treatment. They reported savings between 15 and 40% of therapist time. However, savings depend on a number of factors. Groups for older people involve small numbers of participants and often two therapists which indicate that time and cost may not be a strong determining factor for choosing groups over individual treatment for older adults.
Conclusion

"Groups are a significant part of people's lives, they define the social self, that is the self interacting with others" (Abraham, Niles, Thiel, Siarkowski, & Cowling, 1991). Unfortunately, due to circumstantial changes that are often associated with advancing age (e.g. retirement, chronic illness, loss of family and friends) group membership may steadily decline.

This essay has presented several approaches to therapeutic work with the older person and their objectives. The literature suggests that psychotherapeutic groups with elders (regardless of their method of intervention) enhance feelings of belonging and well being, facilitate social awareness and interaction, and promote a positive adjustment within one's environment. Other common factors to all groups is the instillation of hope, universality, and provision of information (Yalom, 1985). Future studies however, are needed to detect the comparative efficacy of specific group treatments for individual problems.

The essay has also highlighted the difficulties that arise when designing and implementing a group for older people, as well as emphasising the role of the group leader in maintaining group cohesiveness and effectiveness in older adult groups. Clearly, the role of the group leader with older adults is demanding, but one that offers unique opportunities to learn and grow professionally and personally.
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Specialist Essay

"Is Systemic Family Therapy an Efficacious Treatment for Anorexia Nervosa: A Critical Review of the Literature"

Year III

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Introduction

Many of the originating and leading figures in the family therapy field, developed major aspects of their contributions to family therapy through the treatment of eating disorders. Consequently, anorexia nervosa is considered to be the paradigm for family therapy (Dare, 1995).

Salvador Minuchin and his colleagues at the Philadelphia Child Guidance Clinic and Mara Selvini Palazzoli and co-workers at the Milan Centre were the first to devise theoretical models to explain the aetiology of anorexia nervosa. Although the models and therapeutic strategies differed, they had both observed certain specific characteristics of the families within which anorexia nervosa arose. For instance, the closeness of the relationships within the family, the blurring of boundaries between generations, and a tendency to avoid open disagreement or conflict. Both schools also reported successful outcomes as a result of their family therapies, however neither group verified their claims by undertaking controlled trials and systematically following up their patients.

Since then, a number of different family therapy models have emerged, which have different views of the nature of family therapy and the mechanism that bring about change. Due to time constraints, this paper describes only the Maudsley Model and treatment approach to family therapy in detail. This treatment approach was chosen because it has been shaped by series of controlled trials, in which the family therapy has been compared with different forms of control therapies in an effort to identify the specific indications for family therapy. Additionally, it is a multi-factorial model and thus elaborates on the links it has with other family therapy models.
Following a description of the model and the approach of family therapy, the paper aims to review the empirical evidence for the effectiveness of family therapy for anorexia nervosa and focuses on the infamous Maudsley Studies which dominate the literature. The review also aims to identify sources of inconsistencies between the studies, methodological strengths and weaknesses in the existing literature; and directions for future research.

The Maudsley Model

Similar to Post-Milan models of family therapy, the Maudsley approach takes a "neutral" stance as to the origins of the disorder (Boscolo, Chechin, Hoffman & Penn, 1987; White, 1987). They suggest that the problem exists outside the individual and the family, but that it affects all of them and will require all of the families’ efforts to conquer it. This position is considered the least likely to induce disabling guilt in the family members and stresses the importance of external sources (e.g. sociocultural) for the illness (Dare, Eisler, Russell & Szmukler, 1990). The model is shown in Figure 1.

Figure 1 The Maudsley systemic model of the multifactorial aetiology of anorexia nervosa.
An important element of the model is the presence of the life cycle as an organising principle constrained by genetic and social influences. How the individual and the family adapts to and assimilates the genetic and cultural impingement's in turn alters progress through the current phase of the life cycle and hence the passage through the subsequent phase.

Figure 1. illustrates how socio-cultural inputs (specifically the slimming culture) impinge on the individuals of the family and have a strong effect on the nature of the family organisation, which is in accordance with the notion of eating disorders as a culture bound phenomena (Gordon, 1990: cited in Dare & Eisler, 1997).

In the model, genetic influences are also shown as impacting on the individual, the family and the symptomatic presentation. For example, the specific genetic context could potentially make it more likely that an anorexic rather than a bulimic form of eating disorder would occur.

The model also emphasises the major impact of the symptoms on the functioning of the individual and the family. The most obvious of which are the known effects of starvation on an individuals mood, behaviour and social functioning (Vitousek & Manke, 1994). Dare & Eisler, (1997) argue that it is highly likely that some of the apparent dysfunction reported in families of an anorexic patient is not an antecedent of the eating disorder (as suggested in Minuchin’s psychosomatic family model (1978), but rather the “result of the development of a life-threatening illness in a previously well child. Perhaps, even more evident when coupled with the well known effects of starvation on an individual’s mood and behaviour, the possible experience of covert blaming from professionals and the common failure of therapeutic endeavours”.

An advantage of this family therapy model is that it highlights a number of different theoretical sites for therapeutic intervention which can go far beyond an approach based on the individual alone. Therapies may seek to change
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the individual, the family, the role of the symptom on the life of the individual, and the symptom. Nevertheless, it would seem that all treatments would have to accept the genetic organisation of the individual and the currently unchangeable aspects of society as given.

The Maudsley Treatment Approach

The Maudsley approach was developed from the practice of family therapy established by Christopher Dare, in the Child and Adolescents Outpatient department at the Maudsley Hospital in London. The approach closely resembles the structural approach of Minuchin, Rosman & Baker, (1978), but has clear distinctions in specific areas. In younger anorexic patients the approach proceeds through three clear phases (Dare, 1983)

In the first phase, like the Philadelphia group, treatment begins with direct observation of a family meal and parents are urged to work together and are supported in taking control of their child's eating. However, unlike the structural approach, there is no underlying assumption that the observed pattern of family functioning is dysfunctional or that the aim of therapy is to reverse such dysfunction. Instead, there is evidence of the 'Post Milan' influence which emphasises the need to maintain a neutral stance not only in relation to the family (i.e. not taking sides), but also as to whether change should occur (and if so what direction it should take) (White, 1987). Therefore, instead of making direct interventions which aim to alter the family organisation, the therapist interviews the family in a way that elicits differences which urge the parents to identify what their future joint attitude to the feeding pattern of their child should be.

The second phase begins when some consistency in the parents' management of the eating disorder results in steady weight gain. At this stage there is a move towards an intergenerational, developmental understanding of the family organisation and symptomatology. In the style of the Milan school (Selvini Palazzoli, Boscolo, Chechin & Prata, 1978) the therapist develops a
hypothesis about the nature of the family organisation and the "function" of the symptom in this organisation.

When the patients' weight is largely under control, responsibility for continued weight gain is handed back. Discussions are then focused on more normal family concerns. The main focus in adolescents and younger concerns access to increased autonomy and the re-organisation of the parents' marital life after their children's prospective departure form the home. Unlike, Minuchin et al's, (1978) approach, individual or marital counselling or psychotherapy is not used in the final, termination phase of the therapy.

In contrast with adolescent anorectic patients, with older patients there is an understanding that parents (or partners in the case of married patients) are not expected to become involved in the issue of weight control. Much more time is spent trying to help the patient forgo dietary preoccupation and eliminate the use of anorexic symptoms as a medium for family communication. The approach also encourages age appropriate relationships and closely follows the style and focus of Haley's (1980) work on the 'process of leaving home'. It uses strategic interventions to try to disqualify or undermine the use of symptoms as reasons for maintaining the son /daughter in a dependent child like relationship with the parents.

As may be expected, adult patients are often reluctant to involve other family members in therapy. In these situations, Dare & Eisler (1997) suggest that discussing the advantages of inviting other family members to the session, and how, when, and in what combination it would be best to ask them can be a powerful intervention in itself.

**Empirical validation Of Family Therapy**

Family therapy, like most psychotherapies is a difficult subject to investigate. Targets of treatment, the measures of change whether in terms of the individual or interactions within the family, and the exact nature of the therapy
are all difficult to establish. However the practical difficulties in establishing a controlled trial only partly explain the lack of empirical studies in the domain of family therapy.

Dare et al, (1990) comment that “clinicians are often critical of systematic outcome trials on the grounds that they introduce artificial restrictions on the treatment interventions that not only impede the therapy, but also make it difficult to interpret the results in any way that would be useful in clinical practice”.

However, anorexia nervosa is an illness that lends itself to an evaluation of psychological treatments. Diagnosis is based on clear-cut criteria and its course can be easily be followed by means of reliable outcome measures. More importantly however, the author agrees with Gurman (1983: cited in Dare et al, 1990) when he says: "Whether or not it suits our philosophic and epistemological style of inquiry, patients, administrators, insurance companies, and numerous others expect us to produce effects and to produce reliable and valid evidence that we produce effects”.

The first ever controlled trial in which family therapy was compared with a different form of therapy for the management of severe eating disorder was carried out at the Maudsley Hospital by Russell, Szmukler, Dare & Eisler, (1987). The trial aimed to identify an effective form of therapy which would supplement the inpatient regime and improve the long term outcome. The results of this study have directly led to three other randomised controlled trials, which have subsequently shaped the Maudsley treatment approach.

The stages and design of the study posed several methodological strengths. The process of which is shown in Figure 2. The first advantage was the two stage approach. Since, the randomised trial only began after an initial specialist inpatient regime directed at restoring the patients normal weight gain, the psychological treatments could be focused on maintaining and consolidating the gains already achieved by hospital admission. Additionally, it
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reduced the ethical implications of using an unknown control treatment since the patients had already been restored to optimum weights before being randomly allocated to out patient treatment

Figure 2. First Maudsley Study of Family Therapy for Eating Disorder

The second stage study involved the sample of 80 patients (57 with anorexia nervosa and 23 with bulimia nervosa) being randomly allocated to one of two follow up treatments (family therapy or the control treatment, individual supportive psychotherapy). Prior to this the design was refined further so as to introduce greater homogeneity in the patient groups receiving treatment. The anorectic patients were divided into subgroups according to two factors known to influence outcome: A late age of onset and a longer duration of illness are both associated with an unfavourable prognosis (Morgan & Russell, 1975). The patients with bulimia nervosa were placed in a separate subgroup.
Consequently there were four subgroups of patients: (1) Subgroup 1 - age of onset less than or equal to 18 years and duration of illness less than 3 years; (2) Subgroup 2 - age of onset less than or equal to 18 years, duration of illness more than 3 years; (3) Subgroup 3 - age of onset 19 years or older. (4) Subgroup 4 - patients with bulimia nervosa. It was only after entry into the appropriate subgroup that patients were allocated to one of the two therapies (Fig. 2.).

Another strength of the research design was that it ensured that both treatments offered one hour sessions and approximately the same number of treatment sessions were given over the 1-year period prescribed for treatment. Regular, weekly supervision were also provided for both modalities. The design also required each therapist to undertake both therapeutic modalities in order to control for possible variations in the experience, skills, and enthusiasm of the therapists. Over the course of the five year study, four therapists were responsible for treating most of the patients.

Each session of the family treatment approach nearly always involved the whole household of the patient, and sometimes non-resident, but involved, family members (e.g. separated parent). The individual therapy was not a formal psychoanalytic psychotherapy but was supportive educational and problem centred, with elements of cognitive, interpretative, and strategic therapies. In order to maintain the distinctiveness of the two therapies, the individual therapist did not include the family members in the sessions and the family therapist did not see the patients or the parents separately from each other.

As assessors could not be “blind” to the form of treatment provided, objective assessments were facilitated by using a research investigator who was not involved in the provision of treatment to assess the patients at follow up. The two principal assessments were the Morgan and Russell scales (Morgan & Hayward, 1988) and changes in body weight. The scales have been applied in several studies investigating the natural outcome of anorexia nervosa.
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(Morgan & Russell, 1975) and produce two sets of data. The first set concerns categories of general outcome (i.e. good, intermediate or poor), which is based on body weight and menstrual function. The second is a measure of general progress along five clinical dimensions (nutritional status, menstrual function, mental state, psychosexual adjustment and socio-economic status). The average outcome score is derived as the mean of the scores on the five scales.

The results showed that there was a striking difference in the outcome of treatment depending on the age of onset and duration of the illness. In Subgroup 1, family therapy was shown to be statistically significantly more effective than individual therapy. This was clearly demonstrated through a greater weight gain (25.5%) compared to those receiving individual therapy (15.5%) as well as a favourable distribution in patients among the categories of general outcome and an improved average outcome score on the Morgan & Russell scales. This finding is consistent with Minuchin et al's (1978) reports of a favourable response of family therapy in anorexia nervosa. Fifty one of the fifty three cases they report fell within the definition of Subgroup 1. However, it could not be concluded (as Minuchin and colleagues did) that this would also be the case with patients with a late age of onset.

In Subgroup 3, the effects of the two therapies were reversed. Individual therapy led to a more impressive weight gain (19.9%) than family therapy (5.5%). However, there were no statistically significant differences observed in the distribution of patients among the categories of general outcome or in the average outcome score between the two therapies. In subgroups 2 and 4 there were no significant differences in the measures resulting from the two therapies.

Thus, the main finding was that family therapy was an effective treatment for those patients with anorexia nervosa whose illness commences at an early age and the illness has not become chronic. A second more tentative finding
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was that individual supportive psychotherapy was more effective than family therapy in patients in whom the illness commenced at a somewhat older age.

However, despite the methodological rigour in the design of the study, the choice of sample is questionable. A sample of former in-patients who complete in-patient treatment are not necessarily typical of those who have the condition. The sample would not have included patients who refused in-patient admission or who dropped out of in-patient treatment and refused further intervention. Furthermore, although the number of drop outs were not found to bias the results, Subgroup 3 was left with a relatively small number of members and is thus another reason for regarding the possible superiority of individual therapy for patients with a late age of onset, with caution.

It could also be argued that the study did not have an untreated control group which prevents the ruling out of non-specific factors rather than the active treatments as responsible for the improvements. However, Crisp, Norton, Gowers, Halek, Bowyer, Yeldham, Levett, & Bhatt (1991) found the majority of patients in their no treatment control group had proceeded to other forms of treatment which may then have contributed negatively or positively to their status at one-year follow up. Moreover the natural history and severity of the disorder would give rise to serious concern if treatment was denied when necessary. The fourth Maudsley trial of adult anorexia nervosa patients, (currently in progress) has accounted for these flaws, by including a standard control group which involves routine psychiatric treatment and in contrast to this study is conducted on a purely outpatient basis.

67 patients have been followed up 5 years after entry into the Russell et al, (1987) trial (Eisler, Dare, Russell, Szmukler, le Grange & Dodge, 1997) to determine whether the psychological treatments found to be effective gave rise to enduring benefits. Overall there was a trend towards improvement which could be attributed to the natural outcome of the illness. Nevertheless, there was still a clear difference between the four prognostic groups. As predicted, patients in Subgroup 1 showed a good outcome at the end of 5
years. More importantly however, the benefits of family therapy compared with individual therapy had endured up until the 5 year follow up. This provides a powerful argument for family therapy being the treatment of choice in adolescent patients with anorexia nervosa. Subgroup 3 also progressed reasonably well and the benefits of individual therapy compared to family therapy were still detectable at the five year follow up, although the difference in outcome did not reach statistical significance. Subgroup 2 and 4 showed no difference in the benefits of family therapy and individual therapy at the end of 5 years and presented with a disappointing outcome.

Unfortunately, due to the long term follow up nature of the study, several methodological problems were apparent. Firstly, information regarding clinical progress was incomplete for at least 10 patients and has to be viewed more cautiously. Another point of caution was unplanned treatments intervening in the four years. Given that most of the patients returned to their local medical services after the one year of treatment at the Maudsley it was not possible to obtain detailed information on further unplanned treatments, such as the use of antidepressant medication and so on. Although general information was gathered at interview, there was no information for 16 of the 80 patients and it was impossible to assess these treatments in depth because of their variety. Nevertheless, it was noted that those patients who had undergone additional treatment tended to be those where the progress had been worse.

Older patients with anorexia nervosa

Given the somewhat unexpected finding of the benefits of individual therapy in Subgroup 3. The second Maudsley trial aimed to compare the benefits of three psychological treatments in older anorectic patients (ages 19 and over), but otherwise followed the same stages and design as the first study. The treatments compared included 1) family therapy, 2) individual supportive therapy as in the first study and 3) brief focal psychodynamic psychotherapy devised by Malan (1963: cited in Dare et al, 1995). This treatment was chosen because it focused on transference and during Study 1. It was observed that
in individual therapy the anorexic patient would frequently treat the therapist with passive hostility and distrust; as though the help offered had to be rejected- as food is rejected. Only when the therapist and patients somehow found a way to form a co-operative therapeutic alliance, and became joined in an attempt to overcome the patient's problems did the therapy eventually prove beneficial.

This second study is still in progress and 66 patients have been entered into the study to date. Russell, Dare, Eisler, le Grange's (1992) reports on the emerging findings suggest there is a trend for patients with an early onset of illness (i.e. <18 years) to show better progress if they have been in family therapy than those receiving individual therapies. They were not able to make any conclusions from the patients with a late age of onset, but noted that there were no significant differences between the treatments. Therefore, the preliminary results do not provide strong support for psychoanalytic psychotherapy in comparison with family therapy. Consequently, Russell et al, (1992) tentatively concluded that "an illness of early onset may remain associated with a good response to a family treatment even though the patients are no longer young when they receive it". However, these findings are based in a sample of 49 patients and thus the number of patients in each treatment is group is very small. Furthermore, the sample consists of patients with long term histories of eating disorders and for this reason the end of treatment results at one year have to be viewed with considerable caution, as any changes may not be enduring. The results from the long-term five year follow up study currently underway will add to these findings.

Adolescents with anorexia nervosa

The clear implications of the efficacy of family therapy in adolescence led to the third Maudsley trial comparing two forms of family therapy: the conjoint family therapy (so far found to be effective) and a comparison form termed "family counselling". The aim was to explore which components of family therapy were essential for success. The trial is not yet complete and no
results are available, but the results of the pilot study have been reported (le Grange, Eisler, Dare, & Russell, 1992).

The 18 patients in the pilot study had to meet the diagnostic criteria for anorexia nervosa (DSM-III-R, American Psychiatric Association, 1987) be younger than 18 years of age and their illness shorter in duration than 3 years. After the initial assessments patients were randomly assigned to either conjoint family therapy or family counselling. The treatment was conducted on an outpatient basis, with the therapy lasting 32 weeks.

The two treatment approaches had similar aims and generally followed a similar course. However, the main difference in the treatment centred around the issue of being able to see the family as a whole as opposed to seeing some members of the family individually. In conjoint family therapy the whole family was required to attend all sessions. This enabled the therapist to directly observe family patterns of interaction and intervene directly in the ongoing interaction with the aim of altering the way the family organised itself around the abnormal behaviour of their child. In family counselling, on the other hand, the parents were seen together, but the anorexic child on their own, each time the family attended. This did not allow for direct observation of interactional patterns and thus, the therapist could only discuss ways in which the family may modify its behaviour but could not intervene directly in the whole family system. Individual counselling with the patient involved the exploration of the patient's feelings and beliefs about his/her problems with food, body image, self-esteem and relationships (especially those with the parents as they changed their attitudes and management of his/her eating disorder).

At the end of a six month follow up, the group as a whole showed good progress, as shown by their weight gain and improved ratings on the Morgan and Russell scales. Therefore, le Grange et al, (1992) concluded that, “at least in the short term, both conjoint family therapy and family counselling were effective in bringing about significant symptomatic relief”. More
interestingly, the work also produced some evidence that challenged the traditional view of the family as the ‘pathogenic agent’ (Minuchin et al, 1978) and has since had a marked influence on clinical practice (Dare, Eisler, Colahan, Crowhter, Senior & Asen, 1995).

Le Grange et al, (1992) used Expressed Emotion (EE) ratings (Vaughn & Leff, 1976) to evaluate family affective communication. EE taps the feelings that a relative expresses in relation to an ill member of the family and is measured on five principal scales: critical comments, hostility, emotional over involvement, warmth and positive remarks.

As has been found in other studies, EE turned out to be a strong predictor of outcome of family intervention (Szmukler, Eisler, Russell, & Dare, 1985). Le Grange et al, (1992) found that families in which one or the other parent displayed a high level of critical comments that did not lessen during the course of the treatment tended to have a poorer response to treatment. The surprising finding however, was that when the results were examined separately for “high EE” and “low EE” families, critical comments were less likely to be reduced with family therapy. Consequently with this specific situation applied, family counselling was associated with greater improvement than conjoint family therapy.

Contrary to expectations, these results suggest that intervening directly in the ongoing interactions between family members may be less important than many family therapists would believe and even more surprisingly, some families tolerate family counselling more readily than family therapy.

A more direct assessment of the families' experience of the treatment was made at two year follow up by Squire-Dehouck, (1993: cited in Dare & Eisler, 1997) when the families were asked what they thought of the treatment. In both treatment groups the families reported that they had found the major thrust of the therapy (which highlighted the serious life threatening nature of the illness and helped the parents take charge), most helpful. However,
parents in the conjoint family therapy group were more likely to report having open conflicts and struggles with their child and were also more likely to feel blamed. This finding was particularly true in families whose initial levels of criticism as measured by the EE scales were particularly high.

The results of the pilot study suggest that a form of family therapy that does not challenge the family's characteristic patterns is associated with as good an outcome for anorexia nervosa as is the customary family therapy which has access to and challenges those family qualities. These findings do not comfortably fit with a model that assumes that therapeutic change is bought about through a direct restructuring of family patterns (particularly if one of the patterns is thought to be one of conflict avoidance). Dare & Eisler, (1997) add "interventions aimed at conflict avoidance can be counterproductive in families with high levels criticism or hostility, particularly in the early stages of treatment and should therefore be used with extreme caution".

However, it is possible that the higher EE score in the family therapy group could have been due to a number of extreme scores, given the relatively small number of patients in the study. Furthermore, a period of follow up of 6 months is too short to constitute a true outcome, and can only be treated as a preliminary response to treatment. The results of the 5 year follow up study will be more telling (Eisler, Dare, Russell, Szmukler, le Grange, & Dodge, In preparation: cited in Dare & Eisler, 1997).

Despite these cautions, these findings add to the growing evidence that higher levels of criticism have detrimental effects on the engagement and outcome of therapy with anorexia nervosa. This has prompted Dare, Eisler, Russell, & Szmukler (1990) to evolve their family therapy model to consider critical comments as expressions of feelings of guilt and blame. Subsequently they have adapted their clinical practice to reduce criticism of the patient by the parents by forcefully absolving the parents from the responsibility of causing the illness and by complimenting them as much as possible on their positive aspects of parenting.
The only other controlled study of family therapy in adolescent anorexia nervosa has been that of Robin, Siegel & Moye (1995). They compared the impact of behavioural family systems therapy (BFST) versus ego-orientated individual therapy (EOIT) on family relations in twenty two adolescents with anorexia nervosa.

They found that at one year follow up both treatment groups had made significant improvements in terms of body mass index (BMI), menstruation and family interactions between the parents and the patient. This finding confirms the effectiveness of family interventions, but they also report their control treatment of individual therapy as being equally effective. However, in the EOIT group the parents were also seen bimonthly for 54 minutes a sessions throughout the 16 months of therapy (not unlike that of combined individual and family therapy). This study therefore contributes to the overwhelming evidence that parents need to be part of the treatment programme, but not necessarily within the same session as the patient. However, it is assumed that (where possible) it is more convenient to see the family conjointly.

**Combining individual therapy with family interventions**

In clinical practice, individual and family therapy are often combined (Eisler, 1995), which is supported by the theoretical model which depicts several sites for potential therapeutic change. This does not imply however, that individual change is necessarily always best achieved by individual therapy, or that changes in family relations always require conjoint family interventions. Rather, it seems that within family therapy many different issues can be discussed such as identity formation as well as direct relationship difficulties. Similarly individual sessions can be used as a means of input into the family. Dare & Eisler (1997) comment "a combination of individual and family therapy (usually by the same therapist) whether they are delivered in parallel or sequence, can have a mutually facilitating effect on both forms of treatment."
Despite this common belief, only one controlled study was found that stated the use of a combined individual and family therapy in the treatment of anorexia nervosa. Hall & Crisp (1987) used 12 sessions of combined individual and family psychotherapy as one of their treatment conditions and found that it showed a moderate improvement in weight, menstruation, eating patterns, and sexual and social adjustment after one year. However they compared it with a treatment group of 12 sessions of dietary device (DAG), which showed a greater improvement in terms of weight gain but not social and sexual adjustment. However half of the DAG also received some psychotherapeutic treatment prior to follow up and all 15 were felt to require further treatment. Moreover, 12 sessions of psychotherapy that provoke interpersonal changes and emotional awareness seem inadequate and perhaps even detrimental in a condition that requires long term support and guidance even after the improvement of symptoms (Vanderlin & Vandereycken, 1984).

Future research therefore, would benefit from focusing on comparing the combined form of individual and family therapy with individual treatments and family therapy alone to determine whether or not combinations are warranted and if so, in what format would they have the most success.

Conclusions

The clearest finding of the reviewed controlled studies is that family therapy is an effective form of treatment for anorexia nervosa in adolescents and its improved response to family therapy in comparison to the control treatment is sustained at the end of the 5 year follow up. In addition, there is growing evidence that it may also have an important role in the treatment of adults with anorexia nervosa in whom the illness begins before adulthood.

Progress has also been made in the search for the specifically beneficial components of family therapy in adolescents. It was encouraging that both parents and the patient agreed that a crucial component to successful
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outcome was the parents taking strict control over their ill child's eating pattern until they achieved a sustained weigh gain, (despite finding this task difficult initially).

Unfortunately, the findings do not throw light on the question of family causation of anorexia nervosa. There is no evidence that families cause anorexia nervosa despite its effectiveness. Yet the preliminary evidence does show the influence of the family on the course of the problem, (for example, compliance with and responsiveness to treatment) (le Grange et al, 1992).

It is plausible that the high levels of criticism in some families that is associated with poorer outcome, could be equated to the lack of conflict resolution described by Minuchin et al, (1978). However, this characteristic was not consistently found across families and had it been, this would still not necessarily identify it as a causative factor.

The Maudsley model of family therapy lends itself to a variety of therapeutic interventions which reflects the actual treatment of anorexia nervosa in everyday clinical practice. The use of randomised controlled trials to shape the model and approach has also helped to establish its authority in the field of family therapy. Other treatment centres would benefit from systematically evaluating their family therapy approach in an attempt to replicate the Maudsley trials and determine the generalisability of their findings.
References


Eisler, I., Dare, C., Russell, G. F., Szmukler, G., le Grange, D. & Dodge, E. A controlled trial of two forms of family intervention in adolescent eating disorder. Manuscript in Preparation


Clinical Dossier

All client identifiers have been removed or changed

to protect client confidentiality
Adult Mental Health Core Placement
Adult Mental Health Placement Summary

Trust: Chichester Priority Care Services NHS Trust
Placement Location: Graylingwell Hospital, College Lane, Chichester West Sussex PO19 4PQ
Dates: October 1997 to April 1998
Supervisor: Bill Reavley
PSYCHD IN CLINICAL PSYCHOLOGY

ADULT CORE PLACEMENT

TRAINEE PLACEMENT CONTRACT - October 1997

LOCATION: Chichester Priority Care Services NHS Trust.

TRAINEE: Anila George.

PLACEMENT SUPERVISOR: Mr W Reavley.

ADDITIONAL SUPERVISOR: Ms L Norinder.

REGIONAL CLINICAL TUTOR: Paul Davies.

AGENCY DESCRIPTION: Chichester Priority Care Services is a Mental Health and Community Service under the auspices of the NHS Trust. It provides help for people with mental health problems, including inpatient, day patient and outpatient care, from a variety of hospital and community settings. The service is staffed by a range of professionals including psychologists, psychiatrists, psychiatric nurses, occupational therapists, physiotherapists and social workers. Areas of mental health dealt with by the psychology department include Child and Family Services, Adult Mental Health, Learning Disabilities, Rehabilitation and Alcohol and Substance Abuse.

CONDITIONS OF PLACEMENT

1. The trainee will work within the Trust from 15 October 1997 to 3 April 1998 for 3 days each week. Twelve and a half days of annual leave can be taken during this time. The trainee will be based at Graylingwell Hospital.

2. A minimum of one hour 1:1 contact each week will be allocated to supervision in order to review progress of current activities and reflect on issues arising. Supervision will include presentation of patients, tape recordings of clinical sessions and pre and post discussions with supervisors. An additional 1-2 hours per week will be for joint supervision with the placement or additional supervision.

3. One session per week to be allocated to trainee’s private study.

AIMS OF PLACEMENT

a. To provide trainee with experience of the full range of clients referred to adult services.

b. To expose trainee to a wide variety of service settings.
c. To enable trainee to gain experience of using the theory and methods of cognitive behavioural psychotherapy to work with adult patients and their problems.

d. To enable trainee to develop a level of clinical skills and competence consistent with this stage of training.

CLINICAL EXPERIENCE

Experience will be gained along a continuum as follows:

- as an observer;
- a participant in assessment and therapy;
- contributing to ongoing therapy;
- by seeing "screened" clients;
- by seeing clients independently.

1. Range of presenting problems

The trainee should gain experience of independent client work in the following problem areas:

- Anxiety.
- Depression.
- Obsessive compulsive disorders.
- Eating disorders.
- Adjustment and adaption difficulties/bereavement.

It would be desirable for the trainee to gain experience of working with clients with the following presenting problems, either through observation or independent client work:

- Sleep disorders.
- Health/somatic difficulties.
- Problems of emotional control and adjustment, social skills and assertiveness, suicide and parasuicide and personality disorder.
- Survivors of sexual abuse.
- Sexual and relationship problems/family problems.
- Disability.
- Substance misuse.

The trainee should spend up to one session per week working in the area of Acute Psychotic Disorders/Longer Term Mental Health Problems/Rehab and Continuing Care. Experience would include visiting the ward, attending ward rounds, observing assessment approaches of psychologists and other professionals. It is desirable for the trainee to carry out direct client work in this area, possibly involving assessment and psychological intervention.

The trainee will observe the supervisor providing a programme of longer term treatment to a client.
2. Range of clients

The trainee should gain experience of working with the full range of clients referred to adult services.

i) Age - The trainee will see clients across the age span, covering late adolescence and young adulthood, middle and later ages up to 65.

ii) Sex - The trainee will see an appropriate mix of male and female clients.

iii) Ethnic background - Where possible, the trainee will have some level of clinical contact with at least one client from a different ethnic and/or cultural background.

3. Neuropsychology and psychometric assessment

The trainee should gain experience of using psychometric assessment along a continuum as follows:

i) Observing a clinical psychologist carrying out a psychometric assessment.

ii) By conducting a psychometric assessment observed by a qualified psychologist. This allows some realistic check on the trainee’s competency to carry out appropriately formal assessment.

iii) By undertaking at least one additional psychometric assessment independently. The suggested range of assessment measures would be WAIS-R, Wechsler Memory Scale (or equivalent), NART and other more specific tests.

If at all possible whilst on placement it would desirable for the trainee to observe a fuller assessment carried out by a clinical psychologist who specialises in neuropsychology.

4. Structure of therapy and intervention

i) Individual therapy work - The trainee will gain direct experience of individual client work.

ii) Therapy work with couples and/or families - The trainee will gain indirect experience of this type of therapy through observation of qualified clinicians.

iii) Group therapy work - The trainee will gain direct experience of group work through co-facilitating a therapy group with a qualified clinician.

5. Settings

The trainee should gain experience of working in as wide a range of settings as possible, for example:

- Psychology Department and outpatients clinics.
Adult Mental Health Placement Contract

- Community Mental Health Teams and Resource Centres.
- Primary Care Settings.
- Day Centres.
- Hostels and Group Homes.
- Inpatient wards (acute long stay and rehabilitation)
- Client’s homes.

The range of settings should include other agency facilities.

OTHER EXPERIENCES

1. The trainee will write psychological reports, case notes and letters as required.

2. The trainee will keep administrative records consistent with the requirements of the department.

3. The trainee will attend and participate in departmental meetings as well as meetings and other professional development activities appropriate to the placement.

4. The trainee will keep a record of experiences gained in the placement.

5. If possible, the trainee will be involved in teaching or training.

REVIEW

Meetings between the trainee, the placement supervisor and the Regional Clinical Tutor at the middle and end of the placement will be used to review the trainee’s progress towards achieving goals and to renegotiate the contract if required.

Anila George
W Reavley
Adult Mental Health Case Report Summary

A Cognitive Behavioural Assessment and Treatment of an Adult Presenting with Panic Disorder with Agoraphobia

S, a twenty year old, first year, undergraduate student, was referred by her GP for help with her panic attacks and agoraphobia. During a panic attack S described feeling faint, her heart racing and finding it difficult to breathe. They appeared to occur when S was outside by herself and would become more severe the further she was from her house. At the time of referral, S had started to avoid leaving her house, had left university and returned home to her family and boyfriend.

S's difficulties were formulated and addressed using Clark's (1986) cognitive behavioural model of panic. Her Negative Automatic Thoughts (NAT's) and associated beliefs were elicited using a daily symptom diary. They revealed S was interpreting the symptoms of panic as signalling danger. She feared losing control in public (e.g. by fainting) and no one coming to her assistance. These thoughts were challenged by identifying the evidence for and against them in order to help her think in a more realistic way. This was integrated with a graded exposure programme to reinforce the use of newly generated beliefs. Breathing retraining was also employed to help S control her initial anxiety symptoms from escalating into panic and provide evidence that controlled breathing could reduce the symptoms of panic.

The intervention also explored other factors that were potentially maintaining her panic attacks. It was apparent that S was struggling to decide whether to return to university or not and having panic attacks was allowing her to delay the decision making process. A problem solving technique identifying the pro's and cons of returning to university, helped her resolve her dilemma.
Treatment ended with a planned discharge and at follow up six weeks later, her self-report experiences of panic attacks had substantially decreased. Both her anxiety (as measured by the Beck Anxiety Inventory) and her level of depression (as measured by the Beck Depression Inventory) had substantially reduced. Furthermore, she no longer avoided leaving her house and was enjoying an active student life at university.

Learning Disabilities
Core
Placement
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<th>Surrey Hampshire Borders NHS Trust</th>
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<tr>
<td><strong>Placement Location:</strong></td>
<td>Community Team for People with Learning Disabilities, 11 Church Road, Frimley, Surrey GU16 5AD</td>
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<td><strong>Dates:</strong></td>
<td>April 1998 to October 1998</td>
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<td><strong>Supervisor:</strong></td>
<td>Tessa Lippold</td>
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SURREY HAMPSHIRE BORDERS NHS TRUST
11 Church Road, Frimley, Surrey GU16 5AD

LEARNING DISABILITIES CORE PLACEMENT

TRAINING CONTRACT : Anila George
(Supervisor - Tessa Lippold)

DATES OF PLACEMENT : 22.4.98 - 2.10.98

PRIMARY AIMS OF THE PLACEMENT:

1. To develop a range of assessment and clinical skills and knowledge of service systems in working with people with learning disabilities and their carers.

2. To be familiar with and use formal and informal assessment procedures appropriately with this client group, in both individual work and in work with carers and families.

SECONDARY AIMS OF THE PLACEMENT:

1. To understand the different roles of other professionals working within the service, particularly other members of the Community Leaning Disability Team.

2. To understand the "systems" aspect of service delivery and development.

3. To develop observational techniques, information gathering, interpretation, reporting and evaluation skills.

4. To understand the role and organisation of clinical psychology at local Trust and Regional levels.

5. To become familiar with the network of service facilities available for people with learning disabilities within Surrey Hampshire Borders NHS Trust.

RECOMMENDATIONS FOR THE PLACEMENT:

1. The trainee should see clients from a range of ability levels, including mild and severe learning disability, and profound and multiple disability.

2. The trainee should see clients from each of the four life stages: these be adolescence, young adulthood, middle age and older people.
3. The trainee should see a mix of male and female clients with some
level of clinical contact with at least one client (and preferably
substantially more from a different cultural and/or ethnic background

4. The majority of the following areas should be covered during the placement.
   - skills teaching
   - challenging behaviour (both from an individual and service
     system perspective).
   - sexuality issues e.g. relationships, sex education, sexual abuse.
   - bereavement and loss
   - interpersonal skills e.g. assertiveness, anger management.
   - the application of psychological models and clinical skills across
     specialties.
   - client placement issues.

5. The trainee should have knowledge of a range of therapeutic approaches e.g.
   Gentle Teaching, Personal Construct Theory, RET, other psychotherapeutic
   approaches etc.,

6. The Trainee should have knowledge of organisational issues
   - interface with mental health services.
   - service carers
   - interface between social service and education etc.
   - Community Care Act
   - Education Act
   - Statutory Responsibilities
   - Children Act

7. Trainee should have knowledge of the key practical and organisational issues
   related to resettling people with learning disabilities from hospital to
   community settings.

THESE AIMS/RECOMMENDATIONS WILL BE ACHIEVED VIA A RANGE OF
EXPERIENCE TO INCLUDE MOST OF THE FOLLOWING:-

1. Experience working with the following client groups:-
   - adult with mild learning disability
   - adult with a severe learning disability
   - adult with a profound learning disability
   - child or adolescent with learning disability

2. Participating in running a group for clients with a mild learning disability.
3. Experience of formal assessment procedures used to measure.
   - general intelligence e.g. WAIS-R, Leiter (essential).
   - skills e.g. HALO, ABS (essential)
   - basis for teaching programmes e.g. Bereweeke, Portage
   - Sensory loss, physical handicap, language disorder e.g. Leiter, Learning to Learn, Plagetian approaches.
   - Needs e.g. IPP/Life Planning System.

4. Experience of other information gathering, analysis and evaluation:
   - audio tapes of client contact
   - data gathering and analysis related to behavioural approaches

5. Planning and carrying out behavioural programmes by direct intervention to:
   - increase skills
   - decrease problem behaviour (minimum 1 client).

6. Planning and carrying out a behavioural programme through other agencies e.g. parents staff.

7. Joint working with other members of the Community Team.

8. Introduction to a Portage scheme, (via Community Nurse, Portage Adviser or Educational Psychologist).

9. Attendance at Community Learning Disability Team Business Meetings and Allocation/Referral Meetings where possible, at least one PLD Service Development Meeting.

10. Visits to residential and day care facilities as follows:
    - Social Services Resource Centre
    - Group Home
    - School
    - Day Services

11. Liaison with the following professionals as appropriate:
    - Community Nurse
    - Speech and Language Therapist
    - Physiotherapist
    - Doctor (Psychiatrist, G.P. School Medical Officer etc.)
    - Social Worker
Learning Disabilities Placement Contract

- Care Manager
- Day Centre Staff
- Educational psychologist
- Residential Care Staff
- Voluntary Agencies e.g. Mencap, Cheshire Homes
- Teachers
- Employment Development Officer

12. Conduct a piece of small scale research of relevance to the PLD service.

13. Teaching experience, for example:
   - Formal case presentation to colleagues
   - Staff training

14. Attendance at at least one meeting of Learning Disability Special Interest Group

15. Direct observation of supervisor and opportunity to be observed by supervisor.

16. Undertaking suggested reading linked to clinical work.

17. Study leave.

SUPERVISION

Formal supervision at least 2 hours per week, plus informal supervision as required.

ANILA GEORGE
Psychologist in Clinical Training

TESSA LIPPOLD
Chartered Clinical Psychiatrist
Head of speciality (Learning Disability)

May 1998.
The Management of Obsessive Compulsive Behaviour in a client with Down Syndrome

B.M., a 54 year old woman with Down syndrome was referred to psychology by the psychiatrist of the community learning disability team. He requested an assessment of her obsessional behaviours and advice on their management as her current placement with carers was in jeopardy.

The two main obsessive behaviours that required psychological assistance was firstly, S’s excessive hoarding and demanding of sanitary items, such as toilet rolls, kleenex tissues and panty liners. B.M would use these to line her underwear to prevent any accidents from occurring. The second behaviour was her possessiveness over Mrs W (her carer), which had started to interfere with Mrs. W’s relationship with her husband.

Aspects of B.M’s family history shed light on the development of these behaviours. B.M’s mother had devoted most of her time and attention to caring for B.M. and this had led her to believe she was deserving of that level of attention from all her primary caregivers, particularly the maternal figure.

Although B. M had always used panty liners to prevent accidents from occurring which had been a practice encouraged by her mother, the behaviour only became problematic following her mother’s death. It was hypothesised that B,M felt she had caused her mother’s death by bleeding in her underwear (after receiving an injection from the Doctor) just shortly before her mother died. Lining her underwear therefore, may have become a way of reducing her anxiety about her responsibility in her mother’s death as well preventing another ‘accident’ form ever occurring in the future.

A functional analysis of B.M’s demands for toilet rolls and possessive behaviour towards Mrs. W. also showed that her carers were responding
inconsistently to these behaviours and as a result they were being maintained by intermittent positive reinforcement.

A behaviour modification programme was devised on the basis of the functional analysis. To reduce the frequency of B. M's demands for toilet rolls, guidelines were provided which aimed to help B.M. feel less anxious about running out of toilet rolls. The guidelines specified the day of the week she should receive her sanitary supply and the amount. Additionally, it specified that Mrs. W should consistently remind B.M. when her supply was due to be renewed in response to any demands for toilet rolls.

To reduce B. M's possessive behaviour towards Mrs. W, a programme of differential reinforcement of adaptive behaviour (DRA) in conjunction with extinction was employed. This involved praising and rewarding B.M when she was engaging in adaptive behaviour that was incompatible with her possessiveness (e.g. doing her tapestry) and ignoring B.M. when she was purposely disruptive.

Treatment ended with a planned discharge and the ABC recordings showed that B.M. had ceased asking for more toilet rolls in between her supplies. Moreover she had not taken advantage of the situation as she was still using a similar amount each week. As regards to B.M's possessive behaviour, Mrs W. noted that the number of episodes of disruptive behaviour had not yet reduced. Nevertheless, she did report feeling more confident about the way she should respond to B.M's disruptive behaviour and as a result was responding consistently and without any positive reinforcement for the behaviour.
Child and Adolescent Core Placement
Child and Adolescent Core Placement Summary

Trust: Kingston & District Community NHS Trust

Placement Location: Sheen Lane Health Centre, Sheen Lane, London SW14 8LP

Dates: October 1998 to April 1999

Supervisor: Karen Varney

Departmental Base: Child Psychology, Richmond Royal Hamlet, Kew Foot Road, Richmond TW9 2TE
DEPARTMENT OF CHILD CLINICAL PSYCHOLOGY

PLACEMENT CONTRACT

Trainee: Anila George  Supervisor: Dr Karen Varney

Dates of Placement: 13 October, 1998 - 9 April, 1999

The placement is based in Kingston and District Community NHS Trust and the Social Services Department of the London Borough of Richmond. The placement will offer work with children aged from birth to 18 years and their families and formal networks. The trainee will be based at Sheen Lane Health Centre.

Main Aims of Placement

1. To introduce Anila to working as a Clinical Psychologist within a community setting in the Child Protection context and in Primary Care.

2. To introduce Anila to the tertiary services for Social Communication Diagnosis, ADHD and Feeding Team.

3. To gather experience of using behavioural, educational, cognitive and systemic thinking and practice in working with families.

4. To gain experience of working with children in early childhood, middle childhood and adolescence with a range of difficulties.

Methods of Achieving these Aims

• Two-week induction period.

• Supervised clinical practice - independent caseload of approximately 10 families.

• Joint work with Supervisor.

• Participation in Family Therapy Workshop and Clinic.

• Occasional attendance at Departmental meetings.

• Attendance at Specialty meetings.
- Observation of Supervisor working.
- Observation of Trainee by Supervisor.
- Visits to meet other professionals involved with children, School Nurses, CMOs, Health Visitors, Under 5s Centres, Educational Psychologists, and if viable, the Child Protection Team.
- Exposure to and the use of various formal assessment tools.

**Case Reports**

From clinical referrals, the Trainee will allocate one case to be written as a case report before the end of placement.

**Supervision**

Formal supervision will take place on a weekly basis for 2 hours. Informal contact will also be provided when considered necessary by either the Trainee or Supervisor.

**Teaching**

Whilst on placement, it is hoped that Anila will present a small teaching session to colleagues.

**Group**

It is hoped that the Trainee will be able to help organise and co-facilitate a parenting skills group.

**What will be Achieved at the End of Placement**

1. The Trainee will have developed skills in assessing and formulating psychological difficulties in children and families.
2. The Trainee will have undertaken several interventions in individual, joint and team settings.

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**Supervisor's Signature**

**Psychologist in Clinical Training's Signature**

**Date:** 12-11-98

**Date:** 12-11-94
Child and Adolescent Case Report Summary

A Narrative Treatment Approach of a 13 year old's Struggle to Express his Identity

Matt, a 13 year old boy was referred by his GP, for abdominal pains and low mood. The referral letter also suggested that there was an underlying disturbance in the family and on the basis of this, Matt's mother (Helen) also attended the sessions.

A narrative assessment approach using externalising conversations (White, 1984) enabled Matt to express how unhappy he was at school. He felt the school system and some of his friends were trying to suppress his individuality and make him conform to their ideals. For instance, on occasions when he had tried to defend his own beliefs and views in school, rather than being praised for his contribution he was given detentions for being confrontational and disrespectful.

Although Helen had always encouraged Matt to express his own views and think independently, conflicts with school soon escalated and Helen was reminded of her 'dominant story' of being a bad parent and out of desperation referred to the school for guidance. However, this only angered and confused Matt further, as he felt it hypocritical of his mother to side with the school against him. Consequently, Matt withdrew and stopped asking for Helen's help completely.

Having obtained a picture of Matt and Helen's dysfunctional and preferred views, the intervention aimed to shift Matt and Helen's views of self and each other away from the problem story to new stories that confirmed their preferences and positive intentions (i.e. the unique outcomes').
Unfortunately, treatment ended prematurely when Matt contracted mumps. During this time Matt kept up with his academic work by studying at home and decided that since he preferred and learned more from home tutoring than he did at school, he would like to try it full time. After making this decision, Matt also decided further psychological help would be unnecessary.

Although discharge was unplanned, the intervention did appear to have some success in the short term. Rather than escalating the problem story further, Helen and Matt both responded to the possibility of home tutoring in a way that fitted with the preferred views of themselves and each other. Helen chose to offer a non-judgemental and respectful approach to Matt's decision and reclaimed her position as his guide and confidant by allowing him to express his wishes openly with her. However, she also acted in a way that supported her preferred view of herself as a 'competent parent' by making sure he had made an informed choice and that he agreed to return to school while she looked into the possibility of home tutoring.

Despite the apparent success of the intervention, the long term effectiveness of the treatment remained equivocal. Limitations of the current solution to the problem are discussed using a structural family therapy perspective.

Older Adults Core Placement
Older Adults Core Placement Summary

Trust: Kingston & District Community NHS Trust

Placement Location: Psychology Department, Elmside, 1 Oak Hill Surbiton, Surrey KT6 6DR

Dates: April 1999 to September 1999

Supervisor Catherine Dooley
KINGSTON & DISTRICT COMMUNITY NHS TRUST
DEPARTMENT OF CLINICAL PSYCHOLOGY
CORE PLACEMENT - SERVICES TO OLDER ADULTS

CONTRACT FOR: Anila George

AIMS

• To gain an overview of the services available for Older Adults in Kingston and District and an understanding of how these fit together to form an organisation.

• To gain an understanding of the role of the Clinical Psychologist providing services for older adults and how this differs from other professions.

• To have experience of working in a variety of work settings, with a range of client groups and problems and to develop skills and approaches when carrying out interventions e.g. networking, liaising with other professionals, family therapy, martial work, behaviour modification, personal construct theory, bereavement counselling etc.

• To undertake some area of service development/project work/training.

OBJECTIVES

1. To carry out assessment and intervention with approximately ten clients with functional and organic conditions including:-

1a. DIRECT WORK with clients and families in outpatient/community settings including problems of anxiety, depression, bereavement, adjustment to disability, health issues and carers issues.

1b. INDIRECT WORK with clients and staff including dementia care in inpatient or residential settings, networking.

2. To become familiar with different settings - e.g.:

• Oak Day Hospital
• Wards for Older Adults with mental health problems at Tolworth Acacia Unit.
• Wards for Older Adults with physical health problems at Tolworth Hospital.
• Social Services Residential Homes, e.g. Newent House, Murray House.
• Private and Voluntary Residential Homes. South Place.
3. To spend time with a Consultant Psychiatrist, Social Worker and CPN both in client meetings and if possible in individual client work.

4. To meet Managers within EMI Service and Elderly Community Service.

5. To run a therapeutic group for Older Adults - stress management for carers; also later self esteem group on Magnolias.

6. To observe and carry out neuropsychological assessment using WAIS R, Coughlan, MEAMS or Mini Mental State with older people.

7. To attend meetings and seminars in Psychology Department and other meetings within Services for Older Adults.

8. To have 1.5 hours of supervision on a weekly basis.

9. To have one session of study time per week.

10. To possibly carry out some teaching - Tolworth or Surbiton

11. To possibly undertake an area of project work to familiarise self with organisational issues.

12. To have joint supervision with a focus on process/psychodynamic issues with Sarah Fleming.

13. To conduct interviews with carers about moves into residential care.
Personal Goals:

By the end of the placement to:

1. Be familiar with the range of neuro-psychology assessment tools, become more competent in interpretation of findings and applying these to the individual client's situation.

2. Be comfortable in dealing with bereavement and loss, maintaining empathy with the client's situation but being able to formulate positive goals with realistic expectations of change.

3. Be familiar with and competent to apply therapeutic approaches specific to the client group such as reminiscence and life review.

CATHARINE DOOLEY
Consultant Clinical Psychologist

Trainee Clinical Psychologist
Older Adults Case Report Summary

A Neuropsychological Assessment to Determine the Nature and Cause of a 72 Year Old Man's Memory Problems

Mr G, a 72 year old man, was referred for a neuropsychological assessment by his Consultant Psychiatrist. She reported that Mr G had a history of 18 months of memory impairment and following a CT Scan had been diagnosed with multi infarct dementia (MID). However, Mr G also had some mild depressive symptoms and the referrer wanted to know if any of his memory problems were associated with his depression rather than his organic pathology.

Cognitive assessment included clinical interview of both Mr G and his wife and the administration of a number of standardised neuropsychological tests which covered the areas of general intellectual functioning, memory functioning, language, practical judgement and mental flexibility. He was also given the Hospital Anxiety and Depression Scale (HADS) to detect symptoms of depression and anxiety.

Mr G's cognitive profile was consistent with a diagnosis of MID. The severity of impairment in cognitive functioning was greater than that expected of someone suffering from depression alone. Mr G's presentation during testing also resembled characteristics specific to individuals experiencing dementia rather than depression, such as attempting to minimise cognitive problems, avoiding answers, and performing tasks by trivial excuse. He also showed problems learning new information which is uncommon in depressed patients.

Nevertheless, Mr G was an intelligent man and previously a high achiever. He was well aware of his current disabilities and was clearly finding it hard to come to terms with. Therefore, it was not surprising that he was displaying some depressive symptoms, which were likely to exacerbate his cognitive difficulties.
Given that Mr G's memory difficulties were likely to become increasingly prominent over time, several strategies were recommended to help improve his memory management.

It was also suggested that Mrs G may at some point in the future require external support to help care for Mr. G. Thus re-testing was advised (after a minimum of 12 months) if there was evidence of further deterioration, to help plan services.
Systemic Family Therapy
Specialist Placement
Systemic Family Therapy Specialist Placement
(Including experience of working with clients with eating disorders)

Trust: Kingston & District Community NHS Trust

Placement Location: Hampton Community Mental Health Team
Maddison Centre, 140 Church Road,
Teddington, Middlesex TW11 8QL

Dates: October 1999 to March 2000

Supervisor: Karen Partridge

Additional Supervisor for Eating Disorder cases: Jelena Manojlovic

Department Base: Richmond Royal Hamlet, Kew Foot Road
Richmond TW9 2TE
PsychD in Clinical Psychology
Integrating Systemic Models of Therapy into Adult Mental Health
(With an Interest in Clients with an Eating Disorder)

Specialist Placement Contract

Name of Clinical Psychologist in Training: Anila George

Placement Location: The Maddison Centre
140 Church Road
Teddington TW11 8QL

Name of Responsible Supervisor: Dr. Karen Partridge

Additional Supervisors: Dr. Jelena Manojlovic
Richmond Royal Hamlet
Kew Foot Road
Richmond

Dates of Placement: October 1999 - March 2000

Aims

- To gain an understanding of working systemically as a Clinical Psychologist in the NHS
- To understand a number of systemic models and to provide theory practice links in clinical and organisational work
- To become familiar with and competent in the use of various systemic techniques in clinical work.
- To develop an ability to build links between systemic models and other models and approaches used in clinical psychology and to apply these to practice;
- To develop consultation skills with clients and when linking with other agencies and services of a multidisciplinary nature;
Systemic Family Therapy Placement Contract

- To develop an active role in the delivery of service, in general psychology meetings, special interest groups and other relevant meetings with other agencies and services.

- To gain direct clinical experience of working within an eating disorders service and the role of the clinical psychologist within the team.

**Clinical work**

- To carry out joint clinical work with Karen and/or another trainee with up to 4 clients, couples or families as a member of the systemic team.

- To be an active member of the reflecting team and be the lead interviewer for at least one of these clients or families.

- To carry out joint work with Jelena with at least one couple or family with an eating disorder.

- To work as a solo therapist with up to 3 clients or families (one of which, will be a client with an eating disorder).

- To apply and compare systemic and cognitive-behavioural models of working with clients with an eating disorder.

- To run a Life Stories (Narrative therapy) group for day hospital patients.

- To make use of relevant tools (e.g., VCR/audio-tape) to record sessions to learn and practice systemic techniques as well as the adoption of a meta-perspective when reviewing work.

- To practice and learn to apply the appropriate therapeutic techniques to the model that has been selected for any piece of clinical work.

- To understand a wide number of systemic models so that formulations can be prepared within different systemic frameworks and enable the use of theory practice links in clinical interventions.

**Organisational Work**

- To attend and participate in department meetings, policy and service meetings and multidisciplinary meetings as appropriate.

- To attend and participate in the Eating Disorders Team (EDT) meetings.

- To take responsibility of administrative tasks; appointment letters, booking of rooms, and other departmental and trust requirements.

- To meet with other members of the CMHT and EDT to understand and gain knowledge of the skills and work practices of other professionals within the team.

- To gain an awareness of how the current organisational climate within the trust impinges on client work directly and through staff practice.
Research Skills

- To meet with professionals within the Eating Disorders Service to discuss their views and participation in the trainees' current PsychD research.
- To be able to critically consider the relevant literature and apply the findings to the clinical context
- To participate in discussion of this literature and in discussions of research and evaluation.

Training and Teaching

- To attend and participate in seminars organised by the department and take advantage of any other training opportunities provided by the trust.
- To attend courses and workshops as appropriate and relevant to the work undertaken.
- To take the opportunity to present and participate in any training or skills sharing events.

Supervision

- To have 1.5 hours of joint supervision with Karen on a weekly basis and 1.5 hours of solo supervision with Karen on a fortnightly basis
- To have weekly supervision with Jelena for any eating disorders work.

Mid-Placement Review

A mid placement review will take place in mid January between Karen, Jelena, Mary John and Anila to evaluate her progress towards achieving these goals and to re-negotiate any needs/expectations from all concerned if required.

Dr. Karen Partridge
Consultant Clinical Psychologist

Dr. Jelena Manojlovic
Consultant Clinical Psychologist

Anila George
Psychologist in Clinical Training
Systemic Family Therapy Specialist Placement Case Report Summary

A Systemic Treatment Approach of a Man with Morbid Jealousy

Pete, a 41 year old man was referred to the Systemic team by the Clinical Assistant to the Consultant Psychiatrist of the Community Mental Health Team for escalating feelings of jealousy towards his wife, Sarah.

Although jealousy had always been a feature of their 13 year marriage, the problem had escalated in the last three years to crisis point. At the time of referral, Pete would not allow Sarah to attend overnight work conferences and even disliked her spending a night out with the girls.

Using the circular interviewing method, the problem determined system was tracked and the following emerged as significant aspects of Pete's family history. Pete's father and brother were also described as very jealous people and Pete believed jealousy was in his genes. He had grown up in a family where it was normal practice for 'women to stay home and do as they were told' and believed it was the man's responsibility to provide for and protect his family. In the past three years, they had also experienced a series of stressful life events; including the death of Sarah's father and five other close friends, as well Sarah discovering a breast lump and Pete continuously struggling to keep his business afloat. Inevitably, these events all led to an increase in Pete's existing levels of insecurity and anxiety.

Although several systemic hypotheses were generated prior to each session, at the end of three sessions, the systemic formulation that had evolved was in terms of the family's belief system. It appeared that Pete's family belief that 'women need men to take care of them' had guided specific actions, such as providing for his wife financially, taking control in a crisis, protecting Sarah from harm (including other men). Certain recent events however, had changed the fit of the behaviour-belief system and Pete's belief was challenged. For instance, when Sarah coped better than Pete when her father
died, and when she did not turn to Pete for support when she discovered her breast lump challenged Pete's belief that she needed him for support. Moreover, the reminder that she is succeeding at work, whereas he is struggling, suggests to Pete that his wife may no longer need him to support her financially.

Once Pete had started to feel their marriage was under threat, he reacted by increasing his authority over his family, taking charge and acting increasingly jealously. This reverted the balance in their relationship, as Sarah gave in to his demands and reassured him she would not leave him, which only reinforced his jealous behaviour further.

At this juncture, the lead therapist left the service and the case was transferred to another psychologist in the systemic team. Recommendations for future work included re-editing of the family script so that more helpful family beliefs could be established. Additionally cognitive behavioural strategies were suggested to reduce the extent of Pete's jealous behaviour. For instance, not allowing him to talk about his jealousy except during a specific 15 minute interval. The strengths and limitations of the work are also discussed.
Paediatric Psychology Specialist Placement
Paediatric Psychology Specialist Placement Summary

Trust: St. George's Healthcare NHS Trust

Placement Location: Paediatric Psychology Service
5th Floor, Lanesborough Wing,
St. George's Hospital, Blackshaw Road,
Tooting, London SW17 OQT

Dates: April 2000 to September 2000

Supervisor: Gillian Colville
Specialist Placement Contract - Paediatric Psychology

Supervisor: Gillian Colville  Trainee: Anila George

Placement: Number 6, from 16.4.2000 to 31.9.2000
Placement days: Wed/Thurs/Alternate Fridays

Type of Placement: Specialist Child Placement in Paediatric Psychology, St. George's Hospital.

1. Aims of the Placement

To develop broad clinical experience in a Paediatric setting. Including inpatient and outpatient work, assessment and treatment. To include a range of ages (0-17 years) and conditions.

2. Clinical Experience

Assessment: Psychometrics, Pre-schoolers and babies, encopresis, enuresis, behaviour problems, sleep problems, emotional problems, psychosomatic problems, adolescent problems, and chronic illness.

Treatment: Behaviour problems, sleep problems, feeding problems, school problems, encopresis/enuresis, obesity, emotional problems, bereavement, chronic illness, anxiety, somatic problem. In patient -cases as they arise.

Observation of Supervisor's Cases as they arise - including PICU ward visits

3. Group work

To plan and co-facilitate a group for children with obesity.

4. Neuropaediatric psychology

Rehabilitation of a 14 year old with severe temporal lobe amnesia, supervised by Avron Moss, Neuropaediatric Psychologist

5. Other Experience

Ward Visiting - Nichols (Surgery), Pickney (Haematology/Oncology), Frederick Hewitt (General Medicine)
Sit in on the Haematology Clinic and Urology Clinic
Attend Psychology Department meetings
Attend Paediatric Psychology Team meetings and present a case towards the end of placement
Attend Trainee Tutorials
Shadow Paediatric Community Nurse
Nursery visits
Visit the Playroom and School

6. Supervision Arrangements

One hour minimum per week, Wednesday Afternoon 2:00 - 3:00.

7. Mid - Placement Review

June 2000

8. Cover

Sarah Waugh - Clinical psychologist (Paediatric Psychology Service)

9. Case studies

Not required on this placement

10. Log Book

To be kept and completed by trainee and signed by Supervisor at the end of the placement.

11. Research

None on this placement (DClin Psych Thesis at University of Surrey - Tobacco use in women with Eating disorders).

12. Other

Space - Use GC's office on Wednesdays, Spare desk on Thurs am, Clinical Room 4 on Thurs p.m. and Clinical Room 9 on alternate Fridays.

13. Other Trainee obligations

Obtain and wear hospital security badge at all times.
Respect confidentiality
For concerns about child protection issues, trainee to take up concerns with supervisor in first instance, who will then advise on whom else should be informed.
Document all contact relating to patients - direct/indirect, telephone calls, ward visits.
Promptly produce drafts of reports/letters for supervisor to check and advise on distribution.
Ensure coding administration is up to date for all cases and completed by the end of placement.
For sickness - notify supervisor (or departmental secretary) on first day so appointments can be cancelled/covered, subsequently update supervisor on likely length of sick leave.

14. Other Supervisor Obligations

Arrange induction programme for trainee; ensure availability of desk space/filing/telephone/secretarial support.
To arrange a balanced case load with respect to age/type of problem/in-patient-outpatient mix.
Supervisor to observe trainee’s work with patients and their families, and range of work with other professionals.

15. Signatures

Anila George
Trainee Clinical Psychologist

Gillian Colville
Clinical Psychologist

Date: 10.5.00
Research Dossier
Service Related Research

"Residential Key Worker's Perceptions of the Service Provided by a Community Learning Disability Team (CLDT) for People with Epilepsy

Year I

November 1998
Residential Key Worker's Perceptions of the Service Provided by a Community Learning Disability Team (CLDT) for People with Epilepsy

Abstract

Objective: To determine what aspects of the service key workers are concerned with and satisfaction and dissatisfaction with these aspects. Perceptions on the impact of epilepsy on individuals as well as the stresses associated with working with people with epilepsy and staff coping strategies were also investigated.

Design: These issues were investigated using a semi-structured interview and data subjected to a thematic content analysis.

Setting: Eight residential group homes, housed by three housing organisations.

Participants: 12 key workers caring for a client with a learning disability plus epilepsy.

Main outcome measure: Themes were elicited that generated an account of staff perceptions of the current service.

Results: The data showed an overall satisfaction with the service. Aspects of service satisfaction included practical support, availability and connections. Aspects of dissatisfaction included long waiting times, a lack of information and external agencies. The impact of epilepsy on a person with learning disabilities was perceived to be both practical and emotional and lastly, staff became more detached over time when working with people with epilepsy and coped by relying on their colleagues.
Conclusion: The results are compared with recent suggestions for psychology on improving services for people with epilepsy. Suggestions for future research and possible service implications are also discussed.
1. Introduction

A recent survey (carried out by the author, unpublished) of the referrals received between January and March 1998 by a Community Learning Disability Team (CLDT) observed that at least 25% had epilepsy. Consequently, the CLDT felt it was necessary to evaluate the service they provided for such a significant proportion of their clients.

When exploring the literature however, no studies were identified that evaluated the services offered to people with epilepsy plus a learning disability. However, broader studies looking at the normal population such as Brown's (1993) study, identified services for people with epilepsy in the UK as poor in quality, fragmentary and poorly organised. He also highlighted that an estimated 200 people per 100,000 population have a learning disability plus epilepsy, (4 times that of the normal population). This figure suggests that evaluations of services targeted at people with epilepsy plus a learning disability are clearly warranted.

When attempting to evaluate their service the CLDT discovered that given the lack of research literature in the area they were unable to determine what would be the most pertinent service issues for the users. Therefore, as an initial starting point to the evaluation process the CLDT chose to approach the residential key workers as they were considered to be the group most familiar with the clients as well as having considerable dealings with the service. By exploring their views and experiences, the CLDT aimed to discover which service issues were potentially the most pertinent to their clients and subsequently enable the CLDT to develop a focused, yet sensitive interview format when approaching the clients directly.

Since this study was carried out from a psychological perspective, recent literature on the role of clinical psychologists working with individuals with epilepsy was also of interest. Cull & Goldstein (1997) suggest roles are rapidly
developing and have identified a number of areas where they could become more involved.

For instance, Baker (1997) reports that the course of adjusting to epilepsy is complex. People with epilepsy have to deal with the fear of their seizures, make sense of their medical history (i.e., its cause) and try to minimise the negative impact of epilepsy on their own self-worth. He adds that clinicians, (e.g., psychologists) can have a significant role in influencing this process of accommodation, by helping people to have a greater understanding about their epilepsy and demystify any beliefs that they might have about their condition.

As well as helping individuals adjust to epilepsy, Espie et al. (1990), reported that carers had needs too. They reported that staff had difficulties coping with clients' post-ictal aggression or fear, and a prolonged sense of responsibility and anxiety. Espie & Paul (1997) recommended that 'services should face up to the reality of such consistently expressed concerns and provide psychological support and help to carers'.

However it was recognised that these suggestions were largely based on the normal population. Thus the clinical psychologists within the team felt that before developing their 'new roles', it would be worthwhile investigating how warmly these types of input would be received by their service users.

Given the lack of previous research in this area and that qualitative methods have been recommended for gaining views about services (Jeffrey, Burrows & West, 1997), this present study involved interviewing twelve residential key workers using a semi-structured format. The aim of the research was to answer the following research questions:

1. Are residential key workers satisfied with the services provided by the CLDT for people with epilepsy?
2. What emotions and stresses are involved when caring for someone with epilepsy and how do residential key workers cope?

3. What type of impact (if any) do residential key workers perceive epilepsy has on their client with a learning disability and their subsequent adjustment to the condition.

2. Method

2.1 Participants

A list of residential key workers was generated by the author from the survey that identified 36 clients known by the CLDT to have epilepsy. Of the corresponding 36 key workers identified, the first approached to participate in the study were those that worked in one of the three largest housing organisations (providing the majority of accommodation for clients in the Trust). The sample consisted of the first 12 key workers (11 female & 1 male) approached, as they all agreed to participate in the study. The sample worked in eight different residences for people with learning disabilities.

The background of the participants included one qualified nurse, one nursery nurse, and a teacher with adults with learning disabilities. The remaining nine had no professional training. Their ages ranged from 24 to 34 years (mean 28yrs 4 mths, s.d 5.5). The length of the participants' experiences of dealing with people with learning disability plus epilepsy ranged from 6 months to 12 years (mean 3 years 11 mths, s.d 37.2). The range of epilepsy training courses experienced by staff is shown in Appendix II.

This group of key workers were representative of people working with people with learning disabilities in the UK (Allen et al, 1990) with a larger number of female to male staff and a mixture of relatively inexperienced and experienced staff.
2.2 Setting

The interviews took place in the clients' residential homes and where requested (by the housing organisation) at the CLDT's office in order to maintain privacy in the clients' home. In all cases the interview took place in a quiet setting.

2.3 Procedure

Verbal permission to approach key workers was obtained from two of the operations managers of the housing organisations and the third gave written permission (See Appendix I). After granting permission the operations manager informed the home manager of each house (and subsequently the identified key worker) as to the purpose of the study and that a phone call from the researcher was to be expected. A personal phone call was made to each identified key worker giving a brief overview of the study. After obtaining verbal consent for participation and consent to tape record the interview, a letter was sent to confirm and thank them for their co-operation, (see Appendix III).

At the start of the interview participants were reminded of the study's aims and asked to fill in a short questionnaire to obtain some background information on the client they were caring for. A similar questionnaire was given at the end of the interview to gather similar background information on themselves, (see Appendix IV). Confidentiality was maintained throughout by censoring any information from the interviews that identified the participant or their client. Also that any responses used in the results section could not be traced to a particular individual. The length of the interviews lasted between 25 and 45 minutes.
2.4 The Interview

A semi-structured interview was devised on the basis of the literature and ensured that participants addressed the research questions whilst also offering opportunities to talk freely about their own views.

A draft of the interview schedule was given to two clinical psychologists within the team to provide comments on the relevance of the questions to the concepts identified by the literature. Following revision, the interview was piloted on two key workers working with people with epilepsy to establish the precise wording so that the questions would convey the same meaning to each respondent.

The interview schedule shown in Appendix V, began by discussing the various experiences the participants had had with the CLDT whilst caring for their client. Subsequently they were asked to discuss what aspects of the service they found satisfactory and unsatisfactory and substantiate this with an overall satisfaction rating on a 7 point Likert scale ranging from extremely satisfied (+3) to extremely dissatisfied (-3). Questions were then asked on the perceived impact of epilepsy on their client and lastly what stresses were associated with working with a client with a learning disability plus epilepsy and how staff coped.

The interview schedule was followed consistently for all participants using the same precise wording for each question and probes. However, the order in which the questions were asked were altered when it was thought to be more appropriate.

2.5 Data Analysis
The stance adopted for this study was an empirical, realist one. (Kreuger, 1988). This implies that the information gathered from the participants during
the interview bore a close relationship to their genuine views and experiences. This approach seemed fitting as all of the participants were currently working as key workers to an individual with epilepsy and thus were unlikely to have distorted the interview data due to recall bias. Additionally, since the researcher was not part of their own housing organisation, the participants were more likely to have spoken freely and honestly about their opinions.

Having subscribed to a realist framework, the method of analysis thought most fitting to the purposes of this study was content analysis. This procedure aims to tease out the meaning and implications of the data by identifying interpretative sets of statements and recurring systems of beliefs or explanations in the data (i.e. themes). Furthermore it is a process that offers quantification of data. Using this method it was possible to determine what aspects of the service concerned most of the participants (i.e. the most pertinent service issues). Thereby, establishing the areas to focus on when encouraging service change.

Thus all interviews were transcribed and subjected to a thematic content analysis (TCA). This type of content analysis was chosen as it ensured that the themes were derived within their context and thus remained sensitive and open to the specific contents of each individual's representations (Flick, 1998).

The analysis followed a procedure set out by Bannister, Purman, Parker, Taylor, & Tindall (1994). The basic units of data for analysis were sentences. Units that related to each research question were collected together. Within each research question, units reflecting common themes in staff statements were grouped together into categories. Several overlapping categories were subsequently combined and the defining label of the category appropriately altered.
In order to establish reliability in the analytic and interpretative work, a colleague (unrelated to the project or service) was given the research questions and aims along with three transcripts (interviews that were thought to represent all of the themes generated from the data) and asked to generate themes from the interviews. The categories proposed by each rater were then compared and agreed themes negotiated.

Statements or quotations were selected by the researcher to fit a particular category, until the themes accounted for each and every view. To obtain a measure of inter-rater reliability, the (same) colleague was asked to assign all selected quotations to the defined categories. The extent of agreement regarding the assignment of quotations between the two coders was calculated using a simple percentage agreement index formula \[
\frac{\text{agreements}}{\text{agreement} + \text{disagreements}} \times 100\%.
\] An agreement was defined when both raters coded a statement to the same category. Inter-rater reliability was 85.1%. The coders disagreed on 14 quotations which were discarded.

These reliability processes were designed to reduce the risk of the final analysis arising from an idiosyncratic framework. Furthermore, all interpretations are accompanied by quotes from the data set in order to convey the basis of these interpretations. This represents a further attempt to increase transparency and to render the analysis open to evaluation (Smith, 1996).

3. Results

3.1 Description of the clients

The staff interviewed cared for 5 female and 7 male clients. Their ages ranged from 36 to 66 years (mean age 47 years 3 mths, s.d 9.72). Their disability ranged from mild to profound and the epilepsy ranged from well
controlled to not under control. Additional demographic information is shown in Appendix II.

3.2 Sources of Satisfaction

Staff's overall mean rating of satisfaction with the service on the Likert scale was 1.08, suggesting that on average the participants were mildly satisfied with the service. A breakdown of the ratings however, showed that the ratings ranged from extremely dissatisfied with the service to extremely satisfied. Nevertheless, more than half of the participants gave a rating of 2 or above and were thus considerably content with the service offered. None of the participants gave the service a neutral rating.

75% of staff felt that once the CLDT had become involved in their clients' situation they had been extremely helpful. It seemed that the intervention of each professional had been tailor made to meet the specific needs of that client and the key worker had appreciated this.

Examples of staff responses are shown in Table 1. 42% of staff felt that the understanding and availability of the professional from the CLDT was the most valuable resource. 33% identified the most helpful service to have been the professional's offer of an alternative perspective of a given situation. A further view identified by 40% felt that it was the connections and leads that the professional gave to the staff that really helped. It enabled them to access other resources and often made other external services more sympathetic to their clients' needs. Totals do not add up to 100% because staff identified more than one service as helpful.
### Table 1. Sources of satisfaction

<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>“He (team member) has been very available actually, if we’ve phoned him we have had great support. Within a couple of days of phoning he would get back to us. Even when we haven’t needed support he has phoned on a regular basis and asked how things are”.</td>
</tr>
<tr>
<td>Alternative</td>
<td>“The input is helpful, because everybody goes to look at things from a different point of view, also sometimes when you are so involved in the situation it is not easy”.</td>
</tr>
<tr>
<td>Perspective</td>
<td></td>
</tr>
<tr>
<td>Connections</td>
<td>“The involvement of the community nurse has been so helpful, she’s the one who has helped us to get to see the psychiatrist and the neurologist, up until then there was nothing”.</td>
</tr>
</tbody>
</table>

### 3.3 Sources of dissatisfaction

Table 2. Shows staff responses on dissatisfaction. 58% felt that the length of time they had to wait to receive input from the team was unsatisfactory. Despite appreciating and being aware of the long waiting lists, they felt uncomfortable and helpless seeing their client’s health deteriorate, before receiving input.

50% of the staff felt they were unaware of what services were available to people with epilepsy, largely due to not knowing who the team were or what types of professionals the team consisted of. Moreover many felt that unless there was a problem, little help was offered.

Another view apparent from the responses collected was that much of the staff’s dissatisfaction with the service lay not with the team’s involvement but with external agencies. Although this aspect of dissatisfaction was not directly relevant to our research questions, it was important as they were mostly mentioned by the staff who were unaware of who the CLDT consisted of and the services they offered. These staff were thus unable to differentiate between services received from the CLDT and that received from other agencies. Therefore, staff impressions of the services offered by the team
may have been clouded by confusion with negative experiences with other agencies. This possibility is reflected in the low satisfaction score on the Likert scale, which seemed inconsistent with the largely favourable responses when the team was involved. This also stresses the importance of team involvement in helping bridge the gap between key workers and other professionals.

Table 2. Sources of dissatisfaction

<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Lists</td>
<td>“It’s not the service it is the waiting list that is the problem, getting the clients to see anyone just seems to take a very long time, the referrals take so long because the waiting list is too long, but that’s the way it is”.</td>
</tr>
<tr>
<td></td>
<td>“Trying to get involvement in the first place. It took a year and in that time, he declined and perhaps if we’d had involvement sooner it may not have got to such a bad stage. Perhaps they need to be quicker reacting, looking at who needs input most”.</td>
</tr>
<tr>
<td>Lack of Information</td>
<td>“To be honest I don’t know who is from where and it’s knowing what services are available, I mean I don’t know what services are available for people with epilepsy.</td>
</tr>
<tr>
<td>External Agencies</td>
<td>“The doctors and surgeons don’t really seem to want to know,[ ] They don’t seem to believe the extent of the problem that we report”</td>
</tr>
<tr>
<td></td>
<td>“My feeling with people with learning disabilities is that they always get dropped down, as soon as you say learning disability people just don’t want to know”.</td>
</tr>
<tr>
<td></td>
<td>“I’d like to be listened to, if we could just be listened to by the G. P’s. it has to take a community nurse for them to listen to us. They just brush us off with excuses and the community nurse says the same thing we do and then things happen”.</td>
</tr>
</tbody>
</table>

3.4 Impact of epilepsy on a person with a learning disability

83% mentioned epilepsy had had some type of impact on their client. The remaining participants felt epilepsy had no significant impact since procedures existed to help prevent the client feeling different from any other client in the house.
66% of key workers felt that epilepsy did have a practical impact on their clients' lives e.g. limiting them from doing the range of activities available to other clients, or unfairly restricting them due to a lack of staff on duty to ensure the desired activity was safe. Similar concerns were raised by staff in the studies carried out by Espie & Paul, (1997); who mentioned concerns regarding client independence and social restriction.

Only 16% of key workers felt that epilepsy had an emotional impact on their clients. These staff perceived the seizures as frightening and alarming for their clients, particularly when reassurance following a seizure was problematic and seemingly purposeless (see Table 3.). 58% expressed views that their clients although aware of their condition did not seem emotionally or psychologically damaged from knowing they had epilepsy. Staff largely felt that their client had accepted it as part of their everyday lives and given that most of them lived with other clients with epilepsy, seizures were "normal".

Some staff even expressed examples of situations where clients had actually used the condition to their advantage.

"Sometimes you can find them really unmotivated, and it can be really frustrating. Sometimes, they even use the epilepsy to their advantage. So for instance she might say 'I can't do this, because I may have a fit', so she can find an excuse for anything".

Although this attribute could be perceived positively as a display by the client of initiative and intelligence, the attitude and subsequent behaviour was thought unproductive and influenced the manner in which key workers dealt with such behaviour.

In general, key workers perceived epilepsy to have the least impact on clients when the seizures were well controlled. Others felt that being prepared lessened the impact of the epilepsy possibly for the client as well as the staff. Unfortunately it was not possible to determine from the responses to what extent the type of seizure or the severity of an individual's learning disability affected their adjustment to the condition. However, it was possible to ascertain that participants did not share the view expressed by Baker (1997) that people with epilepsy should have individual counselling and education to
adapt to their condition. Especially, for clients that had more than a mild learning disability, as the relevant information was considered too difficult for them to comprehend. Moreover they expressed concerns that unnecessary attention to the condition could be disadvantageous as it highlighted yet another difficulty they had to live with.

Table 3. The Impact of epilepsy on the individual

<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical Impact</td>
<td>“The hardest thing is if you want to go out, like on public transport it becomes more difficult. She has really had a seizure, and gets very disorientated. Sometimes she tries to take her clothes off and runs around. That would not be nice for her in public or for the people watching”.</td>
</tr>
<tr>
<td></td>
<td>“You have to think about their activities e.g. swimming like you have to have two staff on to do something”.</td>
</tr>
<tr>
<td>Emotional Impact</td>
<td>“Communication is difficult, because he is partially deaf. So, it is difficult to reassure him after or during the seizure, and that has got to be frightening for him”.</td>
</tr>
<tr>
<td></td>
<td>“I think they all accept their epilepsy. They don’t seem to get upset about it, usually they get quite tired. It is a very normal environment because they all suffer from epilepsy and so I think they accept is as part of their lives. “He might think we all have them, and it is normal to him, an everyday routine. I don’t think he realises any different. He’s had fits all his life and when he sees (name of another client) having one he probably just thinks, oh it’s her turn”.</td>
</tr>
<tr>
<td>Helping Adjustment</td>
<td>“We have policies in place as to how to deal with her seizures, everyone is aware (client) has epilepsy, so from bathing to getting her dressed we know what we should do, and we all know the procedure”.</td>
</tr>
<tr>
<td></td>
<td>“I think for some it might be beneficial to talk about epilepsy so they could understand and know what is happening but it would have to be on a very basic level. But on the other side for some people it would be better to ignore it because some people with a learning disability don’t want to have a learning disability and would rather you ignored it and so for them then ‘no’ because you would just be focusing on another aspect of what is wrong with them”</td>
</tr>
</tbody>
</table>
3.5 Key workers emotions, stresses and coping strategies

100% of key workers recognised that the first seizure they observed was distressing, but that their emotional feelings had become less prominent over time. This is consistent with Hastings (1995) findings of staff's decreased emotions over time with challenging behaviour in people with learning disabilities. This abatement of feeling could be the result of other factors from the service environment being more salient than staff's own feelings. Alternatively, it may simply reflect habituation process and gradual adaptation to the increasing intensities of the work. Key workers responses are presented in Table 4.

100% of key workers felt that they would adopt the strategy of obtaining emotional support from other staff members to help cope with work-related stress. They felt that sharing experiences with work colleagues was reassuring and enabled them to benefit from other peoples' experiences. Also, since everyone was working in the same situation they were understanding of what was happening and would give people a break or some time out if it looked like things were getting too much for one person.

These strategies seem to highlight an adaptive function of having a cohesive staff culture, which staff were unwilling to jeopardise. Therefore, contrary to Espie & Paul's (1997) suggestion, staff perceived external support (perhaps from the team) only necessary under exceptional circumstances. They felt that since their own internal support systems were satisfactory and successful any additional support would be an invaluable use of resources and may even reduce staff's perceptions of job ability.
Table 4. Sources of stresses and coping strategies

<table>
<thead>
<tr>
<th>Categories</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detachment</td>
<td>“You get used to the seizures after a while. They tend not to affect you so much. The first few seizures you see when you have never seen them before are quite disturbing because you are not totally prepared for what you will see or what might happen, but the more you see you become emotionally detached and you just deal with it”.</td>
</tr>
<tr>
<td></td>
<td>“It is not nice when you have a severely epileptic patient and they are turning blue, but you think of them not yourself and the other residents because they can get upset too”.</td>
</tr>
<tr>
<td>Internal staff support</td>
<td>“I have been caring for people with epilepsy and learning disability for eight years. It is about experience and gaining experience from other people. You talk to them after you have had a particularly stressful day. People share experiences about what they did and communication like that helps, because you don’t feel so alone”.</td>
</tr>
<tr>
<td></td>
<td>“I have recognised times when he has a really bad seizure and I have had to take a half an hour out. Staff are so supportive that I’ve just said to them, ‘I’m just having a short break’ and they have understood”.</td>
</tr>
<tr>
<td></td>
<td>“I think you have to look at your team as a whole and I think we do quite well at supporting one another. If you have to single any one out as needing further support externally, they might feel they are getting preferential treatment. They may worry about why the staff group feel they need more support and whether it suggests that the group feel they are not coping. It could really have an adverse effect and really undermine their own sense of competency in their job”.</td>
</tr>
</tbody>
</table>

4. Discussion and conclusions

Asking staff about their experiences and their views has provided a wealth of information relevant to the CLDT on the service they provide for clients with epilepsy. Firstly, the satisfaction component of this study is favourable for the CLDT as it indicates that overall, key workers are satisfied with the service provided when the team have got involved. They feel they have been supported by the team’s understanding and subsequent action and benefited from offers of alternative viewpoints in difficult situations. Nevertheless, most
key workers felt the time taken to receive team input was too long and consequently damaging to their clients state of physical and psychological health.

Another important finding was that half of the key workers were unaware of services that were available. If staff were more knowledgeable about the services on offer and how to access them, they could refer to the appropriate service more promptly. This could have a significant impact on waiting time, given that most staff initially accessed the G. P. for services or advice, who would then usually refer on to the team. This process was often lengthy and staff perceived external agencies as unhelpful and unsympathetic to the needs of clients with learning disabilities.

Thus, for the service to meet the needs of a client with epilepsy more effectively, it seems worthwhile for the CLDT to publicise their services for epilepsy more widely. A leaflet designed to specifically address this specialised service may describe then input each professional in the team could provide for a client with epilepsy (e.g. the psychologist's role could include behavioural analysis of seizures), how to go about making a referral to the team and perhaps upcoming 'epilepsy training days' for key workers.

Findings in this study did not support Baker's (1997) suggestion that clinical psychologists should provide individual counselling and education for all individuals with epilepsy. Key workers felt that most of their clients would not be able to attain a greater understanding of epilepsy than that which they held currently. Furthermore, some participants felt that focusing on the epilepsy would have an adverse affect on their clients self worth. However, it was acknowledged that the benefits of counselling and education may differ according to a clients level of learning disability as well as the severity of their epilepsy and thus suggested that clients with a mild learning disability may benefit from further knowledge and understanding of epilepsy.
Lastly, it seems that over time key workers become less emotionally affected in their work with people with epilepsy and that they have good support systems. Therefore, contrary to Espie & Paul's (1997) suggestion, the results of this study indicate that any offers of support (if at all) from clinical psychologists might only be appreciated and accepted by new staff. Additionally, practical support and help is perceived to be more useful than support for staff's emotional difficulties. Nevertheless, specific individually tailored help during times of social transition may be useful, provided that it is carried out in groups so as not to disrupt the existing cohesiveness within the system.

5. Directions for future research

This pilot study reflects only 12 participants' views and thus may not be representative of the experiences of all key workers working with individuals with epilepsy. Therefore, a broader study using a more structured interview with a much larger sample of residential key workers would be worthwhile pursuing to verify that these opinions were representative of the populations'.

Furthermore as it only considered the key workers views of the service, at best it provides a guide for subsequent studies but does not guarantee that these same concerns will be shared by the clients themselves. Therefore subsequent research must ensure that clients are offered the opportunity to raise concerns other than those expressed by the key workers. Following that, studies could demonstrate the difference in levels of satisfaction between key workers and clients and in the aspects of service that concern them.

Nevertheless, specific service issues that appear of further interest when asking the clients to evaluate the service potentially include; time taken for needs to be addressed, impact of seizures on their lives, understanding from others and sources of support, awareness of their condition, access to and need for further information about epilepsy.
A current project being undertaken by the psychiatrist in the CLDT, involves the development of simple visual material to explain the condition and common anti-epileptic medication. Giving information to clients in this way focuses on adjustment and self management of the condition, (increasing self worth) and avoids preoccupation with the negative aspects of the condition. This approach seems to fit with the suggestion made by key workers that mildly learning disabled clients may appreciate and benefit from an increased awareness of their condition. Research evaluating the outcome of providing basic information to suitable clients compared with a matched control group may help demonstrate the actual benefits of information for a learning disabled population.

6. Methodological issues

This was a pilot study and as a result had a number of methodological weaknesses.

Firstly, interviewing involves researcher effects. Breakwell (1995) argues that 'characteristics of the interviewer interact with the subject matter of the interview to determine how the interviewee will respond'. In this study all interviews were conducted by a psychologist in clinical training. This has implications on the information obtained as the researchers profession may have inhibited the participants' responses towards the psychology service, particularly unsatisfactory opinions and experiences.

It also introduces the risk of the researcher interpreting the data psychologically. However, many examples of the raw data have been given that illustrate that the themes obtained remain firmly grounded in the data. Nevertheless, (with additional time) checking the results with the participants themselves would have added to the validity and reliability of the study's findings.
Secondly, the sample selected was obtained from a list of key workers of clients known by the CLDT to have epilepsy. This raises the issue of sampling bias since there may be many more clients that the CLDT are unaware of, but that have epilepsy. These clients however would be more unlikely to receive an epilepsy service and thus more likely to have unsatisfactory opinions and experiences with the service. It seems therefore that in order to carry out a worthwhile service evaluation, the CLDT must firstly compile a formal register of clients with epilepsy so that all the service users views can be heard equally.

Despite these methodological limitations the research was useful in suggesting directions for future research and service evaluation. It also highlighted the potential advantages of qualitative methods when addressing aspects of service satisfaction. The qualitative analysis enabled a more participant led approach resulting in some novel aspects of service dissatisfaction being identified such as lack of Information. Further it enabled discrepancies in satisfaction as measured by the Likert scale and analysis of the interview data to be examined and rationalised.
References


Appendix I

Written permission from one of the operations manager's to approach key workers in their housing organisation.
10th August, 1998

Dear Ms George

RE: RESEARCH STUDY

Thank you for your letter dated 5th August, 1998 and I happy for some of my care staff to participate in your research study.

If you could advise me which of my homes you wish to contact I will inform the Homes Managers.

I look forward to hearing from you.

Yours sincerely

Dora Manning
Operations Manager
Appendix II

Additional demographic information on the clients

Types of learning disability

<table>
<thead>
<tr>
<th>Level of learning disability</th>
<th>Number of individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>1</td>
</tr>
<tr>
<td>Mild-Moderate</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
</tr>
<tr>
<td>Moderate-severe</td>
<td>2</td>
</tr>
<tr>
<td>Severe-profound</td>
<td>4</td>
</tr>
</tbody>
</table>

State of epilepsy

<table>
<thead>
<tr>
<th>Control over epilepsy</th>
<th>Number of individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well controlled</td>
<td>6</td>
</tr>
<tr>
<td>Moderately controlled</td>
<td>5</td>
</tr>
<tr>
<td>Not under control</td>
<td>1</td>
</tr>
</tbody>
</table>

Additional health problems

<table>
<thead>
<tr>
<th>Types of additional health needs</th>
<th>Number of individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenging behaviour</td>
<td>6</td>
</tr>
<tr>
<td>Sensory disability</td>
<td>2</td>
</tr>
<tr>
<td>Physical disabilities</td>
<td>4</td>
</tr>
<tr>
<td>Mental health needs (e.g. depression)</td>
<td>3</td>
</tr>
<tr>
<td>Other diagnosis (e.g. autism)</td>
<td>1</td>
</tr>
</tbody>
</table>

Residence:

<table>
<thead>
<tr>
<th>Type of residence</th>
<th>Number of residents</th>
<th>Client : Staff: ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community House</td>
<td>3</td>
<td>3:2</td>
</tr>
<tr>
<td>Residence for profound learning disabilities</td>
<td>3</td>
<td>3:2</td>
</tr>
<tr>
<td>Community House</td>
<td>4</td>
<td>4:2</td>
</tr>
<tr>
<td>Community House</td>
<td>4</td>
<td>4:2</td>
</tr>
<tr>
<td>Residence for profound learning disabilities</td>
<td>5</td>
<td>5:4</td>
</tr>
<tr>
<td>Community Home</td>
<td>5</td>
<td>5:3</td>
</tr>
<tr>
<td>Community House</td>
<td>6</td>
<td>3:2</td>
</tr>
<tr>
<td>Challenging behaviour residence</td>
<td>5</td>
<td>5:7</td>
</tr>
<tr>
<td>Community House</td>
<td>10</td>
<td>10:3</td>
</tr>
<tr>
<td>Residential home for mild challenging behaviour</td>
<td>3</td>
<td>3:2</td>
</tr>
<tr>
<td>Community Home</td>
<td>10</td>
<td>10:3</td>
</tr>
<tr>
<td>Residence for people with epilepsy</td>
<td>5</td>
<td>5:2</td>
</tr>
</tbody>
</table>
Types of specialist training experienced by staff working with clients with epilepsy.

<table>
<thead>
<tr>
<th>Type of training</th>
<th>Duration of course</th>
<th>Number of individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>In service</td>
<td>1-3 hours</td>
<td>3</td>
</tr>
<tr>
<td>In service</td>
<td>One day</td>
<td>4</td>
</tr>
<tr>
<td>In service</td>
<td>2-3 days per year</td>
<td>2</td>
</tr>
</tbody>
</table>
Appendix III

An example of a letter received by a participant following their agreement to participate in the study.

4th August 1998

Dear Ms. W

Re: Research Study

Following our telephone conversation earlier today, I just wanted to thank you for agreeing to participate in my research study. Just to remind you, it is a small project evaluating care staff’s perceptions of the service provided by the community team for people with a learning disability plus epilepsy.

Participating in the study will involve you answering some straightforward questions as well as some more detailed questions on your experiences as a service user. The entire interview process should last between 30-45 minutes depending on the detail of your responses.

All the interviews are entirely confidential, however, during the interview you may give some very valuable information and so I am planning to tape record the interview so as not to lose this information. The interviews will then be transcribed for analysis and any information identifying yourself or your client will be erased from the transcripts as well as all recordings.

The general findings from this project will be reported back to the team, potentially to suggest ways of improving the service. If however, something you have said is quoted in the report, your name will not be attached and thus no-one will be able to trace your comments back to you.

If you have any queries or would like any additional information on the project please do not hesitate to contact me on ****. Otherwise, I thank you for your co-operation and look forward to seeing you at **** on **** at ****.

Yours sincerely

Anila George
Psychologist in Clinical Training.
Appendix IV

The questionnaires completed by the participant to obtain demographic details about firstly their client and then themselves.

Questionnaire 1.

As part of the study assessing the service provided by the community learning disability team for people with learning disabilities and epilepsy it would be helpful if you would complete two short questionnaires. This first one relates to details about the client(s) (with a learning disability plus epilepsy) that you are currently caring for. Please fill in a separate sheet for each client that applies. The second questionnaire will be given at the end of the interview.

(Please circle one answer for each question unless otherwise specified)

1. What is your client’s sex?
   - Male
   - Female

2. How old is your client? __________(years)

3. How well controlled are your clients seizures?
   - Well controlled
   - Moderately controlled
   - Not under control
   - Don’t know

4. What is the extent of your client’s learning disability?
   - Mild
   - Mild- Moderate
   - Moderate
   - Moderate- Severe
   - Severe/Profound

5a. Does your client have any additional health needs?
   - Yes
   - No

5b. Which of the following best describes their additional health needs? (Circle as many as apply)

   - Physical disabilities
   - Sensory disabilities
   - Other diagnosis (e.g. autism) (please specify) ____________________________
   - Mental health needs (please specify) ________________________________
   - Challenging behaviour(s) (please specify) ______________________________
   - Other (please specify) _______________________________________________
Questionnaire 2.

The following set of questions relate to details about yourself. This is so that your opinions from the interview can be compared with those of other people.

1a. Please describe the type of residence you currently work in?

1b. How many residents live there?

1c. What is the client: staff ratio ___:___

2. How long have you been caring for people with a learning disability?

3. How long have you been caring for people with a learning disability plus epilepsy?

4a. How many clients with a learning disability plus epilepsy have you cared for?

4b. Have you received any specialist training for working with clients with epilepsy?
   Yes
   No (Go to Q.5)

4c. Please indicate what type?
   Part of general training
   In Service
   Outside Service
   Other (please specify) ________________________________

4d. What was the duration of the specialist training course? ________hrs/ days

5. What is your sex?
   Male
   Female

6. What is your age? _______yrs.

7. What is your professional background/training?
   HND
   SRN
   RMNH
   No professional training
   Other (please specify) ________________________________

Thank you for your co-operation
Appendix V

Interview schedule

Hello, my name is Anila George. I am a clinical psychologist in training working with the Surrey Hampshire Borders community learning disability team. I am currently conducting a research project evaluating the service provided for people with learning disabilities and epilepsy. Since care staff are important service users too, I am approaching this task from their perspective and would thus like to spend some time discussing your views.

1. Have you had any contact or received a service from the community learning disability team when caring for a client with a learning disability plus epilepsy?

IF NO:

Are you aware of any services that are provided by the community learning disability team for clients with epilepsy, and if so what are they?

IF YES:

On how many occasions?
On this (any of these) occasion(s) was the team involved as a consequence of the epilepsy, an epilepsy related problem, or for a more general intervention?

Ask the following questions for the occasion that the team was involved due to the epilepsy or an epilepsy related problem:

Which professional(s) provided the service
How long did you have to wait for the service(s)?
What service(s) was(were) received?
How helpful was the service(s) provided?
How satisfied were you with the service offered from each professional involved?

2. In more general terms, using this scale, how satisfied are you that the current service provided by the team is meeting your clients needs?

-3  -2  -1  0  1  2  3
V. Dissatisfied Neutral  V. Satisfied

IF IN SATISFIED RANGE

What service have you valued the most and why?

IF IN DISSATISFIED RANGE

What service have you found the least helpful and why?
3. Would you make any changes to the service?

IF YES:

What changes?
Do you have any suggestions on how to make these changes?
What difference would these changes make?

4. Does epilepsy have any impact on your client?

IF YES: What types of impact does the condition have?
Is there anything that can be done to alter the impact?
How aware is your client of having epilepsy?
What effect would increasing your clients' understanding of epilepsy have?

If NO: Ask for more details

5. Are there any stresses involved when caring for a client with a learning disability plus epilepsy?

IF YES:

What are they?
How do you usually cope with these difficulties?
What part if any could the community learning disability team help with these stresses?

IF NO: Ask for more details
Appendix VI

Letter from the psychology department following completion of the study
Anila George  
Psychologist in Clinical Training  
PsychD Clinical psychology  
Department of Psychology  
University of Surrey  
Guildford  
Surrey GU2 5XH  

6 September 1999  

Dear Anila  

Thank you for the final copy of your service related research project on residential staff's perceptions of the service provided by our team to clients with epilepsy. It made very interesting reading. I have given copies to the clinical services manager, the team co-ordinator and consultant psychiatrist and we have discussed the findings.  

You may be interested to hear that since you were with us one of the community nurses has been on an extended course on epilepsy and I would say that awareness of epilepsy and the emotional needs of clients with epilepsy has increased amongst our team. Also some of the difficulties your respondents highlighted with the waiting list have been overcome by the introduction of a triage system, whereby a community nurse visits to complete an initial assessment within a week or two of referral.  

All the best for the remainder of the course,  

Yours sincerely  

Tessa Lippold  
Chartered Clinical Psychologist
Literature Review

"The Relationship between Cigarette Smoking, Body Weight and Weight Concerns: A Review of the Recent Literature".

Year II

July 1999
The Relationship between Cigarette Smoking, Body Weight and Weight Concerns: A Review of the Recent Literature

Introduction

Cigarette smoking has established health consequences and is the largest single preventable cause of ill health in the UK. Despite decades of health education and prevention efforts, nearly 3 in 10 adults smoke, of whom half will die from their habit, a third before the age of 65 years, from cardiovascular disease and chronic respiratory diseases and cancer of the lung and other sites (Reid, 1999).

One reason for the high rate of smoking is the widespread belief that smoking helps control body weight (Camp, Klesges & Rylea, 1993). This belief is substantiated by the compelling evidence that smoking cessation is followed promptly by weight gain (Klesges, Meyers, Klesges, & LaVasque, 1989). Consequently, this has led to the hypothesis that weight concerns and smoking behaviour may be causally linked, (particularly given the high report rates of weight concerns in young women). However, it remains unclear whether concerns about body weight are related to actual smoking behaviour.

This paper briefly introduces the established scientific data on the relationship between body weight and smoking behaviour by highlighting the findings of the review carried out by Klesges et al (1989). Methodological flaws in this review are discussed, as well as new evidence from a recent prospective study that suggests average estimated post-cessation weight gain has been underestimated.

Following this, the paper aims to review the recent scientific data on weight concerns and smoking behaviour. It expands on the work of French & Jeffery (1995) by including data from several recent prospective studies in
population-based samples and cross-sectional studies in populations with extreme dieting behaviours. The review also aims to identify sources of inconsistencies between the studies, methodological strengths and weaknesses in the existing literature; and directions for future research.

Studies were selected for review based on a computer search of English-Language publications since 1995 in psychological and bio-medical databases. Consistent with French & Jeffery's (1995) review, discussion is focused around type of smoking outcome with an emphasis on smoking cessation and relapse since this area seems to have attracted most of the recent research and consequently made the most noteworthy advances.

The Relationship between Smoking and Body Weight

Do Smokers Weigh Less than Non-smokers?

Klesges et al (1989) carried out a review of 70 cross-sectional and longitudinal studies (since 1970), examining the relationship between smoking and body weight and their potential effects on smoking initiation, maintenance and relapse.

Smoking status was found to impact on body weight. Of the 29 cross-sectional evaluations presented, 24 (83%) reported that smokers weighed less than non-smokers. The strength of this review was that the sample sizes of most of the 29 cross-sectional studies were relatively large. Collectively the studies investigated the smoking-body weight relationship in approximately 250,000 people. On the other hand, 69% of the studies had limited samples, including a single socio-economic group, assessment of only one race or in only one city, and restricted age ranges. Moreover, none of the studies used biochemical verification of cigarette smoking to validate smoking status and 7 of the 29 studies relied on self report measures of height and weight which is known to be to be consistently biased (Klesges, 1983).
Despite these flaws, the majority of studies were consistent with one another and concluded (bearing in mind differences in reporting techniques) that overall, smokers weigh an average of 3.43 kg (range = 1.07 to 6.80 kg) less than non-smokers.

**Does Smoking Cessation Promote Weight Gain?**

41 prospective studies of the effects of change in smoking status on body weight were also evaluated in Klesges et al's, (1989) review. 76% of the studies presented evidence that smokers who quit smoking gained weight and consistent with findings from the cross-sectional studies, those that initiated smoking lost weight relative to non-smokers. Collapsing data across these investigations, those who quit smoking gained an average of 2.90 kg (range = 0.23 - 8.20 kg).

Unfortunately, the prospective studies also had a number of methodological problems. Of the evaluations investigating the effects of cessation on weight, the length of follow up varied markedly, from as little as 4 days to as long as 40 years (mean follow up was 2 years 11 months). Again, 19% of the prospective studies relied on self-report of weight and weight gain, and 83% of the studies relied on self-reports of smoking and smoking cessation.

Nevertheless, these prospective studies with a cumulative sample of over 110,000 subjects presented with a high level of consistency showing that smoking cessation was associated with weight gain. However, controversy regarding the magnitude of the weight gain remained until recently.

Klesges, Winders, Myers, Eck, Ward, Hultquist, Ray & Shadish, (1997) assessed the effects of smoking cessation on body weight in a cohort using both point-prevalence and continuous abstinence definitions of cessation. Point prevalence abstinence, refers to smoking (yes vs. no) at a particular follow up period. Continuous abstinence refers to those participants who quit smoking and maintain abstinent throughout the follow up period. Subjects were 196 volunteers who participated in a smoking cessation program and
attended all three follow up sessions (1-month, 6-month, and 12-month). Three smoking status groups were formed, those who either continuously smoked, were continuously abstinent, or who were point prevalent abstinent at 1 year.

The results of this study suggested that the amount of post cessation weight gain varied according to the criteria used for smoking cessation. Continuous abstinence from smoking resulted in a 13 lb. weight gain over a one year period, whereas those who had quit at the one year follow up, but had been smoking during that year period (i.e. point prevalence abstinence) had only gained half that amount (6.7 lbs.).

This study had an important methodological advantage over previously reviewed studies in that self-report of measures of smoking status were confirmed by carbon monoxide tests and participants' weights were measured in all smoking group sessions and at follow up. Unfortunately, weight gain not attributable to smoking cessation could not be determined in this study because all participants had attempted to quit.

Klesges et al's (1997) study has shown that inconsistencies in previous studies regarding the magnitude of post cessation weight gain may be due to their use of a single self-reported point prevalence measure of abstinence. This definition does not take into account previous or subsequent relapses, and subsequently does not distinguish continuous abstainers from the point prevalence abstainers. Thus not only would post cessation weight gain vary in the sample, but the average post cessation weight gain reported would be an underestimate because many in the sample could have smoked before or after the assessment of smoking status.

Consequently, Klesges et al (1997) state “continuous abstinence would be the most accurate method of estimating weight gain when one quits smoking” and would hence give a more consistent measure of post cessation weight gain. Future studies should attempt to replicate the finding, as a 13 lb average post
cessation weight gain is double that which smoking cessation programmes typically advise smokers to expect.

In summary, the literature consistently shows an association between smoking behaviour and body weight. Smokers tend to weigh approximately 7lbs less than non-smokers do, and those initiating smoking lose more weight than non-smokers do. Furthermore, recent evidence suggests that the average weight gain following continuous abstinence smoking cessation is approximately 13lbs.

More recently Crisp, Stavrakaki, Halek, Williams, Sedgwick & Kiossis (1998) found an association between smoking and a weight loss of 7 kg or more since puberty in schoolgirls. More importantly however, they reported that subjects were aware of this association.

The Relationship between Weight Concerns and Cigarette Smoking

French & Jeffery (1995) reviewed 26 studies investigating the relationship of weight concern on smoking behaviour in adolescents and adults. The review included seven prospective studies that examined the effects of weight concerns on smoking initiation, cessation and relapse and sixteen cross-sectional studies examining the relationship between weight concerns and smoking status.

The difficulty they acknowledged when examining the weight concern literature was the multidimensionality of the construct and consequently the various ways it was measured. Dimensions focused on in the smoking outcome literature include: (a) weight gain concerns/fears of weight gain, (b) dieting behaviours or tendency to diet and (c) perceptions of being overweight.

Each of these dimensions has been examined in relationship to one or more smoking outcomes, but few studies have examined more than one measure of weight concern in relationship to smoking outcome. Thus, when inspecting
the smoking and weight concern literature collectively, the interpretations that can be made are limited because the constructs that these different weight concern measures assess are related, but not identical (Lowe, 1993).

**Smoking Initiation**

Only one prospective study examining the relationship of weight concerns with smoking onset was reported in French & Jeffery's (1995) review. High school students (N = 1,705) were surveyed at baseline and one year later by French, Perry, Leon, & Fulkerson (1994). They found ‘females who reported having tried to lose weight in the past year, having two or more eating disorder symptoms, or constantly thinking about weight and shape were more than twice as likely to initiate smoking during the year of observation than those who did not report these dieting behaviours and weight concerns’.

However this study had a number of methodological flaws which Klesges, Elliott, & Robinson (1997) have since improved upon in their recent prospective analysis. Klesges et al, (1997) are measuring a number of known predictors of smoking initiation (e.g. perceived social support for smoking) rather than, dieting behaviours and weight concerns alone, so that their explanatory value can be measured relative to other predictors of smoking initiation. Also, French et al's (1994) sample were 89% white, so the moderating effects of race/ ethnicity could not be examined. The more recent study uses a sample with a majority representation of black children,( N=6, 462) enabling important ethnic comparisons to be made as well as adding to the underrepresented literature investigating weight concerns and smoking behaviours among ethnic populations.

The main limitation of Klesges et al's (1997) study however, is in its sample selection. The sample, albeit large, were all obtained from students dwelling in one mid-south Urban city who attended public schools. Consequently, results may differ if the study were to be based on a more suburban or rural population. Moreover the white students in the sample may not be
representative of the whole community because many attend private schools. Generalisations of the findings to other populations therefore, will need to be made with caution.

Unfortunately Klesges et al's (1997) study is part of a longitudinal investigation. The data available to date is cross-sectional and therefore relies on those subjects who have recently converted to smoking, as well as those who have been smoking for a long time. Consequently, it is not possible to determine whether the onset of smoking is related to dieting concerns. Nevertheless, the methodological strengths of their study promises reliable data that would add considerably to the current literature on predictors of smoking initiation in children.

Prospective analysis of smoking initiation in adults is understandably lacking. However a retrospective study by Jarry, Coombs, Polivy, & Herman (1998) found that dieters agreed more than did non-dieters with the statement that they started smoking for weight control purposes. Unfortunately the retrospective design limits the validity and power of the study as it introduces a bias, by which subjects may think of the past in ways that fit with their present experience.

In summary, existing data suggests that there is a positive relationship between smoking initiation and dieting behaviours and general weight concerns, especially for white girls. However additional prospective studies are necessary to determine how predictive weight concern is, relative to other known predictors, of smoking initiation.

**Smoking Cessation and Relapse**

Given the substantial evidence for post cessation weight gain, French & Jeffery (1995) reviewed four prospective studies that hypothesised that those with weight concerns would be less likely to attempt smoking cessation and if they did, were more likely to relapse.
French, Jeffery, Klesges, & Forster's (1995) study was considered to have the strongest methodologies of the four studies reviewed. Its strengths included (1) its prospective design with smoking behaviour and weight concerns measured at baseline and two years later; (2) the large sample size of the study (N = 4,981); (3) the first of its kind to use a population not involved in a smoking cessation programme, but randomly selected working women and men; (4) the use of various weight concern measures such as reported history of dieting, desired weight loss and personal weight preferences relative to actual weight standards; (5) the use of the more accurate measure of continuous abstinence to define individuals who had quit smoking at follow up (Klesges et al, 1997).

Contrary to expectations, the study found dieting behaviours and weight concerns were unrelated to smoking cessation or relapse. Furthermore, they observed that female smokers who had previously participated in a formal weight control program were three times more likely to quit smoking than those without a history of participation. Thus, it was suggested that dieting behaviours may reflect a "health consciousness predictive of smoking cessation" (French & Jeffery, 1995).

Unfortunately this study lacked a smoking specific weight concern measure and so the data could not adequately determine the role that smoking specific weight gain concerns may play in cessation or relapse.

Given that a stronger relationship is likely to exist between weight concern and smoking cessation and relapse when the weight concern measure is specific to smoking cessation, Jeffery, Boles, Strycker, & Glasgow (1997) attempted to improve on this earlier study by using a smoking specific weight gain concern measure. The study examined cessation rates, quit attempts, and progression in state of change for smoking cessation over a 2 year period among 242 men and women. The weight concern measure was assessed at
baseline and was expressed as a concern about weight gain after quitting smoking.

Jeffery et al (1997) also found that weight concern, and more specifically, concern about gaining weight when quitting smoking did not predict cessation. Additionally, weight concern at baseline did not predict serious quit attempts or progression to a state of change (i.e. their stage at follow up was no nearer to cessation than it had been at baseline).

Although they used a smoking specific measure of weight concern, the limitation of their study was their small sample size. More importantly, two thirds of the sample were men and sex was reported to have significantly associated with weight concern (i.e. men expressed less weight concern than women did). Thus since Jeffery et al (1997) did not publish the range of levels of weight concern in their study, it is possible that most of the sample expressed low levels of weight concern, restricting the range of weight concerns and limiting the power of the study to detect relationships with smoking outcomes.

Another limitation was that both of these studies relied solely on self-report measures to define cessation. This was particularly unsound in Jeffery et al's (1997) study since they used a week long point prevalence measure to define cessation. Thus in their study it was not possible to determine whether smoking specific weight concern had any relationship with continuous abstinence. Indeed, those that were defined as abstinent could potentially have been smoking up to a week before the point of assessment.

Despite these methodological flaws, both French et al's (1995) and Jeffrey et al's (1997) findings were consistent with the results of three other prospective studies that used a clinical sample involved in a smoking cessation programme. The most salient of these three studies was French, Jeffery, Pirie & McBride's (1992) study which used a large sample size (n=417) and various weight concern measures including a smoking specific weight gain concern.
However, significant relationships were not even observed in white women, the population subgroup in which they were thought most likely to be present.

Fench & Jeffery (1995) did mention two studies that found an inverse relationship between smoking specific weight concern and smoking cessation. However both were retrospective, preventing causal relationships from being examined. Also they used small samples, limiting the generalisability of findings and power of the study.

Meyers, Klesges, Winders, Ward, Peterson & Eck, (1997) however, have since carried out a methodologically sound prospective analysis that supports the relationship between smoking specific weight concerns and smoking cessation. The study also assessed the prevalence of concern regarding post cessation weight gain among participants volunteering for a clinic based cessation program.

The study surveyed 580 volunteers and involved a 12 month follow up, but its methodological strengths over other studies were that smoking status was determined by self report and validated using carbon monoxide readings. Additionally, smoking cessation was defined as those who had been continuously abstinent since the quit date and had a carbon monoxide (CO) reading of <10 parts per million (ppm) at the current and all previous assessments. Participants' weights were measured at all assessment points and both a general measure of weight concern (i.e. dieting behaviours) as well as a smoking specific weight concern measure were used at baseline. One weakness was that the sample was predominantly American and European and the authors suggest that extensions and replication of the study should be carried out with other ethnic populations.

Consistent with earlier studies, Meyers et al (1997) found that general weight concerns (e.g. dietary restraint) were unrelated to smoking cessation. However they did find that individuals who reported smoking specific weight gain concerns were significantly less likely to stop smoking. They also found
the prevalence of weight concerns among those presenting at a clinic based smoking cessation program was not as high as expected. ‘The majority reported that they would not relapse to smoking even if they experienced a 20lb weight gain’ (Meyers et al, 1997).

This evidence suggests that previous studies such as French et al’s, (1992) may not have found significant findings because of their sample selection. ‘Individuals involved in a smoking cessation programme accept a fairly high post-cessation weight gain and are thus less weight concerned than the general population of smokers’ (Meyers et al, 1997). Thus, using this sort of sample limits the power of the study as an effect is unlikely to be demonstrated even if one should exist. This was similar to the limitation of the Jeffery et al, (1997) study, in that the range of weight concern may have been too narrow to have shown any significant relationships.

Another reason for inconsistencies in the data concerns the phase of quitting in the study population that is being examined. For example individuals who are in the active phase of quitting (e.g. those involved in a smoking cessation programme) may report greater weight gain concerns because they are aware that quitting will likely result in weight gain. However, voicing those concerns does not imply they would resume smoking in response to an increase in body weight. Borrelli & Mermelstein (1998) suggest that once the decision has been made to quit other variables such as self-efficacy to prevent weight gain may be more important in predicting relapse.

Current smokers who believe most strongly that smoking cessation will result in weight gain are less likely to participate in a formal stopping smoking effort. They may also report lower weight concerns as they are aware that their cigarette smoking facilitates weight suppression and appetite control. Further, they do not need to worry about post cessation weight gain concern until they are contemplating quitting. To expose this discrepancy, the ‘intention to resume smoking after a specific weight gain’ may be a better predictor of
cessation and relapse, than the more general post cessation weight gain concern (Meyers et al, 1997).

In general, although discrepancies still exist in the data, the results suggest that specific post cessation weight gain concern appears to predict relapse, yet more global measures of weight concern are not strongly predictive of cessation or relapse. Different study samples, stages of quitting and different conceptualisations of weight concern seem to account for the disparity in results.

**Smoking Status**

French & Jeffery (1995) reviewed 16 cross sectional studies that examined the relationship between weight concerns and smoking status in adolescents and adults.

They concluded that in adolescents, dieting behaviours, general weight concerns and smoking specific weight concerns are positively related to current smoking, particularly among white females. Studies showed that dieting frequency was associated with greater likelihood of tobacco use in females. Further, current smokers had higher restrained eating scores than never smokers, and current smokers were more likely to hold beliefs regarding the weight-controlling properties of smoking than never smokers.

Two cross-sectional studies have been carried out recently that add further evidence to support this relationship. Klesges et al, (1997) found that white girls in their sample reported more concern for dieting and body weight than any other group, but surprisingly black males were more likely to have weight concerns than white males. This was possibly due to the large representative sample of black youths, allowing this difference to emerge. Additionally 39.4% endorsed the belief that smoking could help control one’s weight and the endorsement of this belief increased as the level of previous smoking exposure increased. Of the 240 respondents with an active smoking history,
approximately 12% indicated that they smoked to control their weight, with white girls endorsing this behaviour significantly more than most.

Crisp et al, (1998) surveyed 1936 British schoolgirls and 832 Canadian schoolgirls to examine the relationship between weight changes, attitudes to body weight and shape, dietary patterns and smoking (as well as other variables). Data analysis revealed links between cigarette smoking and body weight shape concerns, in that the smoking population reported ‘worry about being too fat’ significantly more often than the non-smoking population.

Neither study used biochemical or bogus pipeline procedures to verify smoking behaviour. Consequently, smoking behaviour may have been under reported since young children perceive smoking to be a forbidden behaviour and are either reluctant to reveal it as a past or present behaviour or may tend to play down the amount that they smoke. However, Camp et al, (1993) argue that the best predictor of accurate reporting among adolescents is whether they are assured confidentiality, which both studies did assure.

Crisp et al (1998) also noted that there was a much greater likelihood that smokers would report drinking alcohol. This raises the possibility that smoking and dieting may only be related because they are both part of a larger constellation of undesirable behaviours (such as drug taking, alcohol use etc.) Further prospective studies are required to compare the onset of illicit substance use as well as cigarette smoking with increased weight concerns and dieting behaviours.

Nevertheless, the evidence consistently demonstrates a positive relationship between dieting, weight concerns and smoking status in adolescents. This finding has substantial implications for adolescents with an eating disorder as they have extreme weight concerns by diagnosis and are thus more likely to smoke for weight control.
Wiseman, Turco, Sunday, & Halmi (1998) aimed to substantiate this hypothesis by comparing the prevalence of smoking in adolescent anorectic, and bulimic patients with an adolescent non-clinical sample. They also examined the relationship between smoking and attitudes and behaviours commonly associated with eating disorders. A sample of 411 schoolgirls and 82 in-patients of an eating disorder unit aged between 11 and 18 were surveyed. Smoking status was assessed using a self-report questionnaire and the Eating Disorders Inventory (EDI; Garner Olmstead & Polivy, 1983) was used to measure weight concerns. The EDI includes six sub-scales that measure different attitudes and behaviours associated with eating disorders such as, drive for thinness, body dissatisfaction, perfectionism and so on.

The data showed that anorectic restrictors were significantly less likely to smoke regularly (13.6%) than non-clinical subjects (38.10%) and also less likely to smoke than those with anorexia nervosa-binge purge type or bulimia nervosa. A trend suggested that patients who binged and/or purged were more likely to smoke than non-clinical control subjects.

EDI scores were compared for the smokers and non-smokers. In the clinical group, smokers had higher scores on drive for thinness and body dissatisfaction. In the non-clinical group, consistent with previous findings, regular smokers had higher scores on most of the EDI sub-scales than non-smokers.

The main limitation of this study was its use of a non clinical sample of primarily white, middle class adolescent females. This group report more weight concerns than any other (population-based) adolescent group (Camp et al, 1997; Halek et al, 1993). Consequently, it is more than likely that high levels of weight concerns were reported across both the groups. Furthermore, as the EDI is not a diagnostic tool that can determine clinical cases in a normal population, some of the non clinical sample may have had a history of or a sub-threshold eating disorder themselves. Thus, the high level of weight concern in both groups may explain why only a trend (and not a significant
difference) was found when comparing smoking prevalence rates in the binge-purge/bulimic group with the non-clinical control group.

Nevertheless, as expected, the results demonstrated that the non-clinical smoking subjects had greater levels of weight concern than their non-smoking counterparts. Similarly, in the clinical group with extreme levels of weight concern, the smoking subjects had the highest level of these concerns. Contrary to expectations, the lowest prevalence of smoking was found among anorectic restrictors. Wiseman et al. (1998) suggest that 'their personality characteristics may underlie their low rates of smoking' (e.g. heightened maturity fears and thus, a fear that smoking may either make them look older or bring them closer to adulthood). Future studies may benefit from comparing the beliefs about smoking across eating disordered groups as well as a non-clinical population.

In adults, Jarry et al. (1998) examined the impact of dieting status in 220 undergraduate females on smoking status, post-cessation weight gain and their motivations to smoke. Smoking status was determined by self-report and dieters were operationally defined as those who scored 15 or more on the Revised Restraint Scale (Polivy, Herman, & Howard, 1988).

They found that former smokers had the highest average restraint score, but current smokers agreed more than former smokers with the statement that they continued smoking to control their weight. Current smokers were also more concerned about post cessation weight gain, expecting to gain 10.5 lb. compared to former smokers who expected to gain 6.8 lb.

This data is consistent with earlier studies. However, reliability and validity of the results is questionable since retrospective data quite often include several sources of bias. Furthermore, they did not measure any other motivational factors that are known to maintain smoking (e.g. relaxation, to relieve boredom and so on) besides weight control. Crisp et al. (1998) ranked the reasons for smoking and consequences for giving up smoking in their
population of schoolgirls. They found that the girls smoked most often because they liked it, for relaxation and to relive boredom rather than to reduce hunger. The most reported consequence of giving up smoking however was ‘eating more and gaining weight’. Future studies with adult women should similarly assess a number of motives for continued smoking including weight control, so that its motivating value can be measured relative to other known motives for continued smoking.

The only other study since 1995 to examine the relationship between weight concern and smoking in adults followed in the same vein as Wiseman et al’s (1998) study and used an adult population of women with bulimia nervosa.

Welch & Fairburn (1998) assessed the prevalence of smoking in 102 women with bulimia nervosa compared with 204 normal matched controls as well as a clinical control group of 102 subjects with anxiety or affective disorders. Since all subjects were interviewed, it was possible to exclude any controls with a history of eating disorders. Thus the range of weight concerns across the groups was potentially quite large, increasing the likelihood that a relationship between weight concerns and smoking status would be observed if it existed.

As predicted, bulimia nervosa cases (with the highest expressed levels of weight concern) were more likely to have been smokers than either normal or psychiatric controls. Also a higher proportion of bulimia nervosa cases were current smokers than in either control group. Bulimia nervosa smokers also reported that they sometimes smoked to control their weight and acknowledged concern about weight or shape as one reason for having resumed smoking after abstaining for 6 months.

In summary, there is substantial evidence to suggest weight concerns and dieting behaviours in white adolescent females are positively related to current smoking status. In adults, dieting is more common in ex-smokers than current smokers which most likely reflects the influence of smoking cessation on body weight. Current smokers do however express a greater belief that
smoking controls weight and stopping smoking leads to weight gain than non-smokers.

More recent results indicate that the positive relationship between current smoking and weight concern is also apparent in adolescents and adult women that binge and purge (e.g. bulimics). The high rates of smoking in this population are worrying since it suggests that smoking related morbidity could prove to be an important indirect consequence of the disorder (Wiseman & Fairburn, 1998).

Summary

This paper reviews the recent research data on body weight, weight concerns and smoking behaviour. Data assessing the relationship between body weight and smoking behaviour consistently shows that smokers weigh less than non-smokers, that those who start smoking lose weight and that those who stop smoking gain weight. Estimates of post cessation weight gain vary, but recent studies using more accurate definitions of cessation estimate it as averaging approximately 13 lbs. This merits future studies to explore how smoking intervention programmes may best prepare an individual for post cessation weight gain (e.g. by reducing weight concerns, altering dieting behaviours, or by preventing or delaying cessation related weight gains).

The most consistent findings in the literature assessing the relationship between weight concerns and smoking behaviour is observed in populations of white adolescent girls. In this group, dieting and weight concerns are positively related both cross-sectionally and prospectively to smoking. Interestingly, recent evidence suggests that a similar relationship is more likely to be observed in black than in white adolescent boys. More prospective studies are required to explain this relative higher weight concern in black boys as well as the value of weight concern as a predictor of smoking initiation compared with other predictors of smoking initiation.
The relationship between weight concerns and smoking behaviour in adults remain less clear, but recent prospective studies have demonstrated that much of the inconsistencies in the data are caused by the different dimensions of weight concern that are being assessed and differences in the samples used across studies. Bearing these factors in mind, the evidence suggests that, although general weight concerns do not hinder cessation efforts and increase the risk of relapse, smoking specific weight gain concerns do. Moreover, future studies should address the claim that the 'intention to quit given a specific amount of weight gain' may be an even better predictor for cessation and relapse.

Data from cross-sectional studies are less diverse and clearly demonstrate the significant relationship between weight concerns and smoking status in adults. Given the consistency of findings it is not surprising that more recent cross-sectional studies have started to look at the significance of these findings for sub-groups at high risk for indulging in unhealthy weight control practices (e.g. females with eating disorders). Amongst this population, it appears that bulimics are the most likely to report that they use smoking for weight control purposes. These preliminary findings merit further investigation since, if bulimics are tending to use cigarette smoking as yet another weight control strategy (similar to that of laxatives and diet pills), then smoking use can no longer be ignored during their clinical treatment.
References


Large Scale Research Project

“Cigarette Smoking in Women with Eating Disorders”

Year III

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Cigarette Smoking in Women with Eating Disorders

1.0 ABSTRACT

Objectives: Recent research suggests that women with eating disorders may have unusually high rates of tobacco smoking. It has been suggested that this may be due to their additional motivation to use tobacco to control their weight. The aim of this study is to assess the role of cigarette smoking in women with eating disorders in comparison with women with other mental health problems.

Method: The participants were 24 women with anorexia nervosa, 22 women with bulimia nervosa or binge eating disorder and 31 women with non-psychotic mood or anxiety disorder (the psychiatric comparison group). All participants were currently being seen by a health professional for their mental health problem and were recruited from the same geographical location.

Results: The women with bulimia or binge eating disorder and the comparison psychiatric group did not significantly differ in their current smoking prevalence rates (50% and 48% respectively). Women with binge-purge behaviours were however more likely to have smoked than women with anorexia nervosa (77% vs 46% respectively). Of the current smokers, the women with eating disorders were no more dependent on smoking, but there was some evidence (although it did not reach significance) to suggest they were less inclined to give up smoking than the comparison group. Of those smokers who had reached at least a 6 month period of abstinence, the women with eating disorders were no more likely than the comparison group to resume smoking or to attribute the reason for their relapse as a result of weight concerns. Women with eating disorders however, reported to a greater
extent than the comparison group that they used smoking ‘to keep their weight down’, where as women in the comparison group were more likely to report that they smoked to ‘concentrate and stay alert’.

**Conclusions:** Women with eating disorders share similar smoking characteristics to women with mood or anxiety disorders. However, women with eating disorders are more likely to use smoking to help them control their weight. Clinical psychologists working with women with a clinically significant eating disorder are hence advised to assess the use of cigarette smoking in their patients before embarking on treatment.
2.0 INTRODUCTION

Smoking is the single greatest cause of preventable illness and premature death in the UK. Smoking kills over 120,000 people in the UK a year—more than 13 people an hour. The government is determined to see a major improvement in health in the UK and recently proposed several specific new targets for health improvement (Our Healthier Nation, 1998). One of these targets is to reduce the number of cancer deaths, another is to reduce heart disease. Tackling smoking is central to cutting deaths from cancer and heart disease and therefore, tackling smoking is central to improving health in Britain.

The government recommends that smoking cessation services should be made universally available at all levels of the NHS. Hospitals, doctors and all other health service providers are advised to recognise nicotine addiction as a medical priority and should be required to provide appropriate cessation support to all smokers accordingly. The government has also highlighted the need for health communication programmes and smoking cessation services to be directed with particular emphasis towards those sectors of society in which smoking is most prevalent e.g. the most disadvantaged sectors of society.

The presence of a mental health problem is also associated with higher prevalence of smoking and consequently, mental health professionals are in an ideal situation to address the use of smoking in patients and assist them to stop smoking. Further, clinical psychologists should already have an interest in the smoking status of their patients since nicotine withdrawal can lead to a range of negative psychological states: nervousness, irritability, depression, poor concentration and impaired task performance (Parrott, 1998). Recent evidence has also shown that not only are individuals with major depression more likely to smoke, they are also likely to have more difficulty trying to stop
and when they manage to succeed in stopping, are at increased risk of experiencing mild to severe states of depression (Covey, Glassman, Stetner, 1998).

2.1 Smoking and Depression

Although the association between cigarette smoking and schizophrenia has been readily accepted, over the last two decades there has been a growing interest in the association between cigarette smoking and other psychiatric disorders (Foulds, 1999). Recent epidemiological studies have reported an association between smoking and major depression. For instance, Glassman, Helzer, Covey, Cottler, Stetner, Tipp & Johnson (1991) noted that 60% of smokers who wished to stop smoking had a previous history of major depressive disorder and were twice as likely to fail to stop smoking as those free of such a history. Interestingly, they also reported a stronger effect of depression on smoking in women than in men. Similarly, Hughes, Hatsumaki, Mitchell & Dahlgren, (1986) found the prevalence of smoking among psychiatric out patients was 1.6 times that of population based control groups and the prevalence of smoking was higher than expected among those with schizophrenia, mania, depression and anxiety and personality disorders.

General population surveys of adults and adolescents have also shown the rates of depressive and anxiety disorders to be higher among smokers or those with nicotine dependence. Breslau, Kilbey, & Andreski (1991) reported that, compared to the rate of nicotine dependence among participants with no psychiatric disorder, the rate was twice as high among individuals with an anxiety disorder but no depression, three times as high among those with a lifetime history of major depression but no anxiety disorder and four times as high among smokers with both conditions. Ferguson, Lynskey, & Horwood (1996) also found strong evidence of moderate to strong co-morbidity between depression and nicotine dependence at age 16 years. Teenagers
with a depressive disorder had odds of smoking 4.6 times those of teenagers without a depressive disorder.

2.2 Why do individuals smoke?

Although various models have been proposed to explain the maintenance of smoking, Russell, Peto & Patel (1974) provide one of the most comprehensive models of smoking motivation to date. They defined seven types of motives, which are reinforced by either non-pharmacological or pharmacological rewards. They suggest that initially non-pharmacological rewards, such as psychosocial (social reinforcement), indulgent (watching smoke, enjoying the sensory experience in the mouth, throat and lungs) and sensorimotor manipulation (i.e. handling the cigarette) motivate smoking. Quite soon however, the pharmacological rewards of nicotine, due its direct and indirect effects on the brain, exert more control as the smoker increasingly uses nicotine to modulate arousal (stimulation) and negative affect (sedative).

The nicotine resource model suggests that nicotine leads to real psychological gains and it is widely accepted that nicotine activates neural systems that mediate arousal (Gilbert, 1995). A major motivation of many smokers is therefore, the use of smoking as a means of obtaining desired stimulant effects. Many smokers report that smoking helps them to think and concentrate and consequently, many studies have investigated the effects of nicotine on cognitive performance. Nicotine has been shown to enhance performance in vigilance tasks and the rapid visual information processing task (Foulds, 1996) and in tasks requiring selective attention (Provost & Woodward, 1991). Nicotine has also been shown to influence the functioning of memory (Perkins, Grobe, Fonte, Goettler, Caggiula, Reynolds, Stiller, Scierka, & Jacob, 1994).
The other frequently given reason for smoking is stress reduction, with 80% of smokers using cigarettes when feeling stressed or angry (Ikhard, Green & Horn, 1969; cited in Parrott, 1998). Parrott and colleagues have carried out a series of field studies investigating participants' mood and arousal over a day of normal smoking. Mood questionnaires were completed before and immediately after smoking and most studies found feelings of anxiety/stress were significantly lower post-smoking than pre-smoking (Parrott, 1993). Other, laboratory studies have also shown acute smoking can reduce stress under certain circumstances (Kaseel & Shiffman, 1997; Perkins, Grobe, Fonte, & Breus (1992).

Given that smoking is perceived to help with stress control, stress levels would be expected to rise after quitting. However, several longitudinal cessation studies have monitored feelings of stress over time, and found reduced stress after quitting (Parrott, 1995; Hughes, 1992). Parrott (1999) maintains that this finding provides clear evidence that the stress-relieving effects of nicotine do not reflect a genuine gain, but merely the reversal of abstinence effects (the deprivation resource model). This finding is consistent with Russell et al's (1974) hypothesis that, as nicotine intake increases and the pattern of intake becomes more regular, avoidance and relief of withdrawal become paramount, and the automatic and addictive motives become stronger. Despite evidence to the contrary however, the subjective reports of smokers remain: 'smoking calms me down when I am tense and anxious' and as a result, the use of smoking to reduce stress cannot be denied.

The pharmacological rewards (either through direct gains, or via relief of withdrawal) of stimulation and sedation are thought to explain the increased rates of smoking in patient groups. Although the exact causal mechanism is not yet known, the most commonly held view is that the association
represents an attempt to self-medicate symptoms of depression and anxiety (Khantzian, 1985). More over the reinforcing effects of nicotine’s mood-altering characteristics are thought especially powerful in smokers with symptoms of depression, since withdrawal or continued abstinence from nicotine has been shown more likely to lead to a significant mood disturbance or full blown depression (Covey et al, 1998).

2.3 Smoking and Eating Disorders

More recently, investigators have explored the relationship between cigarette use and eating disorders. This move stems from overwhelming evidence in the general population that females with weight concerns are more likely to engage in smoking behaviour to help them control their weight or appetite. Nicotine’s effect as an appetite suppressant is as well known in the general population as is its effects on body weight (Crisp, Stavraki, Halek, Willimas, Sedgwick & Kioss, 1998). Smokers weigh an average of 2.4 to 4.0 kg less than non-smokers do and those initiating smoking lose more weight than non-smokers do. Cessation efforts are also hampered by post-cessation weight gain, which can lead to a net mean gain of 2.4 to 5 kg of weight depending on whether a point prevalence or continuous abstinence measure of smoking cessation is employed (Froom, Melamed, Benbadssat, 1998).

Although the exact mechanism is unclear, the inverse relationship between smoking and body weight is thought to result from changes in dietary intake or changes in energy expenditure, or both. Most short-term evaluations (e.g. 3 days or less) found that food intake, particularly the consumption of sweet foods and simple carbohydrates increase after smoking cessation. Stamford and colleagues (1986) analysed changes in food intake, physical activity and resting metabolic rate in 13 sedentary females who quit smoking for 48 days and found mean daily intake increased by 227 kcal and this explained 69% of the variance in weight. No changes in physical activity or metabolic rate
were observed. Perkins, Epstein & Pastor (1990) evaluated calorie intake, resting energy expenditure (REE), and physical activity in seven female smokers for 3 weeks, which included normal smoking (week 1), smoking cessation (week 2) and resumption of smoking (week 3). Although total calorific intake did not increase during the week of cessation, caloric intake did reduce significantly once smoking was resumed in week 3. The REE also did not decrease compared to the baseline during the cessation week, but a significant increase in REE was observed when participants resumed smoking. Again, no changes in physical activity were observed. Although tremendous individual variation exists, the literature generally indicates that both dietary and metabolic changes are responsible for weight gain after smoking cessation, whereas physical activity plays little or no role in the relationship between smoking and body weight (Report of the Surgeon General, 1990).

Recent studies have consistently demonstrated a significant relationship between weight concerns and smoking behaviour in adolescent and adult females (see French & Jeffery, 1991 & literature review, pg. 175 of this portfolio for reviews). Studies have shown that dieting frequency was associated with greater likelihood of tobacco use that current smokers had higher restrained eating scores and that current smokers are more likely to hold beliefs regarding the weight control properties of smoking than never smokers.

Females with an eating disorder are by definition known to have extreme weight concerns and engage in a range of weight control practices. Therefore, research evidence from general population samples would suggest that female patients with eating disorders are likely to have even higher rates of smoking than the general population because of their intense motivation to control their weight.
Consistent with this prediction, Bulik, Sullivan, Epstein, McKreer, Kaye, Dajhl, Weltzin (1992) found that the rate of smoking was almost twice as high in women with bulimia (52%) than in the general population of the same age range (27%), based on the Morbidity & Mortality Weekly Report, (1989). However, significantly fewer women with anorexia nervosa reported the use of cigarettes (6%). They also observed that women with bulimia reported that they smoked to reduce their appetite but of the women with anorexia that smoked, no effects on appetite were reported.

Wiseman, Turco, Sunday & Halmi (1998) compared the prevalence of smoking in adolescents with anorexia nervosa and bulimia with an adolescent non-clinical sample. (A more detailed discussion of the study's methodology and its limitations can be found in the literature review on pg. 189 of this portfolio). In their study, due to small sample sizes and similar psychopathologies, Wiseman et al, (1998) combined the anorexic binge-purge type with the group with bulimia for the analysis. They found that the anorectic-restrictors were significantly less likely to smoke regularly (13.6%) than non clinical subjects (38.1%) and also less likely to smoke than those with anorexia nervosa-binge purge type or bulimia nervosa (58.2%). Although not significant, there was a trend showing that those patients who binged and/or purged were more likely to smoke regularly than non-clinical control subjects.

The evidence therefore suggests that the positive relationship between current smoking and weight concern is also apparent in adolescents and adult women who binge and/or purge. Contrary to expectations however, is the finding that females with anorexia nervosa- restricting type (with perhaps the most extreme concerns about body and weight) are the least likely to smoke.
Wiseman et al (1998) suggested that 'the personality characteristics of anorectic-restrictors may underlie their low rates of smoking' (e.g. heightened maturity fears and thus a fear that smoking may either make them look older or bring them closer to adulthood). These reasons would also have an impact on smoking rates as adults, since the vast majority of people who become regular smokers begin their smoking career in adolescence (Royal College of Physicians, 2000).

However, the finding that females with anorexia-restricting type have the lowest rates of smoking remains puzzling since the diagnostic classifications of individuals with eating disorders do not always remain static over time (Garner & Garfinkel, 1997). For example, an individual with anorexia nervosa restricting type may begin with binge eating and or purging, but a subtle shift in eating behaviour is unlikely to stop a person from smoking once they had started. Moreover, there is still a lot of uncertainty around the boundaries of the sub-types of anorexia nervosa. For instance, the frequency of binge eating and or purging that should cause an individual to be classified as having the binge-eating/purging type is not clear, nor is the precise meaning of binge-eating for an individual who is underweight with anorexia nervosa (Garner, Garner & Rosen, 1993).

Given the current scepticism around the sub-types of anorexia, it seems hasty to accept that anorexia-restricting type cases are the least likely to smoke, without exploring the finding further. Nevertheless, the research to date would suggest that women with binge-purge behaviour are more likely to smoke than women in the general population. This is thought to be because of specific concerns about eating and weight, and higher smoking rates appear to reflect their use of smoking to control their weight.
However, neither of these studies included a general psychiatric control group. Therefore it was not possible to determine whether the increased rates of smoking were due to weight concerns alone or as a result of their being a group with higher levels of psychological distress generally, which has already been shown to have a positive association with smoking.

2.4 Smoking, Eating Disorders and Depression

Clinicians have frequently noted the occurrence of depressive symptoms in patients with eating disorders (Devlin & Walsh, 1989) and some women with bulimia typically have depressive and anxiety symptoms of equivalent severity to those with primary or affective disorders (Fairburn & Cooper, 1984). Hudson & Pope (1987) reported that roughly one third to one half of patients with eating disorders suffer from concurrent major depression and this fraction rises to one half to three quarters when past depression is included. These observations have led to clinical trials of antidepressant medication in eating disorders, which in the case of bulimia nervosa have proven successful (see Kennedy & Goldblum, 1991; Walsh, 1991, for reviews).

Given the co-morbidity of eating disorders and depression, in 1998, Welch & Fairburn carried out a study that did include a general psychiatric control group. They predicted that women with bulimia, would have higher rates of smoking than women with mood or anxiety disorders. This is because they not only have the typical motivations for smoking seen in mood disordered patient groups (e.g. to help cope with stress, for stimulation and so on) but then also have the added motivation to smoke to control their weight. They also suggested that women with bulimia would have more difficulties maintaining abstinence from smoking because of their concerns about weight gain.
In their study they assessed the prevalence of smoking in 102 women with bulimia nervosa compared with 204 control participants without an eating disorder (normal controls) and with 102 control subjects with affective or anxiety disorders (psychiatric control group). The participants were recruited from the case registers of 23 general practices in Oxfordshire (United Kingdom).

The bulimia nervosa cases met the Diagnostic and Statistical Manual of Mental disorders, 4th Edition, (DSM-IV) (American Psychiatric Association (1994) criteria for bulimia nervosa, based on ratings on the Eating Disorder Examination. The normal controls had no history of an eating disorder, established at interview. The psychiatric control group were required to have a current Axis I Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition -Revised, (DSM-III-R) (American Psychiatric Association (1987) psychiatric disorder, confirmed by interview. Potential psychiatric controls with a history of an eating disorder were excluded. The two control groups were individually matched to the bulimia nervosa cases with respect to age (within 1 year) and parental social class. This study was part of a larger community -based study on identifying the risk factors in the development of bulimia nervosa, which incorporated information on smoking. (Fairburn, Welch, Doll, Davies, & O'Connor, 1997).

As they had predicted, they found that bulimia nervosa cases (74%) were more likely to have been smokers than either normal (44%) or psychiatric controls (46%). A higher proportion of bulimia nervosa cases were current smokers (57%) than either the normal control group (24%) or psychiatric control group (29%). Among current smokers, the median number of cigarettes smoked daily by bulimia nervosa cases was 15, compared with 10 in the normal control group and 15 in the psychiatric control group. There were also no significant differences in body mass index between smokers and
non smokers, either in the sample as a whole or within the bulimia nervosa group.

They also found that of those with a history of smoking, a higher proportion of bulimia nervosa cases reported that they had sometimes smoked in order to avoid eating or to control their weight: 73% as compared with 13% for normal controls and 19% for psychiatric controls. Of those that had succeeded in abstaining for 6 months, a higher proportion of bulimia nervosa cases (58%) than normal controls (25%) had subsequently resumed smoking. Twenty eight percent of the bulimia nervosa cases (10/36) acknowledged concern about their weight or shape as one reason for having resumed smoking while only one subject form each control group gave this reason.

Although the results of this study do confirm Welch & Fairburn's hypothesis, it is not clear whether individuals were asked if they had sometimes smoked for any other reason than to avoid eating or to control their weight. Therefore it is plausible that had they been given a range of motivations for smoking to chose from, reports of smoking for weight control in the women with bulimia may not have been so significantly different from the control group. Moreover, comparing the weight control motive with other smoking motives would determine the importance of this motive for women with bulimia relative to other known motives.

If women with binge-purge behaviour report smoking to control their weight to a greater extent than women with mood and anxiety disorders, but are similar in regard to their other smoking motives, then women with bulimia are undoubtedly smoking to control their weight more than a comparison group. If such a case was found, cigarette smoking should no longer be ignored during treatment. Indeed, it may even be that clinicians would need to include questions about smoking behaviour as part of their routine assessment,
similar to that of other known weight control practices, such as laxatives, diuretics and so on.

Welch & Fairburn (1998) also chose not to study patient samples and focused only on women with bulimia nervosa who met full DSM-IV criteria. However, there are a number of individuals who do not meet the diagnostic criteria for either of the two main eating disorders, but still have clinically significant eating problems that require prompt clinical attention. DSM-IV terms this large and heterogeneous diagnostic category, “eating disorder not otherwise specified (EDNOS)”. Unfortunately, this group has been relatively neglected in previous research, despite their abundance amongst patient samples and despite their problem being as complicated and serious as that of persons with the two main eating disorders.

2.5 Aims of the Project

The aim of this study is to assess the role of cigarette smoking in women with eating disorders in comparison with women with mood or anxiety disorder, who are considered to have similar levels of psychological distress. A general population control group was not included, as substantial national data on the smoking prevalence rates and motives in the general population already exists. This study aims to replicate previous research findings that smoking prevalence will be higher in women with binge-purge behaviour than women with a comparable level of psychological distress. The study also aimed to replicate previous research findings that have shown women with anorexia nervosa to have lower smoking prevalence rates than women with binge purge behaviours.

Unlike previous studies however, this study intends to include a sample that is representative of those women presenting at an eating disorders service.
That is, women suffering from a clinically significant eating disorder (EDNOS), as well as those who meet full DSM-IV criteria for anorexia nervosa and bulimia nervosa. By doing so, the study includes women with atypical anorexia nervosa, atypical bulimia nervosa (terms used by ICD-10 criteria, World Health Organisation, 1992) and binge-eating disorder. The latter are thought to be conceptually similar to women with bulimia nervosa, but with the important absence of the inappropriate compensatory behaviours (Spritzer, Devlin, Walsh, Hassin, Wing, Marcus, Stunkard, Wadden, Yanovski, Agras, Mitchell, & Nonas, 1992). However, a number of individuals with the non-purging subtype of bulimia nervosa are like many patients with binge-eating disorder and as such this author felt it was appropriate to group women with binge-eating disorder together with women with bulimia nervosa since they both engage in uncontrolled episodes of binge eating and precisely at what point someone would be better classified as having bulimia nervosa versus binge-eating disorder is unclear at this time. It was hoped that by including the entire spectrum of eating disorders in the sample, the research findings would be considered of greater relevance to everyday clinical practice.

Additionally, the study aims to raise clinician's awareness of the significant impact of smoking on all women with a clinically significant eating disorder. Irrespective of lower prevalence rates found in women with anorectic behaviours, those that do or have smoked, are likely to for the same reasons as those with binge-purge behaviour, (i.e. to help control their weight. Consequently, it is suggested that similar behaviour and attitudes towards smoking are found in all women with an eating disorder who smoke and as a result, are all more likely to be dependent on smoking, have greater difficulty abstaining from smoking and are more likely to relapse due to concerns about weight, than a comparison mood and anxiety disorder group.
The study also aims to make some additions to the design of Welch & Fairburn's (1998) study. Participants with a history of smoking are asked to give ratings on six different motives which could potentially explain their smoking behaviour. This establishes whether or not the higher rates of 'smoking in order to control weight', reported in their study by women with bulimia nervosa were specific to that smoking motive or typical of an overall higher rate of reporting for any smoking motive suggested. Having a profile of ratings for the smoking motives, would also show which motive (if any) was the more important in the maintenance of smoking behaviour, in both an eating disorder group and the comparison mood and anxiety disorder group.

2.6 Hypotheses:

The following hypotheses were made, based on the previous research findings.

**H1.** Women with binge and/or purge behaviours (i.e. bulimia nervosa and binge eating disorder) are more likely to smoke than women with a mood or anxiety disorder, since their increased rates of smoking are attributable to both specific concerns about eating and weight and to general psychological distress.

**H1.1.** Women with anorexia nervosa will be less likely to smoke than women with bulimia nervosa and binge eating disorder.

**H.2** All women with eating disorders who smoke will be more dependent on smoking, have greater difficulty abstaining from smoking and are more likely to relapse due to concerns about weight gain than women with mood or anxiety disorders.

**H.3** Of those with a smoking history, women with eating disorders will report to a greater extent than the comparison group that they use smoking to control their weight.
3.0 METHOD

3.1 The Design
The basic design for this study was a between group comparison design, comparing smoking behaviour and attitudes between female patients with an eating disorder and female patients with a non-psychotic mood or anxiety disorder.

3.2 Participants
The participants were 46 female patients with an eating disorder comprising: 24 females with anorexia nervosa and 22 females with bulimia nervosa or binge eating disorder. They were compared with 31 patients with mood or anxiety disorders (the psychiatric comparison group). All participants were aged between 18 and 65 years.

The participants with an eating disorder were required to meet a clinician's diagnosis of Anorexia Nervosa, Bulimia Nervosa, and Eating Disorder Not Otherwise Specified based on DSM-IV criteria. The psychiatric controls were required to meet a clinician's diagnosis of mood and or anxiety disorder based on DSM-IV criteria. Exclusion criteria that applied to both patient groups were women who were currently pregnant or were pregnant up to four months prior to the study. Those with a psychotic illness were, also excluded as were those with a lack of fluency in English.

Selection criteria for the psychiatric comparison group excluded participants with a current eating disorder of clinical severity (as defined by DSM-IV) or those known to have a history of an eating disorder, but not participants with normative degrees of dieting or overeating or normative levels of concern about body shape and weight.
3.3. Recruitment procedure

Ethical approval was sought and obtained from three NHS trusts in the South of England who had large out-patient eating disorder services (see Appendix I for an example).

To recruit patients with an eating disorder, the head of each outpatient eating disorder service was contacted and presented with the background and purposes of the research. After several subsequent meetings with the team, clinician's within the team were asked to volunteer if they were interested in helping recruit the eating disorder patients required for the study. The head of adult psychology services and clinical psychologists of several community mental health teams who provide a service to the same community from which the eating disorder patients were recruited, were similarly approached to help recruit the psychiatric comparison group.

Once clinician's had volunteered to help with recruitment they were given 5-10 questionnaire packs (which included the information sheet, consent form, a series of questionnaires and a stamped addressed envelope) and a set of instructions on how to approach patients for the study (see Appendix II. Part A & B). This included a flow diagram which clinicians were instructed to refer to, each time they saw a female patient to assess her suitability for the study. If the eligibility criteria was met, clinicians were asked to briefly inform the patient about the study at the end of their session and ask her if she would be willing to participate. In some instances, clinicians preferred to ask the eligible patient to briefly meet with the researcher (if available), who would then inform them about the study directly.

In either case, potential participants were given the same information prior to the study (see Appendix II Part B & Appendix III). In brief, patients were asked to participate in a study that concerned the use of cigarette smoking in women experiencing stress. They were informed that they did not have to be
smokers to participate in the study, as the study concerned smokers', non-smokers' and ex-smokers' attitudes towards smoking and smoking behaviour. It was explained that participating in the study would involve filling in several widely used questionnaires that addressed their smoking status, attitudes and behaviour and various aspects of their health, diet and eating behaviour. They were also reassured that any information they gave would be treated confidentially. The patients belonging to one particular trust that gave ethical approval at a later stage were also assured anonymity, as their ethical committee requested that the data was collected in a way what preserved patient anonymity.

Each time a patient agreed to participate, a consent form (see Appendix IV) was signed and a code number which identified their diagnostic category (i.e. atypical/anorexia nervosa, atypical/bulimia nervosa, binge-eating disorder, mood disorder or anxiety disorder) was written on the back of the questionnaire pack (see Appendix II Part C). The participant was then given the questionnaire pack and asked to send it back as soon as possible in the stamped addressed envelope provided. The number of refusals to participate were recorded. Participants were not paid to take part in the study.

All clinicians were reminded that once they had started to ask patients to participate in the study, it was essential that they asked each consecutive patient that was eligible to participate so as not to bias the sample. In two of the trusts, patients were approached for up to six months, and in the trust which began participating later, patients were only recruited for two months.
3.4 Measures

3.4.1 Demographics
Demographic information was first obtained from each participant. These items included self-reported height and weight, age, ethnicity, highest educational qualification, and smoking status.

Current smokers were defined as those who responded “yes” to the question ‘Are you smoking at least one cigarette or roll up per day’? Ex-smokers were defined as those that responded “no” to the earlier question but “yes” to the question, ‘If you do not currently smoke, did you ever smoke at least one cigarette per day for at least six months’? Never smokers were defined as those who responded “no” to both of these questions.

3.4.2 Smoking Measures
Smokers were administered a number of smoking-related questions while ex-smokers were also asked to report on selected questions.

3.4.2.1 Fagerstrom Test for Nicotine Dependence (FTND: Heatherton, Kozlowski, Frecker, & Fagerstrom, 1991) (shown in Appendix V Part A).

Current smokers were asked to compete the FTND. This is a short self report measure of psychological dependence on nicotine. It is a revised version of the original Fagerstrom Tolerance questionnaire (FTQ, Fagerstrom, 1978) and has been to shown to have good test-restest reliability (r = 0.88) and its internal consistency (r= 0.64) is somewhat higher than that of the FTQ (r=0.58) (Pomerlaeu, Carton, Lutzke, Flessland & Pomerleau, 1994).

It consists of six items which assess typical smoking behaviours assumed to be indicative of one's level of nicotine dependence. It has a maximum score
of 10, and highly dependent smokers are considered to score 8 or more and moderately dependent smokers, between 4 and 7. Although there have been some problems relating to the validation of the FTQ or FTND, the FTQ has been able to predict such measures as cotinine, a nicotine metabolite that serves as a biological index of intake (Pomerlau, Pomerlau, Majchrzack, Kloska, & Malakuti, 1990) and success in smoking cessation (Pinto, Abrahms, Monti, & Jacobus, 1987).

Smokers were also asked the frequency and duration of previous quit attempts and the main reason for relapse. They were also asked to rate on a four point Likert scale how much they would like to quit smoking and how difficult they would find it if they did.

Ex-smokers were asked for how long they had remained abstinent from smoking and their main reason for giving up smoking.

3.4.2.2. Questionnaire of smoking motives, (see Appendix V Part B)

Smokers were also administered a 6 item, 5 point rating scale inventory used in several studies investigating the effects of nicotine. (e.g. Hajek, West, Foulds, Burrows & Meadow, 1999; Browning 1999; unpublished thesis). The participant is required to identify their degree of agreement with six statements that identify possible motivations for their smoking. For instance, participants would be required to rate how much they agree with the following statement, ‘Do you use smoking to help you cope with stress?’ using a five point Likert scale, where 1= Not at all, 2 = Not really, 3= Yes a little, 4= Yes quite a bit and 5= Yes very much.

Other motivations identified include, to help them socialise, to give them something to do when they are bored, to help them concentrate and stay alert, because they feel uncomfortable if they don’t and lastly to help them
keep their weight down. Ex-smokers were also administered this questionnaire, but were asked to rate the motivating aspects of their smoking while they still smoked. In addition smokers and ex-smokers were required to identify which of these motives (or another of their choice) was their primary reason for smoking.

3.4.3. The Eating Attitudes Test -26, EAT-26; (Garner, Olmstead, Bohr & Garfinkel, 1982)

The EAT is the most widely used screening questionnaires for eating disorders in both clinical and non-clinical populations (King, 1989). The Eat - 40 has been used successfully as a clinical tool to identify both clinical (Garner, & Garfinkel, 1979) and sub-clinical cases of anorexia nervosa (Button & Whitehouse, 1981).

The EAT-26 (Garner et al, 1982) is a 26 item version of the original 40 item EAT (Garner, & Garfinkel, 1979). The shorter version, derived from a factor analysis of the original and was developed in order to eliminate the unnecessary items on the EAT. Inter-correlation between EAT variables suggests that that the EAT-26 score was highly predictive of the EAT-40 (r=0.98) and its internal consistency is 0.90 (Garner et al, 1982).

Items are scored on a 6-point forced choice Likert scale. Each extreme response in the anorexic direction is scored as 3 points, while the adjacent alternatives are weighted as 2 points and 1 point respectively. A cut off score of 20 or above on the Eat-26 is considered indicative of symptoms of anorexia nervosa.

All participants completed the EAT-26. Any participant in the psychiatric comparison group that scored above the cut off score of 20 on the EAT-26 was excluded from the analysis. Although it would be inappropriate to assume
that high EAT scores are diagnostic for anorexia nervosa in a non eating disordered group, Button & Whitehouse, (1981) have shown that a score above the cut off indicates a disturbed eating pattern which interferes with normal psychosocial functioning (i.e. a sub-clinical case of anorexia nervosa).

3.4.4. The Bulimic Investigatory Test, Edinburgh (BIT-E; Henderson & Freeman, 1987).

The BIT-E (Henderson & Freeman, 1987) is a 33 item self-report measure, designed to identify participants with symptoms of bulimia or binge eating and provide clinical information on cognitive and behavioural aspects of the disorder. The authors and Waller (1992) also recognise its ability to identify sub-clinical cases in a given population and therefore encourage its use as a screening device in out-patient settings.

The BITE consists of two sub-scales. The symptom scale, measures the degree of symptoms present. A score of 20 or more on this scale indicates a highly disordered eating pattern and the presence of binge eating. The severity scale measures the severity of bingeing and purging behaviour, as defined by its frequency. A score of 5 or more on this scale is considered clinically significant. A score of 10 or more indicates a high degree of severity. The authors suggest that a possible diagnosis of binge-eating should only be made when the subject scores above 25 on the combined scales.

Similarly to the EAT-26, the BIT-E was administered to all participants. Any participant in the psychiatric comparison group that scored above 25 on the combined scales was excluded from the analysis, since a high score in the non-eating disordered group could be due to a current or past eating disorder unknown to their clinician or a sub-clinical form of bulimia nervosa.
The scores on these two measures were also expected to reflect the presence of a disturbed eating behaviour in the eating disorder group (that is a score of above 20 on the EAT-26 and/or above 25 on the BIT-E). However, given that these tests are screening instruments and not diagnostic tools and that patients with an eating disorder are prone to under-reporting their symptoms (Vitousek, Daly, & Heiser, 1991) a score below the cut off did not warrant exclusion from the clinical group.

3.4.5 The General Health Questionnaire-28 (GHQ-28; Goldberg & Hillier (1979)

All participants were administered the GHQ-28, which is a widely used psychiatric screening instrument designed to identify persons likely to have a psychiatric illness characterised by subjective distress. Several versions are available and these are known by the number of items used.

The GHQ-28 as its name suggests has 28 items and 12 studies have reported on the validity of this version. Sensitivity (i.e. the probability that a true case will be detected) is between 44% and 100% (median 82%) and specificity (the probability that a true normal will be detected) between 74% and 93% (median 82%) (Goldberg & Williams, 1991). In addition, Goldberg & Bridges (1987) compared the GHQ-28, with practitioner assessments and diagnostic interview schedules and found the GHQ-28 to have satisfactory diagnostic-specific sensitivity when identifying anxiety and depressive disorders (median 82.6%).

The GHQ scoring method of assigning values of 0-0-1-1 to the columns was used to verify that each participant in the study did meet the criteria for 'probable caseness'. Higher scores on the GHQ are indicative of higher levels of subjective distress and increased likelihood of a clinical diagnosis of a mental disorder. In this study a threshold score of 4/5 was used as it has
been shown to have the greatest overall sensitivity (88%) and specificity (84.2%) (Goldberg & Hillier, 1979).

The 28-item GHQ also has four sub-scales including; somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. A Likert scoring method of assigning values of 0-1-2-3 to the columns (recommended by Goldberg & Williams, 1991) was used to obtain a profile of the scaled scores to compare the severity of psychological distress in the two groups.

3.5 Approach to Analysis

Data was collated on SPSS and analysed in three stages. Firstly the smoking prevalence rates was compared between the women with anorexia nervosa, women with bulimia and binge-eating disorder and women in the comparison psychiatric group using the chi-squared likelihood ratio.

The second stage of analysis explored the differences in smoking behaviour, (including dependence, abstinence attempts and reasons for relapse) between the group with an eating disorder and the group with mood and anxiety disorders.

The last stage of analysis explored the difference between the two groups in their ratings for each of the smoking motives. The difference in ratings within each group was also analysed.
4.0 RESULTS

4.1 Response Rates

The pattern of responses is shown in Table 1. The overall response rate of the patients who gave consent to participate was 59 % (82/139). Of all those who were approached and asked to participate in the study 53% (82/155) consented and completed the questionnaires.

Table 1. Response rate of the sample

<table>
<thead>
<tr>
<th></th>
<th>Sample approached by the clinicians</th>
<th>Sample approached by the researcher</th>
<th>Total sample approached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients approached</td>
<td>105</td>
<td>50</td>
<td>155</td>
</tr>
<tr>
<td>Patients who refused</td>
<td>12 (11%)</td>
<td>4 (8%)</td>
<td>16 (10%)</td>
</tr>
<tr>
<td>Patients who gave consent</td>
<td>93 (89%)</td>
<td>46 (92%)</td>
<td>139 (90%)</td>
</tr>
<tr>
<td>Non-responses</td>
<td>44 (47%)</td>
<td>13 (28%)</td>
<td>57 (41%)</td>
</tr>
<tr>
<td>Response rate of those consenting</td>
<td>49 (53%)</td>
<td>33 (72%)</td>
<td>82 (59%)</td>
</tr>
<tr>
<td>Excluded from analysis</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Total included in the analysis</td>
<td>46</td>
<td>31</td>
<td>77</td>
</tr>
</tbody>
</table>

* Five patients within the comparison psychiatric group were excluded from the analysis, since their EAT-26 and/or BIT-E scores indicated the possibility of a history of or a sub-clinical eating disorder.

The response rate was somewhat higher in the sample approached by the researcher (77%). Given the apparent difference, the response rates between the two samples were compared using a chi-square test. The results indicated that there was a significant difference in response rates between the two samples ($X^2 = 4.62, df=1; p =0.03$).
Given the significant difference in response rates, the two samples were compared to detect a potential bias in the clinicians' sample, which would explain the different response rates. Small numbers in the researcher's sample made statistical comparisons unfeasible, however, similar percentages of current, never and ex-smokers were observed for each diagnostic category in each sample. For instance, the percentage of non-smokers in the mood and anxiety disorder group was 38% in the researcher's sample and 40% in the clinicians' sample. This suggested that the sample recruited by the clinicians was similar to that recruited by the researcher.

It was not possible to determine whether the response rate differed according to diagnosis, since diagnostic information was only available for those that returned the questionnaire.

Statistical comparisons were made with parametric tests when the data was approximately normally distributed. However, when the data did not fulfil the criterion of normal distribution, non-parametric analyses were conducted since unequal variances and non-normal distributions make the use of parametric statistical methods suspect and the non-parametric tests likely more powerful (Sawilowsky & Blair, 1992).

4.2. Demographic details of participants
A summary of participant characteristics and scores on psychometric measures are presented in Table 2.

Of the bulimia and binge eating participants, 15(68%) belonged to the bulimia nervosa category and 7(32%) to the binge-eating disorder category. The comparison psychiatric group consisted of 21(68%) with a mood disorder and 10 (32%) with an anxiety disorder. The sample was primarily white and all groups had similar levels of educational attainment.
Table 2. Description of the sample

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean age (sd) in years</th>
<th>Mean GHQ-28 (sd)</th>
<th>BMI Index N=69</th>
<th>EAT-26 score N=71</th>
<th>Bit-E combined score</th>
<th>Ethnic Background</th>
<th>Highest educational attainment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia Nervosa</td>
<td>24</td>
<td>31.6 (10.8)</td>
<td>39.3 (13.2)</td>
<td>17.4 (2.1)</td>
<td>40.2 (13.1)</td>
<td>20.3 (11.5)</td>
<td>24 White</td>
<td>2 None</td>
</tr>
<tr>
<td></td>
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<td>2 GCSE or equivalent</td>
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<td>6 A-level or equivalent</td>
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<td>4 Teaching</td>
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<td></td>
<td>10 degree</td>
</tr>
<tr>
<td>Bulimia nervosa or Binge Eating</td>
<td>22</td>
<td>30.6 (10.5)</td>
<td>40.7 (16.0)</td>
<td>27.6 (8.3)</td>
<td>30.7 (14.5)</td>
<td>34.7 (11.3)</td>
<td>20 White</td>
<td>2 None</td>
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<td></td>
<td></td>
<td>1 Other</td>
</tr>
<tr>
<td>Mood and/or Anxiety disorder</td>
<td>31</td>
<td>43.8 (10.9)</td>
<td>34.4 (19.7)</td>
<td>26.4 (6.5)</td>
<td>5.7 (4.9)</td>
<td>6.2 (6.7)</td>
<td>30 White</td>
<td>6 None</td>
</tr>
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<td></td>
<td></td>
<td>3 Other</td>
</tr>
<tr>
<td>Total sample</td>
<td>77</td>
<td>36.2 (12.3)</td>
<td>37.7 (16.9)</td>
<td>23.7 (7.5)</td>
<td>23.6 (18.8)</td>
<td>18.0 (15.1)</td>
<td>97% White</td>
<td>13% None</td>
</tr>
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<td>3 % CSE Ungraded</td>
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<td>4 % CSE or equivalent</td>
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<td>18% GCSE or equivalent</td>
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<td>9% Teaching</td>
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<td>31% Degree</td>
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<td></td>
<td></td>
<td></td>
<td>5% Other</td>
</tr>
</tbody>
</table>
The entire sample scored above the threshold score (4/5) on the GHQ-28 and an Analysis of Variance showed that the three participant groups did not differ significantly in terms of total GHQ score, \( F(2,74)=1.06; p<0.35 \). This supports our assumption that the mood and anxiety disorder group are a valid comparison group since they have similar levels of psychological distress to women with anorexia nervosa and women with bulimia and binge eating disorder.

However there was a significant difference in age between the groups \( F(2,74)=12.93; p<0.001 \). A post-hoc unplanned multiple comparison with Tukey HSD test, showed that the mood and anxiety disorder group differed significantly in age \( p<0.001 \) from both the anorexia group and the bulimia and binge eating group, but the anorexia group did not differ significantly from the bulimia and binge eating group.

Analysis of the Body Mass Index (BMI) using the Kruskal Wallis Test showed a significant difference between the three groups \( \text{Chi-square} = 39.6, \text{df} = 2; p<0.001 \), with the Anorexia group having the lowest mean BMI score. There was also a significant difference between the groups on the Eat-26 score \( \text{Chi-square} = 52.24, \text{df} =2; p<0.001 \) and the BIT-E combined score \( \text{Chi-square} = 46.0, \text{df} =2; p<0.001 \). These results were not unexpected and indicates the diagnoses given by the clinicians were accurate.

### 4.3 Comparison of participant groups

#### 4.3.1. Smoking prevalence

Table 3 summarises the current and ever smoking prevalence rates in all three groups and the results of the statistical analysis between the three groups. It also shows the statistical differences found between the anorexia group and the bulimia and binge eating group, as previous research suggests
that the anorexia group will have a lower smoking prevalence rate than the bulimia and binge eating group.

As shown in Table 3, the smoking prevalence rates did not significantly differ across the three groups\( (X^2 =3.95; \text{df} = 2; \ p =0.14)\). Although not significant, there was a trend showing that the anorexia nervosa cases (25%) were less likely to smoke regularly than the bulimia and binge eating disorder group (50%). \( (X^2 = 3.08; \text{df}=1; \ p=0.08)\) and also less likely to smoke than the mood or anxiety disorder cases (48%) \( (X^2 =3.14; \text{df}=1; \ p=0.08)\) No significant difference in smoking prevalence was found between the bulimia and binge-eating group and the mood and anxiety group \( (X^2 =0.01; \text{df}=1; \ p=0.91)\)

There were no significant differences found in the prevalence rates of the ever smokers in all three groups \( (X^2 = 4.792, \text{df}=2; \ p=0.09)\), but a trend was observed. The bulimia and binge eating group were however, significantly more likely to have been smokers than the anorexia nervosa group \( (X^2 =4.76; \text{df}=1; \ p=0.03)\). Although not significant, there was a trend to show that the mood and anxiety group were more likely to have been smokers than the anorexia group \( (X^2=3.08; \text{df}=1; \ p=0.08)\). There were no significant differences found in the prevalence rates of ever smokers between the bulimia and binge eating group and the mood and anxiety group \( (X^2 =1.51; \text{df}=1; \ p=0.22)\).

Analysis of the BMI did not indicate a significant difference between smokers and non-smokers in the sample as a whole (Mann-Whitney \( Z =1.23; \ p=0.22)\), nor was there a significant difference in BMI between smokers and non-smokers in any of the individual groups.
Table 3. Prevalence of current smoking and ever smoking in the three groups.

<table>
<thead>
<tr>
<th></th>
<th>Anorexia Nervosa Group (N=24)</th>
<th>Bulimia nervosa &amp; Binge eating Group (N=22)</th>
<th>$X^2$ df p</th>
<th>Mood &amp; Anxiety Group (N=31)*</th>
<th>$X^2$ df p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently smoking</td>
<td>6 (25%)</td>
<td>11 (50%)</td>
<td>3.079 1 .079</td>
<td>15 (48%)</td>
<td>3.95 2 .139</td>
</tr>
<tr>
<td>Ever smoked regularly</td>
<td>11 (46%)</td>
<td>17 (77%)</td>
<td>4.763 1 .029*</td>
<td>19 (61%)</td>
<td>4.792 2 .092</td>
</tr>
</tbody>
</table>

* Comparison of anorexia nervosa, bulimia nervosa and mood and anxiety disorder group.  
* $p<0.05$

Table 4. Abstinence and relapse rates between the groups

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever succeeded in abstaining from smoking for 6 months or more*b</td>
<td>4 (36%)</td>
<td>9 (53%)</td>
<td>13 (46%)</td>
<td>6 (32%)</td>
<td>1.036 1 .309</td>
</tr>
</tbody>
</table>
| Resumed smoking for any reason*c | 2 (50%)                       | 4 (44 %)                                   | 6 (46%)                              | 3 (50%)                      | Fischer's exact Test  
  p = 1.00       |
| Resumed smoking because of concerns about weight*c | 0                             | 0                                          | 0                                    | 0                             | Fischer's Exact Test  
  p = 0.11       |
| Resumed smoking because of concerns about shape and weight after any length of abstinence*d | 2 of 5 (40%)                  | 2 of 9 (22%)                               | 4 of 14 (29%)                       | 0 of 11 (0%)                 |

* Current and former smokers only  
* Smokers who have achieved abstinence for six months or more  
* Current smokers only, who have relapsed after a smoking cessation attempt (of any length)
4.4 Comparison of the eating disorder group with the mood and anxiety disorder group

The remainder of the analysis refers to current smokers and ex-smokers only. At this stage of the analysis the two eating disorder groups were grouped together to form a combined eating disorder group, as smokers in the anorexia group were expected to share similar attitudes and behaviour towards smoking as those in the bulimia and binge eating group. Consequently, the remaining statistical analysis compares the combined eating disorder group and the mood and anxiety group only and the statistical results are summarised in Tables 4, 5 & 6. Statistical comparisons between the anorexia and bulimia and binge eating group were not pursued for the remainder of this study. However, responses between the three groups can be visually compared since each table presents the results from the two eating disorder groups separately, before presenting the combined score.

4.1 Abstinence & relapse

Table 4. shows the proportions of smokers that succeeded in abstaining for six months or more, those that relapsed and the frequency with which weight concern was given as the reason for the relapse. Analysis of the proportions of ever smokers that had at some time succeeded in giving up smoking for six months found there were no significant differences between the two groups ($X^2=1.04$, df=1; $p<0.31$) Similar proportions of each group resumed smoking after a six month abstinence (Fischer's exact test $p<1.00$) and of these none (0/9) acknowledged concerns about weight gain as a reason for having resumed smoking.

However, of the current smokers who had attempted to quit smoking (for any length of time), 44% of the anorexia nervosa cases (2/5) and 22% of those with bulimia nervosa and binge eating (2/9) reported concern about weight gain as the main reason for their relapse, while none of the 11 participants in
the mood and anxiety group gave this reason. Nevertheless this was not shown as a significant difference between the two groups (Fischer’s exact test; p =0.11).

4.4.2 Dependence on smoking

Table 5. summarises results of the dependence on smoking between current smokers in the eating disorder group and current smokers in the mood and anxiety disorder group. Independent t-tests revealed that there were no significant differences between the two groups on mean number of cigarettes smoked daily (t=0.39, df=30; p= 0.70), mean score on the Fagerstrom test for nicotine dependence (t= 0.26; df =30; p=0.76) or average number of quit attempts (t=1.14, df =30; p= 0.26).

Responses to the question how much would you like to give up smoking indicated a trend towards participants in the eating disorder group being less likely to want to give up smoking than the group with mood or anxiety disorders (Mann-Whitney Z = 1.49, p= 0.05). In contrast, both groups perceived similar levels of difficulty if they were to give up smoking (Mann Whitney Z = .06, p =0.96).
Table 5: Dependence on smoking of the current smokers in the sample

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean number of cigarettes smoked per day (sd)</td>
<td>15.8 (5.9)</td>
<td>14.0 (11.5)</td>
<td>14.7 (9.7)</td>
<td>15.9 (9.1)</td>
<td>.386 df 30 p .702</td>
</tr>
<tr>
<td>Mean Fagerstrom test of nicotine dependence score (sd)</td>
<td>4.3 (2.4)</td>
<td>2.9 (2.8)</td>
<td>3.4 (2.7)</td>
<td>3.7 (2.8)</td>
<td>.261 df 30 p .796</td>
</tr>
<tr>
<td>Mean number of quit attempts (sd)</td>
<td>1.0 (0.6)</td>
<td>1.9 (1.3)</td>
<td>1.6 (1.2)</td>
<td>1.1 (1.1)</td>
<td>1.143 df 30 p .262</td>
</tr>
<tr>
<td>Desire to give up smoking (Range =1-4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (sd)</td>
<td>2.7(1.0)</td>
<td>2.5 (.69)</td>
<td>2.5 (.80)</td>
<td>3.2 (.94)</td>
<td>1.982 p .047</td>
</tr>
<tr>
<td>Median</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Perceived difficulty in giving up smoking (Range =1-4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (sd)</td>
<td>3.5(1.2)</td>
<td>3.4(.67)</td>
<td>3.4(.87)</td>
<td>3.4(.83)</td>
<td>.064 p .949</td>
</tr>
<tr>
<td>Median</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

n. b. Statistical test results refer to comparisons between the combined eating disorder group and the mood and anxiety disorder group only.
4.5 Comparison of smoking motives

4.5.1 Comparison of the motives given for smoking between the two groups

Table 6. shows a summary of the ratings given to each smoking motive between the groups. Of those with a history of smoking, the eating disorder group rated using smoking to help them cope with stress to a significantly greater extent than the mood or anxiety group (Mann-Whitney Z = 2.34, p=0.02) They also rated the use of smoking to keep their weight down significantly greater than the mood and anxiety group (Mann-Whitney Z = 3.75, p < 0.001)

In order to determine whether these group differences were due to the significant difference in age found earlier between the two eating disorder groups and the mood and anxiety group, a Spearman's rank correlation was carried out. The analysis showed that age did not significantly correlate with the ratings on the motive 'do you use smoking to keep your weight down' in the eating disorder group (r =.308; p=0.11) or the mood anxiety disorder group (r =.080, p=0.75). Whereas the diagnostic group participants were categorised in, correlated with ratings for using 'smoking to keep weight down' highly significantly (r=.553, p <0.001). This suggests that the eating disorder group rated the motive smoking to keep weight down as greater because of their common concerns about weight and eating, rather than as a result of their younger age.

There were no significant difference between the groups in their responses to using smoking to help them socialise (Mann-Whitney Z =1.28, p=0.20), or using smoking when bored (Mann-Whitney Z = 1.25, p=0.21) or using smoking to help them concentrate and stay alert (Mann-Whitney Z =0.51, p=0.61), or using smoking because they felt uncomfortable if they didn’t (Mann-Whitney Z =0.41, p=0.68).
Table 6: Ratings given to the six smoking motives by ever smokers (i.e. current and ex-smokers).

<table>
<thead>
<tr>
<th></th>
<th>Use smoking to cope with stress (1-5)</th>
<th>Use smoking to help socialise (1-5)</th>
<th>Use smoking when bored (1-5)</th>
<th>Use smoking to help concentrate (1-5)</th>
<th>Feel uncomfortable if don’t smoke (1-5)</th>
<th>Use smoking to keep weight down (1-5)</th>
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<tr>
<td>Anorexia (N=11)</td>
<td>4.36 (1.29)</td>
<td>3.45 (1.04)</td>
<td>3.36 (1.57)</td>
<td>2.64 (1.36)</td>
<td>2.18 (1.33)</td>
<td>3.36 (1.21)</td>
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<td>Mean (sd)</td>
<td>4.36 (1.29)</td>
<td>3.45 (1.04)</td>
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<td>2.64 (1.36)</td>
<td>2.18 (1.33)</td>
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<td>Median</td>
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<td>Bulimia (N=17)</td>
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<td>3.12 (1.41)</td>
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<td>Combined Eating Disorders (N=28)</td>
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<td>2.61 (1.31)</td>
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<td>Mean (sd)</td>
<td>4.07 (1.25)</td>
<td>3.25 (1.27)</td>
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<td>Mood/Anxiety Disorders (N=19)</td>
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<td>.200</td>
<td>.213</td>
<td>.608</td>
<td>.679</td>
<td>.000*</td>
</tr>
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</table>

*p < 0.05;  *p < 0.001

a Comparing the smoking motive ratings between the combined eating disorder group and the mood and anxiety disorder group.

b Comparing smoking motive ratings within the combined eating disorder group.

c Comparing smoking motive ratings within the mood and anxiety disorder group.
4.5.2 Comparison of the ratings given for smoking motives within each group

Within group comparisons of responses on the smoking motives questionnaire using the Friedman test showed that there was a significant difference between the motives within the eating disorder group (Chi-square = 34.50; df = 5; p< 0.001) and the mood and anxiety disorder group (Chi-square = 24.03; df = 5; p< 0.001). A summary of the results is shown in Table 6.

Wilcoxon signed ranks test, (with a bonferroni correction of $\alpha = 0.01$ to lower the probability of making a Type 1 error), was used to compare the use of smoking to keep weight down with each of the other motives. In the eating disorder group, the use of smoking to help cope with stress was rated significantly greater than the use of smoking to keep weight down ($Z = 3.14; \ p< 0.002$). There were no significant difference in ratings between the use of smoking for weight control and smoking to help socialise ($Z = 2.43; \ p=0.81$), or using smoking when bored ($Z = .859; \ p=0.39$) or feeling uncomfortable if they didn’t smoke ($Z = 1.95; \ p=0.05$). Although a significant difference was not observed (with the bonferroni correction), there was some evidence to show the eating disorder group used smoking to keep weight down to a greater extent than they used smoking to help concentrate and stay alert ($Z = 2.20; \ p=0.03$).

In the mood and anxiety disorder group, the use of smoking to keep weight down was rated at a significantly lower extent than to help cope with stress ($Z = 3.46; \ p<0.001$), to help socialise ($Z =2.53; \ p< 0.01$), using smoking when bored ($Z = 2.97; \ p< 0.003$) and using smoking to concentrate and stay alert ($Z=2.73; \ p<0.01$). There was no significant difference in ratings between smoking to keep weight down and smoking because it felt uncomfortable if they didn’t ($Z = 1.92; \ p=0.06$)
4.5.3 The primary reason for smoking

The smoking motive selected as most important by 36% of the eating disorder group was using smoking to keep weight down. Other motives that the eating disorder participants selected included: to help cope with stress (29%), to help socialise (14%), smoking when bored (11%) and other (11%).

In the mood and anxiety disorder group, 31% selected smoking to concentrate and stay alert as the most important motive for smoking. Other motives included, smoking to help cope with stress (21%), to help socialise (16%), when bored (16%) and other (16%). Patterns of the most important motive for smoking given differed between the eating disorder and mood and anxiety disorder groups. 10 of the 28 subjects in the eating disorder as opposed to none in the mood and anxiety disorder group engaged in smoking for the primary reason of keeping their weight down (Fisher's exact test, p<0.003).
5.0 DISCUSSION

5.1. Summary and Interpretation of the Results

The aim of this study was to assess the role of cigarette smoking in women with eating disorders in comparison with women with non-psychotic mood or anxiety disorders.

**H1. Women with binge and or purge behaviours (bulimia nervosa and binge eating disorder) are more likely to smoke than women with a mood or anxiety disorder.**

The first hypothesis was not confirmed. There was no evidence to suggest that women with bulimia and binge eating disorder were more likely to smoke on a regular basis than women with mood or anxiety disorders. There was also no evidence to show they were more likely to have been smokers than the psychiatric comparison group.

50% of the bulimia and binge eating group were current smokers, which is similar to the 57% reported in women with bulimia nervosa in the Welch & Fairburn (1998) study. As expected, this percentage is considerably higher than the percentage of women smokers of the same age range in the normal population (28%; General Household Survey (GHS), 1996). The percentage of current smokers in the psychiatric comparison group was 48%. This is similar to the 47-49% percent found in other studies examining smoking prevalence in individuals with major depression and anxiety (Hughes et al, 1986).

Our finding which did not confirm the hypothesis, is contrary to Welch & Fairburn's finding in which women with bulimia were more likely to smoke than women with affective or anxiety disorders. One possible explanation for this is that the binge eating cases in this study have lowered the smoking
prevalence in the bulimia and binge eating group. However this seems unlikely as both groups engage in uncontrollable episodes of binge eating and the demarcation between the non-purging subtype of bulimia nervosa and binge eating remains unresolved. Moreover, a 7% increase in smoking prevalence in the bulimia and binge eating group in our study would not have made any significant impact on the results.

What seems a more likely explanation for the different findings, is the unusually low smoking prevalence rate (29%) found in the psychiatric control group in Welch & Fairburn study. Despite having the larger sample size, this percentage seems surprisingly low given that average prevalence rates reported in other studies are more similar to that found in this study.

In summary, although the bulimia and binge eating group do appear more likely to smoke than women in a non clinical population, the results suggest this is most likely attributable to their higher levels of general psychological distress. However, the additional motivation to smoke to control their weight has not been shown to increase their prevalence of regular smoking above that of patients with similar levels of general psychological distress.

**H1.1. Women with anorexia nervosa will be less likely to smoke than women with bulimia nervosa and binge eating.**

There was however, statistically significant evidence to indicate women with bulimia and binge eating disorder were more likely to have been smokers than women with anorexia nervosa. There was a trend showing bulimia and binge eating women had a higher proportion of current smokers than the anorexia nervosa group, but this difference did not reach statistical significance. Similarly, (although the results did not reach statistical significance), a trend showed women with anorexia nervosa were less likely
to smoke than the women with a mood or anxiety disorder and likewise, less likely to have ever smoked.

This finding was consistent with Bulik et al’s (1992) study. It was also similar to Wiseman et al’s study (1998), but demonstrated that the lower smoking prevalence rates are found in the anorexia group as a whole rather than particular to one subtype. Unlike these studies however, the smoking prevalence in the anorexia group (25%) did not appear to differ very much from the prevalence of regular smoking reported in a non clinical population of the same age range (28%; GHS, 1996).

The results demonstrate that women with bulimia and binge eating are more likely to have smoked than women with anorexia nervosa. Tobacco use primarily begins in early adolescence, typically by the age of 16, with almost all first use occurring before 18 (Royal College of Physicians, 2000). However, certain personality characteristics of anorexics are likely to protect them from the non-pharmacological rewards that would normally motivate an adolescent to initiate and continue smoking. For instance, several studies have reported high levels of social anxiety (such as social phobia and social avoidance) in individuals with anorexia nervosa. (Halmi, Eckert, March, Sampugnaro, Apple & Cohen, 1991; Deep, Nagy, Weltzin, Rao & Kaye; 1995). Social withdrawal and decreased motivation to engage in social contact and activities ensures they have little exposure to the presence of smoking friends and subsequently are less vulnerable to ‘social reinforcement’ rewards for smoking, which is highly predictive of adolescent smoking.

Strober (1980) and Casper (1990) have also demonstrated that anorexic’s show excessive compliance and conformity to moral standards and established rules. As a result they are less likely to engage in a behaviour
such as smoking, that children as young as 7 have been found to view as wrong and bad for one's health (Bhatia, Hendricks, Bhatia, 1993).

Children also ascribe different personality characteristics to smokers than to never smokers and may view smoking as a way to project maturity, independence or toughness. A study by Evans, Henderson, Hill & Raines, (1979; cited in Camp, Klesges & Relyes, 1993) reported that adolescents perceived looking more mature as one of the major benefits of smoking. An adolescent with anorexia nervosa however, is likely to avoid any behaviour that portrays an image of maturity as they tend to fear the challenges adulthood brings. Crisp (1980) incorporates this 'maturity fear' into his model of anorexia nervosa, which has a phobic avoidance of an adult body weight and shape at its central psychopathology. He suggests the "fatness" that goes with normal adult body weight in females will always have a sexual dimension, serving as it does both direct reproductive and related social and biological purposes. Puberty therefore, can often be an unwanted, threatening and destructive experience, either to the individual or to some part of the family system. According to this model, starvation becomes the mechanism for avoiding psychobiological maturity, the pursuit and maintenance of a subpubertal body weight results in a return to prepubertal appearance and hormonal status and essentially the security of childhood.

In summary, despite high levels of body image disturbance, there is strong evidence to suggest anorexic women and adolescent females with anorexia nervosa are less likely to smoke than their counterparts with bulimia nervosa and binge eating. It is possible that specific personality characteristics of anorexics make them less vulnerable to the non-pharmacological rewards that motivate adolescents to initially experiment with smoking. Future studies should employ questionnaires such as the Eating Disorders Inventory (EDI-2; Garner (1991), which includes 8 sub-scales that cover psychological traits
such as maturity fears and perfectionism to determine if these traits can predict regular smoking.

Studies could also trace the pattern of eating disturbance in current smokers and ever smokers with anorexia nervosa to determine whether their smoking coincided with past history of binge-eating or purging behaviour. It seems likely that smoking would be initiated and used as a weight control strategy during a time when their eating was out of control.

**H2: All women with eating disorders who smoke are likely to be more dependent on smoking, have greater difficulty giving up smoking and are more likely to relapse due to concerns about weight than women with mood and anxiety disorders.**

The results of this study did not support our second hypothesis. As expected, the smoking characteristics between the two eating disorder groups did not visibly differ, but unexpectedly no significant differences in smoking characteristics were found between the combined eating disorder group and the mood and anxiety disorder group.

The two groups did not differ in their average daily cigarette consumption, which also did not differ from the average consumption of cigarettes found in female smokers in the non-clinical population (14 cigarettes per day; GHS, 1996).

The mean scores on the FTND were not significantly different and on average, individuals in both groups fell into the less dependent category of smokers. Nevertheless, the median response to the question 'how difficult would you find it to give up smoking?' was 4, which indicates that most current smokers reported that they would find it 'extremely difficult' to give up smoking. 32% of smokers in the non-clinical population in Britain report that they would find it 'very difficult' to go without smoking for a whole day (GHS,
In contrast, although not statistically significant there was a trend showing women with eating disorders were less keen on giving up smoking than women with mood or anxiety disorders.

Unlike the Welch & Fairburn (1998) study, our results did not show a higher proportion of women with eating disorders to resume smoking after 6 months of abstinence. Neither did any of these participants report 'concern about weight gain' as their main reason for resuming smoking after a six month abstinence. 4/14 in the eating disorder group did, however give weight concern as their main reason for relapse after shorter attempts at abstinence, although this was not statistically significantly different from the mood and anxiety group.

Other studies measuring relapse at long term follow-ups (6 months to 1 year) have found that greater post cessation weight gain is actually predictive of continued abstinence (Hall, Ginsburg & Jones, 1987). However, the impact of post cessation weight gain on relapse in the short term (i.e. within the first three months after quitting) is less clear. This explanation fits with our observation that 4 of 14 women with eating disorders reported that they relapsed due to weight concerns after a smoking cessation attempt of less than 6 months, where as none in the mood or anxiety group gave this as their main reason for relapse. Future studies with bigger sample sizes should assess whether women with eating disorders have shorter quit attempts than women with mood or anxiety disorders due to concerns about weight.

Recent research also suggests that weight concerns are more likely to prevent individuals from wanting to give up smoking in the first place. Meyers, Klesges, Winders, Ward, Patterson, & Eck, (1997; see literature review pg. 185 of this portfolio for a fuller description of their study) suggested that current smokers who believe most strongly that smoking cessation will result in weight gain are less likely to participate in formal stopping smoking efforts.
Thus, weight concern is thought to predict intention to quit, but once the decision is made other variables may be more important in predicting smoking outcome (Borelli & Mermelstien, 1998). Although the eating disorder women in our study did not have significantly less quit attempts than the mood or anxiety group, future studies again with a large sample of smokers should explore this possibility further.

The difficulty abstaining from smoking observed in the women with eating disorders was similar to and characteristic of individuals with higher levels of general psychological distress. Therefore it was most likely due to the intensity of the cigarette withdrawal syndrome, and altered little (if at all) by additional weight gain concerns. The ‘cigarette withdrawal syndrome’ is a characteristic set of signs and symptoms associated with abstinence from cigarette smoking (e.g. anxiety, restlessness, poor concentration, irritability or aggression and so on) and is observed in all smokers abstaining from cigarette smoking. However, in patient groups with higher levels of general psychological distress, such as women with eating disorders, mood or anxiety disorders, the withdrawal symptoms are considered to have greater intensity and a greater relief from withdrawal after smoking, which inevitably makes it harder to give up smoking.

The differences in responses regarding ‘weight concern as a reason for relapse’ between this study and Wiseman & Fairburn’s (1998), was also due to a different question being asked and consequently a different answer being given. In this study, participants were asked to report on what they considered to be their main reason for relapse from a range of possibilities, where as in the earlier study, patients were asked ‘if concern about weight or shape was one of the reasons for their relapse’. Thus our findings add to Wiseman & Fairburn’s (1998) study by demonstrating that, although weight concern may be one of the reasons that explain relapse in women with eating disorders, it
is unlikely to be the only reason or even the main reason for relapse after 6 months of smoking abstinence.

Therefore, these results would suggest that women with eating disorders are as dependent on smoking as women with similar levels of psychological distress. They have no greater difficulty abstaining from smoking and are no more likely to relapse due to weight concerns than women with mood or anxiety disorders. Thus, post cessation weight gain concerns may not have as great an impact on the smoking behaviour of women with eating disorders as was first thought. Nevertheless, it remains feasible that weight concerns may predict intention to quit smoking and have a greater effect on short term abstinence attempts (< 3 months). Future studies should aim to investigate these possibilities.

**H.3 Of those with a smoking history, women with eating disorders will report to a greater extent than the comparison group that they use smoking to control their weight.**

This hypothesis was confirmed by the results of this study. Women with eating disorders reported using smoking to keep their weight down to a greater extent than women with mood or anxiety disorders. They also reported using smoking to help cope with stress to a greater extent than the comparison psychiatric group. There were no significant between group differences for any of the other smoking motives.

This replicates Wiseman & Fairburn’s (1998) results and strengthens their conclusions. Since the women with eating disorders did not report using all six of the smoking motives to a significantly greater extent than women with mood or anxiety disorders, it seems logical to conclude that women with eating disorders do use smoking to control weight to a greater extent than women with mood or anxiety disorders.
The results also demonstrate that both groups of patients used smoking to help them cope with stress, significantly more than any other reason (including, weight control). There was also some evidence to show the eating disorder group used smoking to keep their weight down more than they used it to concentrate and stay alert. The women with mood and anxiety disorders on the other hand, used every other motive (other than, 'feeling uncomfortable if they didn’t') more than they used smoking to keep their weight down.

These results suggest that the use of smoking to control weight is an important motive in women with eating disorders. Moreover, a significant proportion, when asked to choose between the motives, reported using smoking to keep their weight down as their most important motive for smoking.

Investigating the different reasons for smoking also demonstrated that certain motives for cigarette smoking are relevant to all smokers, e.g. 'using smoking to cope with stress'. However the pertinence of other motives may depend on the nature of the individual's difficulties. For instance, the majority of individuals with mood and anxiety disorder chose 'using smoking to concentrate and stay alert' as their most important smoking motive, where as none of the participants with eating disorder chose this as their most important motive. Similarly, the majority of women with eating disorders chose 'smoking to keep their weight down as their most important motive and rated using smoking 'to keep their weight down' to a greater extent than they rated using smoking to 'concentrate and stay alert'. Future studies should attempt to replicate these finding and explore the possibility that individuals with mood and anxiety disorders find nicotine's positive effects on concentration more rewarding and thus, more reinforcing than women with eating disorders.
6.0 IMPLICATIONS FOR CLINICAL PRACTICE

These findings have several clinical implications. Similar to other women with generally higher levels of psychological distress, women with eating disorders use smoking to help them cope with stress as well as for other reasons. However, women with eating disorders also smoke to control their weight and for some it may be the main reason they smoke. Not only was this the case for women with bulimia nervosa or binge eating disorder, but also for women with anorexia nervosa and those with sub-clinical forms of an eating disorder who engage in smoking behaviour.

These results suggest that clinical psychologists working with women with eating disorders need to be aware that their patient may be using smoking for the same reasons as they use other weight control devices, such as diet pills, diuretics, laxatives and so on. These latter weight control methods however, are discussed during the assessment of an individual with an eating disorder and book chapters are dedicated to helping patients refrain from using them in the future. The use of smoking on the other hand is ignored.

Bearing this in mind with the new government initiatives would suggest a need for professionals working in eating disorder services to start addressing the smoking behaviour of their patients. Not only is this important because they have a higher prevalence of smoking than the average population, but also because cigarette smoking may play a vital role in their treatment progress. For instance, if patients assume smoking is allowed where as the other weight control methods are forbidden, smoking behaviour may increase in order to compensate for the loss of weight control practices they previously used. Future research could assess this possibility by comparing the smoking behaviour of eating disorder patients before, during and after treatment with another patient group undergoing treatment.
The evidence suggests therefore, that cigarette smoking can no longer be ignored in the treatment of women with eating disorders. Clinical psychologists would gain important information if they included questions about smoking status and if appropriate, reasons for smoking during their assessment. Having this information prior to treatment would help clinical psychologists detect any changes in smoking behaviour during treatment, and enable them to include information on the health risks of smoking when focusing on other similarly, unhealthy weight control practices. Given the probable weight gain after smoking cessation, patients with an eating disorder should also be closely monitored during the initial stages of a cessation attempt to assist with any specific concerns about weight gain.

It should also be acknowledged that a significant proportion of the smoking sample, regardless of their diagnosis, reported that they thought it would be very difficult to give up smoking, yet wanted to give up to some extent. This reflects the literature that reports, patients with mental health problems find it particularly hard to give up smoking (Covey et al, 1998). It also highlights the need for professionals, particularly clinical psychologists, to advise and help their patients with smoking cessation efforts. More so, when new products such as Zyban (bubpropin hydrochloride sustained release(SR), which are allegedly effective in smoking cessation are contraindicated for individuals with eating disorders and bipolar disorder (GlaxoWellcome, 2000).
7.0 LIMITATIONS OF THE STUDY

The major limitation of the study was the poor response rate and subsequent small sample size. A response rate of 53% invites a greater possibility of bias in the sample. For instance, the difference or similarity in smoking prevalence rates may be due to the smokers in a particular diagnostic group being more or less likely to return their questionnaires. However, any bias in responses is difficult to ascertain because diagnostic information was only available for those who returned the questionnaire. Nevertheless, a significantly better response rate from the researcher’s sample, without a difference in proportions of smokers in the groups, suggests a different and more probable explanation.

It had been anticipated that having a clinician (who was familiar) approach the patient would improve the response rate, but this assumption turned out to be untrue. Rather, the better response rate was found in the sample approached by the researcher. This suggests that the method by which the individual was informed about the study had the greatest impact on whether the individual decided to complete and return the questionnaires. It seems possible that the researcher, who had more to gain from the patient participating in the study, may have approached potential participants with more enthusiasm or was better equipped to answer any questions the patient may have had.

This study needs to be repeated using a larger sample of participants and preferably employ a team of researchers who are enthusiastic about the research to approach patients to take part in the study. Additionally, this sample was primarily white and of well educated backgrounds, which limits the generalisability of these findings.

Ideally, the patients in the two groups should have been matched for age to remove a potentially confounding variable. However, since age did not
correlate with the motive 'do you use smoking to keep you weight down', it seems highly unlikely that any significant difference found between the groups was due to age rather than their diagnostic presentation. Anonymity was not assured to all of the participants. However, the sample with the better response rate was not anonymous, which suggests that anonymity could only have decreased the response rate, which seems unlikely.

Unfortunately this study had to rely on self-report measures of smoking status and weight and height due to insufficient time and resources. However, it was unlikely that any of the patients had any reason to fabricate their smoking status and BMI was as expected in each of the groups. With more time, structured diagnostic interviews may also have been employed when recruiting the sample. However, the clinicians diagnosis based on established criteria (DSM-IV) seemed sufficient (Hughes et al, 1986), especially when supported by the self-report questionnaires such as the Eat-26, Bit-E and GHQ-28.
8.0 CONCLUSIONS
The hypothesis that women with binge-purge behaviour would be more likely to smoke than a comparison psychiatric group of women with mood or anxiety disorders was not supported in this study. There was however, some evidence to suggest women with binge-purge behaviour are more likely to have smoked than women with anorexia nervosa. It is suggested that the personality characteristics of women with anorexia nervosa make them less likely to initiate smoking in adolescence and consequently become never smokers as adults.

The study also did not support the hypothesis that women with eating disorders would be more dependent on smoking and have greater difficulty abstaining from smoking due to concerns about weight than the psychiatric comparison group. There was some suggestion however, that women with eating disorders may be less likely to want to give up smoking due to weight concerns and weight concerns may have a greater impact during the first 3 months of an abstinent attempt.

The hypothesis that women with eating disorders are more likely to report using ‘smoking to control their weight’ to a greater extent than women with mood or anxiety disorders was confirmed by this study. Although women with eating disorders reported smoking for other reasons, (such as to help them cope with stress), a significant proportion said that weight control was one of the most important reasons for their smoking. In contrast, women with mood and anxiety disorders reported smoking to help them concentrate and stay alert as their most important motive.

In conclusion therefore, women with eating disorders may smoke to control their weight, but this additional motivation does not increase the likelihood of their smoking when compared with a group of women with similar levels of psychological distress. This seems to be a result of different aspects of
cigarette smoking being more or less rewarding depending on the nature of the individuals difficulty. For example, both patient groups used smoking to help them cope with stress; the women with eating disorders however, were also motivated by its beneficial effects on appetite and weight, whereas the mood and anxiety group were more motivated by its stimulatory effects.

Given the difficulty in giving up smoking, there is clearly a need for clinical psychologists to discuss the reasons their patient is smoking to help target smoking cessation interventions more effectively. Perhaps more importantly, clinical psychologists should be aware that patients with mental health problems, particularly women with eating disorders use smoking as a way of coping with their current difficulties and this method of coping should be addressed prior to treatment.
References


APPENDICES

Appendix I - Approval from Ethics Committee

Appendix II - Recruitment Pack for Clinicians
Part A - Is this Patient Suitable to Participate?
Part B - Recruitment Instruction Sheet
Part C - Clinician’s Coding Sheet

Appendix III - Patient Information Sheet

Appendix IV - Patient Consent Form

Appendix V - Smoking Measures
Part A - Items and scoring for the FTND
Part B - Questionnaire of Smoking Motives
Appendix I

Approval from Ethics Committee
29 November 1999

Ms Anila George
Psychologist in Clinical Training
Psychology Dept.
University of Surrey
Guildford, Surrey GU2 5XH

Dear Ms George,

An investigation into the prevalence and motives for smoking in females with eating disorders compared with those with mood/anxiety disorders - 99.60.8

The Local Research Ethics Committee of 24 November 1999, ratified Chair's action in approving the changes to the information sheet and consent form for the above named study.

Yours sincerely

Canon Ian Ainsworth-Smith
Chairman
Local Research Ethics Committee

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

(a) when the project is complete.

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

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

(d) all investigators whose projects have been approved by this Committee are required to report at once any adverse experience affecting subjects in the study.
Is your patient a woman aged between 18-65?

Yes

Is your patient pregnant or was she pregnant less than 4 months ago?

No

Is your patient currently experiencing any psychotic symptoms?

No

Does your patient's presenting problem fulfill diagnostic criteria for one of the following:

- Mood disorder
- Anxiety Disorder
- Atypical/Anorexia Nervosa
- Atypical/Bulimia Nervosa
- Binge Eating Disorder

Yes

Go ahead
Appendix II - Part B

How to Ask Patients to Participate in the Study - Instruction Sheet for Clinicians

1. Introduce the study by saying the following:

"I was wondering if you would be interested in taking part in a study we are currently assisting with. The study is investigating the use of cigarette smoking in women experiencing stress. It aims to see if certain types of stress make people more likely to smoke and harder for them to stop smoking. It involves asking smokers, ex-smokers and non-smokers for their views on this topic and participation is completely voluntary. If this sounds interesting to you, I suggest you take a minute to read the information sheet which gives a fuller explanation of the study and what you have to do to take part."

2. Refer them to the Information Sheet

Try to answer any questions they may have. If they ask a question you feel unable or prefer not to answer, please ask them to contact the researcher.

3. Ask them if they would like to take part in the study?

If they say YES:
- Ask them to fill in their name and address on the consent form and sign it.
- Witness the consent form
- Write down the code number that classifies their diagnosis on the last blank page of the questionnaire pack. (Use the Coding Sheet attached)
- Give them the questionnaire pack and ask them to have to fill in the questionnaires in their own time, but to send them back as soon as they can in the SAE provided.

If they say NO:
- The appropriate box on the consent form should be ticked to indicate this response.

4. Keep the consent forms

Keep all the consent forms together with any unused questionnaire packs; they will be collected periodically by the researcher.

N. B: After the above has been carried out with the first potential participant (irrespective of their decision to participate or not), it is essential that the same process is repeated with each consecutive eligible patient, until the end of the agreed date.

Thank you for all your help
Appendix II - Part C

Clinician’s Coding Sheet

Before giving the participant the questionnaire pack, turn to the last blank page on the pack and write down the code number that best fits with the patients’ diagnosis.

Thank you.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia Nervosa or Atypical Anorexia Nervosa</td>
<td>12</td>
</tr>
<tr>
<td>Bulimia Nervosa or Atypical Bulimia Nervosa</td>
<td>16</td>
</tr>
<tr>
<td>Binge Eating Disorder</td>
<td>43</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>24</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>31</td>
</tr>
</tbody>
</table>
PATIENT INFORMATION SHEET FOR PARTICIPATION IN RESEARCH PROJECTS AND CLINICAL TRIALS

Title of Project A study of the use of cigarette smoking in women experiencing stress

It has been suggested that certain types of stress make people more likely to smoke tobacco. Smoking maybe perceived as helping with aspects of their stress which makes it more likely that the person continues to smoke and makes it harder for them to stop.

This study you have been asked to participate in is designed to compare the number of smokers, ex-smokers and non smokers in various patient groups as well as the motives for smoking in those that currently smoke. The information we obtain will help us gain more knowledge about the most likely reason why an individual is smoking in any particular clinical group. Targeting these issues in treatment should improve the chances of success in any future attempts to quit smoking.

Participating in the study involves filling in a few questionnaires that should take no longer than 45 minutes to complete and posting them back to the researcher using the stamped addressed envelope provided.

The questionnaires have been used in many other studies and there are no known discomforts or risks involved in completing them. All questionnaires are treated confidentially.

You are free not to take part in this study without giving a reason for doing so and this will in no way affect the care you receive as a patient.

Thank you very much for considering to take part in this study.

Anila George
Psychologist in Clinical Training
Psychology Department

Contact number :01483 259 441
CONSENT FORM FOR PARTICIPATION IN RESEARCH PROJECTS AND CLINICAL TRIALS

If you would like to participate please fill in the section below

__________________________________________________________
I (name) __________________________________________________

of (address) _____________________________________________

Telephone No: ______________________________

hereby consent to take part in the above investigation, the nature and purpose of which have been explained to me. Any questions I wished to ask have been answered to my satisfaction. I understand that I may withdraw from the investigation at any stage without giving a reason for doing so and that this will in no way affect the care I receive as a patient.

SIGNED
(Volunteer) __________________________ Date____________________

(Witness) ___________________________ Date____________________

Clinician’s use only:-

Please tick this box if the patient did not wish to participate
### Appendix V - Part A

**Items and Scoring for Fagerstrom Test for Nicotine Dependence (FTND)**

To be filled in by Current Smokers only

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How soon after you wake up do you smoke your first cigarette?</td>
<td>Within 5 minutes</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>6-30 minutes</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>31-60 minutes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>After 60 minutes</td>
<td>0</td>
</tr>
<tr>
<td>2. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g. in church, at the library, in cinema, etc.)?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>3. Which cigarette would you most hate to give up?</td>
<td>The first one in the morning</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>All others</td>
<td>0</td>
</tr>
<tr>
<td>4. How many cigarettes a day do you smoke?</td>
<td>10 or less</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>11-20</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>21-30</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>31 or more</td>
<td>3</td>
</tr>
<tr>
<td>5. Do you smoke more frequently during the first hours after waking then during the rest of the day?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>6. Do you smoke if you are so ill you are in bed most of the day?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>
### Appendix V - Part B

**Questionnaire of Smoking Motives**

To be filled in by Current and Ex-smokers
Ex-smokers should answer in terms of when they were still smoking.

**Please answer all six questions (Circle one number for each question)**

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Do you use smoking to help you cope with stress?</td>
<td>Yes very much</td>
<td>5</td>
<td>Yes quite a bit</td>
<td>4</td>
<td>Yes a little</td>
</tr>
<tr>
<td>II.</td>
<td>Do you use smoking to help you socialise?</td>
<td>Yes very much</td>
<td>5</td>
<td>Yes quite a bit</td>
<td>4</td>
<td>Yes a little</td>
</tr>
<tr>
<td>III.</td>
<td>Do you use smoking to give you something to do when you are bored?</td>
<td>Yes very much</td>
<td>5</td>
<td>Yes quite a bit</td>
<td>4</td>
<td>Yes a little</td>
</tr>
<tr>
<td>IV.</td>
<td>Do you use smoking to help you concentrate and stay alert?</td>
<td>Yes very much</td>
<td>5</td>
<td>Yes quite a bit</td>
<td>4</td>
<td>Yes a little</td>
</tr>
<tr>
<td>V.</td>
<td>Do you use smoking because you feel uncomfortable if you don't?</td>
<td>Yes very much</td>
<td>5</td>
<td>Yes quite a bit</td>
<td>4</td>
<td>Yes a little</td>
</tr>
<tr>
<td>VI.</td>
<td>Do you use smoking to help you to keep your weight down?</td>
<td>Yes very much</td>
<td>5</td>
<td>Yes quite a bit</td>
<td>4</td>
<td>Yes a little</td>
</tr>
</tbody>
</table>