Reductions of Eating Disorder Symptoms during Pregnancy:
An Interpretative Phenomenological Analysis

by

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Volume I

Submitted for the degree of Doctor of Psychology (Clinical Psychology)

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July 2009

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ACKNOWLEDGEMENTS

I wish to thank everyone at the University of Surrey Psych D course team, and everyone I worked with on placement or in a research capacity. More specifically, I wish to thank Vicky Vidalaki and Sue Thorpe for their support as my academic and research tutors respectively, and Nan Holmes and Louise Deacon for fulfilling the role of my clinical tutor. I also wish to acknowledge Sophie Doswell and Heidi Ashead, who both took the role of my honorary clinical tutor for a period during my training, and Drew Alcott, for his role as my mentor throughout.

I wish to thank Twickenham CMHT, Sutton CAMHS and JAS, Croydon JCLDT, Kingston Psychological Therapies in Primary Care, the older adults wards at Barnes Hospital and Richmond Older Adults CMHT for allowing me to complete placements with their services. More specially, I would like to extend my thanks to the following individuals for clinically supervising me on these placements; Leo Estall, Joanna Seller, Tammy Surgenor, Julian Morris, Susan Rodgers and Catherine Dooley for their role and support as my primary placement supervisors, and Jenny Rahetulla, Emma Corstorphine, Beth Freeman and Jo Billings for additional supervision in specific therapeutic settings or for specific pieces of work.

Regarding the main research component, I would like to thank Vicki Mountford and Laura Simonds for their roles as my field and university supervisors respectively, the Eating Disorder service at South West London and St George's NHS trust, and the eating disorders charity BEAT. I would additionally like to thank Jane Street and the PTSD service at South West London and St Georges NHS trust for their assistance in my first year service related project.
“Even people who feel paranoid have enemies! Discuss the possible meaning and function of paranoid/persecutory ideas. How might clinical psychologists work with people who feel so afraid?”

Adult Mental Health Essay

December 2006

Year 1
Until relatively recently the general perception in mental health was that psychotic beliefs were qualitatively different from neurotic or "normal" beliefs, being bizarre and held with such strength that they were unreceptive to contradictory information (Jaspers, 1963 cited in Bentall et al, 1994). However, historically there have been challenges to this approach, and with the growth of Cognitive Therapy and its increasing acceptance with other mental health professionals, psychological theories of persecutory delusion are growing in favour. They argue that when contextualised, paranoid delusions become meaningful and these meanings can be worked with therapeutically. I chose this essay topic as it has at times been easy to internalise ideas of delusional thought as qualitatively different, and I wished to learn more about an area I lack knowledge in. Whilst this essay cannot summarise all theories it will focus on three of the main cognitive theories due to the growing importance of Cognitive and Cognitive-Behavioural Therapy (CT/CBT) in the NHS, and Klein's theory of object-relations. For each model, I shall consider issues regarding therapeutic application.

What is Paranoia?
Strong paranoid thoughts and/or delusions are a common feature of various psychiatric diagnoses, most commonly associated with paranoid schizophrenia, but featuring in paranoid personality, schizoaffective, bipolar and severe depressive disorders. For a state to be paranoid, the individual must believe they specifically will come to harm (ranging from upset to physical harm) from a persecutor who intends to harm (Freeman & Garety, 2000). Not only does paranoid thought result in distress, but its nature can exacerbate difficulties in therapeutic relationships. Whilst paranoia can be a symptom of various diagnoses, most of the literature reviewed in this essay refers to paranoid delusions in psychosis with no or little evidence supporting them and often involving a conspiracy (Chadwick et al, 1996). When this essay does refer to non-delusional paranoia it will specify when, and will spend the most part referring to delusional paranoia.

When information has not been found for persecutory thought alone, references to schizophrenia have been made if considered relevant. I recognise that not all individuals with a diagnosis of schizophrenia experience paranoid delusions, and generalising some of the results to persecutory delusions is problematic. Therefore conclusions based on this data are somewhat more tenuous.
Cognitive Models

Does paranoia protect self-esteem?

In the mid 1990s Bentall et al. (1994) proposed persecutory ideation could be conceived as a mechanism to protect self-esteem from the effects of negative self-schemata. Basing their ideas on cognitive theories of depression they argued that like depressives, paranoid individuals made global and stable attributions for negative situations, but in contrast made external rather than internal attributions, which focused upon other people, not situational factors. By blaming other people for negative outcomes, persecutory delusions narrow the gap between an individual's perceived "actual self" and their "desired self". Evidence of underlying negative schema has been found to co-exist alongside seemingly high self-esteem (Bentall & Kaney, 1996). Whilst some studies indicate that paranoid individuals maintain high self-esteem, there is also contradictory evidence indicating paranoid individuals have low self-esteem that the Attributional Model does not account for (Freeman et al., 2002). A recent study almost found the opposite results; no self-serving bias in individuals with persecutory delusions (although it did exist in non-paranoid individuals), evidence of an underlying depressive style not associated with level of paranoia, and a low positive/high negative self-esteem profile associated with paranoia until general psychiatric symptoms were controlled for (Humphreys & Barrowclough, 2006). The model at this stage of development has difficulties due to this conflicting data, although its revision will be returned to later in the essay.

Two types of paranoid thought

One year later, a qualitatively different form of paranoid delusion was suggested to exist alongside this self-esteem protecting paranoia. These two types of were characterised as "poor me" and "bad me" paranoia (Trower & Chadwick, 1995). The theorised mechanisms for both types of experience differ somewhat, revolving around negative interpersonal evaluations rather than pure attributional style. The self is perceived as being constantly reconstructed around the objective self (the observed public self), the subjective self (the internal "agent" who evaluates, makes decisions etc.) and the other (other individuals). "Poor me" paranoia is characterised by an "insecure" self in which an adequate objective self is not made due to others neglecting and ignoring the individual, with its roots in childhood experience. This slight is reduced by believing that the other does not ignore, but instead wants to harm, thus making the individual important to the other. This defensive quality makes it similar to Bentall and colleagues' interpretation. "Bad me" (or punishment)
paranoia refers more to an "alienated" self where the other is instead extremely controlling, not allowing the subjective self form its own version of an objective self, instead dictating a foreign self for the individual. The individual feels smothered, sees the other as formidable and perceives himself as weak, bad, and in need of punishment. The self-serving bias of the "poor me" paranoid is reversed, with the individual attributing the negative to themselves and the positive to others. Avoidance of the other as negatively reinforcing is typical.

Empirical support been suggested for "poor me"/"bad me" paranoia, with a "bad me" group exhibiting more negative self evaluations and less negative evaluations of others compared to a "poor me" group. They also had higher levels of anxiety and depression, and controlling for depression, lower reported self-esteem (Chadwick et al, 2005). In another study, individuals described as having "bad me" paranoia made more internal attributions for negative events when symptomatic than the "poor me" group (Peters & Garety, 2006). However, sample sizes were small. However, whilst Trower and Chadwick propose individuals arrive at the different states due to their experiences of being raised (either neglected or over-controlled), they do not account for differential outcomes, i.e. what makes one neglected or controlled child paranoid as an adult, and another depressed or psychologically resilient. Also there is no empirical evidence that individuals with "poor me" paranoia were raised in a neglectful way and that "bad me" individuals were over-controlled.

**Evolution of the Model of Attribution**

The Attributional Model was reviewed because it did not account for paranoid individuals with low self-esteem. The revised model (Bentall et al, 2001) proposes that attributions affect self-perception and mood, and that those changes to self-perception alter successive attributions. Other factors which lead to specific attributions being made consist of a combination of information specific to the situation (changeable), factors specific to the person (more stable) and the event. When an event occurs, a "cognitive search" precedes attributions being made. Possible internal attributions are processed initially and will be adopted if they fit the individual's current self-perceptions/self-representations. If not, external-personal possibilities (i.e. blaming others) are processed next, and finally external-situational attributions (blaming situations). For negative events, both types of external attribution would enable the individual to preserve self-esteem, although external-personal attributions have the consequence of causing distressing mistrust and may be "easier" to make. Paranoid individuals are more attuned to interpersonal threat
information, have difficulties processing situational information (due to prematurely making judgements at the external-personal stage) and/or have poor Theory of Mind skills (the ability to perceive other people as thinking differently from oneself). However, the model does not adequately explain why these features would occur. It does however note that the pathological defence processes are exaggerations of “normal” mechanisms in which non-psychiatric individuals maintain high self-esteem.

In experimental conditions, attributional style has been observed to change from external-personal to internal in paranoid participants after a mildly stressful task (Bentall & Kaney, 2005). However, if it can change after what is described as a “mildly” stressful task, it may suggest that the self-serving bias is not very resilient at all! If persecutory paranoia is meant to be a defence, perhaps it should be able to defend against more than “mild” stress. Nevertheless, other studies have suggested that “discrepant” self-esteem (high explicit and low implicit self-esteem) in non-clinical populations is correlated to both high narcissism and a subjectively more unstable self-esteem (Zeigler-Hill, 2006), indicating that discrepancies in self-esteem can lead to changes in self-perception, providing partial support if persecutory delusions are seen to be on a continuum. However, some findings show external-personal biases are only evident in individuals with paranoid thoughts of delusional strength (McKay et al, 2005) so a consideration is that there may be different mechanisms for delusional compared to non-delusional persecutory thought.

The model has perhaps, with its increased tendency to explain both types of attribution as part of the same theory, become more difficult to test; a point also made by Humphreys and Barrowclough (2006). An example of this can be found with findings that paranoia alone is not related to attributional style, although individuals with paranoid and grandiose delusions did demonstrate an externalising attributional bias (Jolley et al, 2006). Whilst this contradicts the first manifestation of the theory, the emergent grandiose delusions could be explained as the necessary change in self-perception leading to the attributional bias being activated.

**Differing types of paranoid delusions - state or trait?**

The revised Attributional Model accounts for individuals with paranoia and low self-esteem and could be used to suggest Trower and Chadwick’s “poor me” and “bad me” paranoid types are two sides of the same coin; when defences fail to protect
self-esteem the individual is overwhelmed by their negative self perception. One of the major differences revolves around whether self-blame/other-blame is state or trait. Whilst Trower and Chadwick concede that not every person with paranoid delusions may fit their two categories, the clear distinction between “bad me” and “poor me” paranoia as a constant thing would seem to preclude the possibility of overlap. Generally psychology is moving away from ideas of polar opposites in favour of continuum models. In my own clinical experience I worked with a client whose first psychotic episode involved elements of punishment and internal “badness”, but whose second episode was typically “poor me”. When well he presented with low self-esteem and an attributional style more self-blaming than other-blaming. This suggests that for some, “bad me” and “poor me” are not representative of two different unchanging personalities and that persecutory delusions have a protective role in self-esteem. However, this is just one case and should not be generalised from.

Clinical application, risk and team involvement

If persecutory paranoia has a role in preserving self-esteem and the therapy process requires these thoughts being made explicit, this may have implications for risk. It is well known in clinical settings that the suicide rate of individuals with schizophrenia is high. In the case of psychotic depression, individuals with delusions relating to persecution or punishment are at greater risk of suicide than those with bodily disease, damage, and malfunction (Miller & Chabrier, 1987). If negative defended-against thoughts are uncovered in therapy clients may experience depression, adjustment difficulties and confusion which may increase risk to self. If anger or a retreat further into their defensive delusional world is the result this may have implications for risk to other people (as well as the therapeutic relationship). In order to manage risk, the therapist should ensure the client has adequate coping mechanisms and support networks in place. Increased possible risk must be discussed with the multi-disciplinary team (MDT) in order to tailor care to the client’s needs. MDTs should be warned of possible outcomes before work is started.

Chadwick and colleagues (1996) suggest initial explorations of negative other-self (how people think others view them) and self-self (how people view themselves) beliefs are harder in individuals with “poor me” paranoia due to their being hidden by the defensive delusional network. Also if the problem is viewed as due to other people, not themselves, motivation to participate in therapy may be lower and the
Therapist may be incorporated into the delusional structure if they are not careful to reduce perceived confrontation. They recommend thought chaining to discover and link other-self and self-self beliefs to the delusion, through Socratic questioning whilst temporarily assuming the delusion is false. Once defended-against thought structures are identified, persecutory delusions as well as negative self-self evaluations can finally be challenged. In "bad me" negative self-evaluations are accessed by temporarily assuming the delusion is true, and are explored and challenged before being linked back to the delusion, which is finally challenged. If "bad me" delusions have an element of truth (e.g. the person is terrible because they once did a terrible thing) the therapist can condemn the behaviour without condemning the client, thus showing the client they can be accepted despite past deeds. Chadwick (2006) later proposes a "two chairs" technique where clients voice self-critical thoughts, and then move to another chair to "speak" to and challenge their negative thoughts/schemas in an explicit clear way.

The therapy is cognitive rather than cognitive behavioural, which means that behavioural aspects of consolidating new explanations are absent. This is not necessarily a problem depending on the client. "Pure" CT is commonly thought to demand a high level of psychological mindedness that may not always be possible (particularly considering the cognitive impairment observed in some individuals with chronic schizophrenia). It also appears to suggest a progress in therapy that may be a little too "perfect" and linear. If persecutory delusions are defensive mechanisms then one might expect the client to retreat back into their defensive world, or even terminate therapy.

Notably it assumes that the model is correct, and thus therapists may miss important things reported by the client but which do not quite fit the model. Therapists can be as subject to cognitive dissonance as anyone else. This point has also been made by Zapparoli and Gislon (1999), and is further discussed later. If it is possible that delusions do not provide a predominantly defensive role then firm adherence to exploring for these may be counterproductive. Cognitive theories of defence neglect to explain why individuals "switch" a bad self-image into a good one. It may be that other factors are involved which could inform the therapeutic process.
A non-defensive cognitive model of persecutory delusions and clinical implications

Rather than framing persecutory delusions as primarily defensive mechanisms, Freeman et al (2002) focus on how individuals “search for meaning” to explain unusual sensations, distressing cognitions or emotional experiences. Contextualised in a biopsychosocial stress-vulnerability framework, precipitating events (e.g. a stressful occurrence or drug use) cause anxiety based arousal (sometimes exacerbated by insomnia) and henceforth “inner-outer confusion” e.g. voices, and/or “perceptual irregularities”. Perceptual irregularities can either be directly prompted by an event, the emotions, or the cognitive distortions caused by the event. These are “explained” by the delusional network, as are external events that are difficult to otherwise interpret. These explanations are not led by psychological defences like Bentall and colleagues propose, but on existing schemas framing the world and others as dangerous and themselves susceptible to harm. Cognitive biases such as jumping to conclusions, attributional bias and difficulties in interpreting the objectives of others (Theory of Mind deficits) are involved in explanation formation. After delusional ideas are formed they are maintained through safety behaviours, with avoidance taking a primary role.

An advantage is that the model takes some factors outside the individual into account, such as a lack of trusted social supports with whom to test emerging paranoid ideas. Findings that the “befriending” of clients with schizophrenia has been shown as effective as CBT as a treatment option (Milne et al, 2006) is supportive of this. The existence of pre-morbid social anxiety as a predictor has also been supported in predictive studies of individuals developing schizophrenia (Johnstone et al, 2005). The model also states that different individuals may have different processes involved and that one explanation does not fit all. This makes the model much more flexible for individual clients though like Bentall and colleagues’ later model, perhaps the wider scope makes it more difficult to test.

It is conceded that when faced with conflicting explanations that either the world is dangerous or they are mad, the person will pick the least damaging to their self-esteem (i.e. that they are sane in a dangerous world). They postulate this is not the same as Bentall and colleagues’ theory because they do not argue for a discrepancy between low and high self-esteem. Whilst Attribution Theory has much conflicting data, it also has supporting evidence, and indications of explicit high self-
esteem and implicit low self-esteem could likewise contradict the theory of Freeman and colleagues (Bentall & Kaney, 1996).

The integration of other experiences (e.g. perceptual anomalies) helps conceptualise psychotic paranoid thought in combination with other symptomatology. After all, despite the growing psychological approach of focusing on symptoms of psychosis rather than syndromes we can expect individual symptoms not to act in isolation. As there is a focus on unusual experiences and sensations the model is less readily transposed onto other forms of paranoid thought, e.g. paranoid personality disorder, than the other two models described, and if paranoia is viewed on a continuum, this is a flaw. However, as the model is quite explicit in how pathways can be different, the anomalous perceptual aspect perhaps does not affect individuals with non-psychotic paranoia.

As Freeman and colleagues' model recognises that different individuals may have different paths to their persecutory delusions, and different maintaining factors, the precise pattern of therapy would be determined by these factors. The authors recommend a classical CBT style, focusing on developing alternative meanings for their experiences in a manner extremely sensitive to the inherent distrust in persecutory delusions and the effect of stigma, and the phasing out of safety behaviours. Its primary aim is to reduce the emotional distress associated with persecutory ideas, achieved through hypothesising alternative meanings, normalisation and exploring processing biases. However, unlike Chadwick and colleagues almost seemingly schema based approach, the model's focus on maintenance behaviours leads to a similar focus in therapy. By encouraging clients to give up their safety behaviours and by discussing why the harm has not yet occurred, the maintenance cycle may be broken. However, considering the possible high level of mistrust inherent with persecutory thought, convincing a client to drop the few things they think is keeping themselves safe may be extremely difficult. In my experience, the dropping of safety behaviours in people experiencing anxiety disorders can be initially traumatic before full benefits are appreciated. This could be so traumatic as to precipitate them dropping out of therapy, or leading to the therapist being incorporated into the conspiracy. However, as with other CBT applications, engrained negative thoughts can only be challenged when the safety behaviours are extinguished. An individualised model, which is also subject to change throughout therapy, may be necessary.
If paranoid delusions are shaped by existing schema of the world and other people, this may support the assertions of several theorists that delusional behaviour may arise from real experiences of persecution, an argument particularly relevant when considering why specific groups are diagnosed more often with delusional disorder.

Is mild paranoia adaptive for persecuted groups?
Diagnoses of schizophrenia are more common in ethnic minority (specifically Afro-Caribbean, and particularly second generation immigrants) and poorer populations, with men reported as more likely to be diagnosed than women or in equal numbers with earlier onset (Reid, 2004). If the function of delusions is to be examined it is important to consider why this might occur.

Whaley (1998) argues that in America, ethnic minorities, particularly Afro-Caribbean, and individuals with low socio-economic status who perpetually experience discrimination develop mild non-clinical paranoia as a self-protective mechanism for not internalising failures resulting from prejudice. Women, ethnic minorities and individuals with low socio-economic status have been shown to have decreased levels of interpersonal trust compared to men, ethnic majorities and individuals with higher socio-economic status (Terrell & Barrett, 1979, cited in Whaley, 1998). While Whaley argues that cultural mistrust can be wrongly confused for delusional ideation, it has been suggested that cultural mistrust can grown and be manifested as delusion (Yamada et al, 2006). This is consistent with both models framing delusions as protecting self-esteem and as arising from existing schemas of others as hazardous. Whilst this may apply to ethnic minorities and those who are poor, it does not account for why more women than men do not have schizophrenia (it is commonly assumed that women, as an overall group, experience more oppression). In fact, in non-psychiatric populations men may have a greater tendency to paranoid thought than women, who in turn may be more susceptible to voices (Johns et al 2004).

If "adaptive" paranoia does exist then this must be taken into consideration in therapeutic settings. Challenging a generalised paranoid belief is unlikely to be successful if it represents real oppression. My own experience of working in forensic inpatient settings with an urban, largely Afro-Caribbean, poor and paranoid population suggested to me that it is highly possible that paranoid thought can start and be maintained as a result of very real social oppression. For therapists seen as
belonging to the oppressing ethnic or social-economic group, this may be another barrier to the therapeutic relationship that will have to be overcome.

**Psychodynamic Perspectives on Paranoia**

**Klein and the application of object relations theory to paranoia**

According to Klein (1946/1996) and object relations theory, up to six months of age when a baby feels uncomfortable it projects feelings of “badness” onto its mother’s breast (due to its prime role in the infant’s world) and wants to attack it. At times of comfort it projects “goodness” and idealizes it. Because the baby at this stage does not have a consistent separate self, both projections of badness and goodness are introjected back and incorporated into its developing ego. However, it cannot accept both goodness and badness can exist in the same object (and thus itself) whilst it remains in this paranoid-schizoid stage, leading to splitting. The object is not integrated at this stage. Whilst in “normal” development both opposites states and objects become integrated over time as the ego develops, in some children (those who suffer bad parenting and/or extreme self-destructive drives) the split states occur too long and often and the ego is unable to integrate, giving the child grave difficulties moving on to the depressive position. Klein argues these infants will be at risk of psychosis in adulthood.

When a hostile inner world is projected onto an object, it is introjected back, and vice versa. Therefore when a powerful desire to persecute is projected onto another person persecution is reflected back and absorbed, which adds to the impression of being controlled. This splitting and projection of the bad parts of the self weakens the ego, which adds to its disintegration. Internal objects are not integrated and projected parts of the self cannot be regained. This cycle of projective-identification, whereby more and more objects are needed for the ego to project its increasing badness onto, continues until all objects are persecutory and good objects are tainted (Waska, 2002). The therapeutic aim is to decrease the defences associated with paranoia (omnipotence, splitting, denial and projective-identification) through insight. The role of the therapist is to interpret and thus “detoxify” the client’s projections, a difficult task due to the client’s conscious reluctance to take back their projections.

As omnipotence may be a defence, the already distrustful client may be even more resistant to being advised by a professional telling them what to do. One way to minimise client distrust and beliefs is for the therapist to take the role of a
“nonqualified person” to appear less challenging to the client’s view of the world (Zapparoli & Gislon, 1999). If the client initially sees the therapist not as an authority figure but instead someone at the client’s disposal it can avoid initial power struggle. There may also be issues surrounding dependence, and clients may have unfavourable or ambivalent attitudes to treatment (risking disengagement) that the therapist must address carefully.

One difficulty with Klein’s theory is that due to its concern with the first 6 months it doesn’t fit with suggestions that societal persecution can lead to paranoid delusions. It could be argued that if the mother or caregiver is persecuted then this may be projected onto the baby. However, this would also imply that individuals from oppressed groups make worse parents. Whilst it could be argued that poverty may reduce parental resources, without firm evidence the implication should be perceived as potentially oppressive in itself. Essentially, Klein’s theories are difficult to place alongside some of the findings relating to diversity. At the very least they seem to ignore factors on the societal level. It also may not fit, even after adaptation, to more non-traditional family structures.

Is integrative therapy an option in the NHS?
An issue with relying on one particular model when working with this client group is that therapists throughout the assessment process may assume needs based on their own experience rather than those of the client (Zapparoli & Gislon, 1999). Also, more than one therapeutic model may be beneficial. In the case of a man diagnosed with paranoid personality disorder, firstly a cognitive perspective was used to work with the client’s distrustful world view as it was causing severe difficulties in the therapeutic relationship. When these beliefs had been challenged enough for him to feel more comfortable, psychoanalytical therapy commenced to explore his fear of attachment and dependence, his denial of these needs and his defensive betrayal of others. The authors report the technique was successful.

Whilst this approach may have “covered all bases” it has the problem of being lengthy, and thus not cost effective compared to shorter approaches. The CT stage lasted 20 sessions alone! Within the resource-stretched NHS there is a focus on offering the shortest treatments necessary. Unless this approach provides significant and frequent gains, it is unlikely to be accepted as an NHS treatment option.
In a resource-tight NHS, managers and other team members may not look upon such a long therapeutic process favourably. Whilst the biopsychosocial model was hoped to reduce inter-disciplinary fighting, many believe views remain polarised, particularly regarding medication, and the biological section carries much more weight in mental health settings (e.g. Margison, 2005). I have recognised this culture before when working on mental health wards, where either psychological therapy was not even considered for clients with paranoid thoughts or limited to illness awareness, social skills or drug education work. Whilst a growing number of services see psychological therapies as an essential part of care, for those who are still a little sceptical, CBT may be more appropriate, especially since its recommendation over other forms of therapy (apart from family therapy) in the NICE guidelines for Schizophrenia (2002). However, CBT does not suit everyone. Perhaps in some cases, illness awareness and more psycho-educational models are the most appropriate for the particular client. The endorsement of CBT through NICE guidelines may well be pushing clinicians into the same trap as Zapparoli and Gislon warn against. Therefore a balance perhaps needs to be met with evolving styles of cognitive therapy. Person-based Cognitive Therapy, or PBCT (Chadwick, 2006) for example incorporates the concepts of metacognition and mindfulness to help apply cognitive theory to a currently difficult-to-treat disease.

One such balance might be to ensure therapies are decided on a case by case formulation rather than general guidelines. Formulation, an essential part of all therapeutic work, not only highlights the relationship between problems but can help choose whether treatment is individual or should involve significant others, what intervention might be most appropriate, can pinpoint areas which may be beneficial to focus on outside therapy, and considers next steps if initial therapy is unsuccessful (Morrison et al, 2004).

Conclusion
As in all areas of mental health, tensions are evident; tensions between the academics and clinicians who construct the models and between what an individual may ideally require, and services’ needs for short, cost effective treatments. Despite some of these divergences there are similarities equally of note. To me, it is apparent that the different models all have the idea that persecutory thoughts can be defensive in some way, albeit to different degrees. There remains much difference between conceptualising low self-esteem as a small aspect of the overall framework and as conceptualising it as the main thrust behind it, especially in
regards to therapeutic applications. Whilst I do not think there is sufficient evidence at this stage to disregard or fully endorse any of the models discussed (although the conflicting evidence for Bentall and colleagues' theory is an important consideration), if a therapist searches for deeply hidden and defended-against fundamental beliefs in a case where they are few or unimportant, they risk not focusing adequately on the more overt thought processes. Likewise if these fundamental beliefs are not looked for in therapy, they may be missed. As suggested by Zapparoli and Gislon, perhaps therapists need to approach each client individually, with no clear initial framework in mind, especially as there is no consensus as to which model is correct. However, this may be more a luxury of the clinician with more experience and confidence in their intuition. It may also be not possible in a service where CBT is increasingly seen as the only therapeutic framework worth implementing. However, techniques are not necessarily exclusive to own models. Techniques focusing on safety behaviours could be used in conjunction with thought chaining specifically designed to uncover hidden beliefs about the self. Finally, in regards to therapeutic implications, there is also a theme across the different models that the therapeutic relationship can be particularly fragile, and this links back to the title question of how therapists can work with fearful clients who find it difficult to trust. One theme is that the delusion should not be challenged head on until a secure therapeutic relationship is formed. In contexts where resources are limited and there is a pressure to offer as few sessions as necessary, the temptation to skip to the therapy before the therapeutic relationship is solid must not be given into.
REFERENCES


"What are some of the strengths and weaknesses of multidisciplinary teams from the perspectives of staff and service users? How can you as a psychologist contribute to teams functioning optimally?"

Professional Issues Essay

January 2008
Year 2
The use of multidisciplinary teams (MDTs) in public care services has been recommended by the government for several years. Fundamentally, they are groups of professionals from different disciplines who work together and share their specialist knowledge to provide a coordinated service for their client group, although their precise composition and working methods can differ. MDTs teams are recommended in a number of spheres which psychologists work within, including mental health (DOH, 1989), learning disabilities (DOH, 2001), and child and adolescent services (DES, 2003). However, a criticism is that government support of such teams is based more on rhetoric than peer reviewed evidence, and that the benefits are overemphasised (Zwarenstein & Reeves, 2000). After examining the rationale of MDTs, this essay will review some of the benefits and disadvantages of MDT work from the perspectives of staff members and clients. Due to a limited amount of literature specific to settings in which Clinical Psychologists commonly work, research within the wider field of health has been included in the essay. The essay will then explore how a psychologist may act within teams to help them function at their best. In addition to the literature, I will be reflecting on my personal clinical experience throughout the essay.

MDT working occurs on many levels, from a service planning/commissioning/purchasing level, to teams of front-line clinicians meeting regularly and offering a coordinated service (Sloper, 2004). Due to the word limit of this essay and to allow a more full exploration of the level of MDT working most relevant to my experiences at this stage of my career, this essay will focus on “front-line” multidisciplinary and multi-agency teams that provide care through direct client contact, unless otherwise stated. The terms multidisciplinary and multi-agency are used interchangeably by many clinicians and researchers, although they can also represent different things (Sloper, 2004; Mental Health Commission, 2006). Therefore there may be some diversity in the precise structure and working methods of the teams discussed.

**Theory and rationale for the multidisciplinary team**

The idea of the MDT gained recognition in the 1970s/1980s, as the importance of a holistic perspective of clients was recognised. In 1984, the Department of Health document “Planning for the Future” recommended the use of MDTs to offer fully comprehensive treatment to those experiencing mental illness (DOH, 1984, cited in Mental Health Commission, 2006). The basic principle of MDTs is that individual clinicians are unable to offer such a comprehensive approach, as there is a limit to
their skills and knowledge. However, professionals in an MDT can work together to offer a fuller intervention. In mental health, MDTs are seen as increasingly important since the move to community services led to clients being recognised as psychological and social beings, rather than passive recipients of medical/psychiatric care. Whilst the composition of MDTs can vary, in order to work effectively, teams must

"...have shared goals and values, need to understand and respect the competencies of other team members, need to learn from other disciplines and respect their different views and perspectives. Individual team members may need to reassess exclusive claims to specialist knowledge and authority in order to form effective multidisciplinary teams which can provide the best possible care to the individual service user." (Mental Health Commission, 2006, p. 11).

Sharing information amongst professionals is also described as an important feature of MDT work. Whilst this may be beneficial for clients in numerous services, in the case of child services it is perceived as essential for reasons of child protection (DES, 2003). Unless information is shared between professionals, services may fail to discover a child is at risk of serious harm. In adult services, information sharing may be important in assessing other risk issues e.g. suicide risk.

The advantages and disadvantages of multidisciplinary teams for staff
The Mental Health Commission suggests MDTs benefit staff in the following ways: They provide peer support, particularly in distressing circumstances e.g. client suicide, and ensure the biopsychosocial model is adhered to and that all professionals utilise their specialist skills and knowledge. They are also forums for sharing clinical information, discussing clinical work for multidisciplinary peer review, and enabling skill sharing, collective responsibility and decision making, and coordination. This supposedly leads to increased job satisfaction and more cost-effective services (Mental Health Commission, 2006). Some MDTs are able to work in this optimal way. MDTs have been reported to reduce stress amongst staff and increase satisfaction and motivation (Sloper, 2004). Abbott and colleagues (2005) reported improvements in communication and understanding about other team members’ roles, leading to opportunities for professional development and a reduction in "blame culture". Different professionals benefited from debating issues that affect them all (e.g. confidentiality) leading to greater consistency across the
team, and even from a subtle peer pressure to complete tasks they had offered to do. A study examining multi-agency working across public services supporting people with learning disabilities at the management/partnership level noted that they worked together more effectively, with greater coordination and improved use of resources, improved governance, less duplication, shared knowledge and greater respect between professionals (McConkey, 2005).

Watson (1990) wrote about her experiences as a Clinical Psychologist in a multidisciplinary CMHT. In her experience, there were several advantages, which can be summarised as those that improved interdisciplinary communication and those that facilitated learning. Alongside better general communication regarding client work, there was increased information on re-referrals to supplement case notes. The team was a forum for learning from colleagues (including from their mistakes), modelling "helpful" behaviours such as curiosity and positive regard, and potentially offering constructive criticism for more "unhelpful" behaviours, such as negativity. The MDT also facilitated staff communication regarding what specific interventions professionals could offer, and recruitment for group work. Watson described an increased understanding of the roles and limits of team members, an increased opportunity for professional joint working and a positive environment that helped staff develop their clinical skills.

However, such positive staff accounts of MDT working are balanced by less positive accounts, suggesting the strength of an MDT is dependant on the specific team. When team members' individual professional commitments contradict those of other team members, or when team members feel isolated from their own discipline, then this can impact on effective team functioning (Madge and Khair, 2000). In addition, teams can foster elitism and complacency, potentially deskilling colleagues whose reliance on the team hinders their own professional development. Whilst a theoretical advantage of an MDT is that there are different professional perspectives to draw upon, sometimes perspectives are incompatible with each other (McCourt, 2002). A resultant high level of conflict can disadvantage teams.

Conflict within MDTs is not necessarily negative; when perceived as non-threatening it can promote new ideas and act as a motivator, or offer an alternative viewpoint to prevent a team becoming too entrenched in one model (Rowe, 1996; Gelsthorpe, 1999). However, if individuals within the team give conflict a negative, personalised meaning, then it damages intra-team relationships and hinders team
working. This would imply that the way conflict is perceived within a team determines how comfortable staff members feel within it, and how well they work together. In my experience of working in an MDT characterised by negatively interpreted conflict, staff felt unhappy about coming into work and this may have been responsible for a high sickness rate. Staff felt they should take “sides”, often influenced by their profession, i.e. allied health professions versus nursing versus medical. On one occasion when a team member had criticised me heavily, their “opposition” quickly tried to recruit a fellow ally. Some staff felt too intimidated to speak their opinion, whilst others became defensively entrenched in their opinion. This was certainly not an MDT team that benefited staff.

Conversely, some literature suggests that due to a perception that a team should present a united front, staff feel they have to comply with a team viewpoint. Whilst presenting a “united front” in MDTs has been perceived positively (Abbott et al, 2005), in a study looking at a unidisciplinary community nursing team, staff reported feeling pressured to conform with their colleagues’ opinions rather than offer alternatives (Griffiths & Luker, 1994). If this happens in unidisciplinary teams, it is possible that it occurs in MDTs, and I have witnessed accusations of “team splitting” because a staff member offered an alternative viewpoint directly to a client. Pressure to comply may be a particular problem when one professional viewpoint has precedence, i.e. the medical model, and when there is a perception that some professionals have greater status and power. Medically dominated teams can be difficult places for non-medical staff to work, as they can be discounted and discredited (Johnstone, 1993/1997) and devalue their own roles, leading to passivity in team discussions (Gair & Hartery, 2001). Such professional or model dominance is opposed to the theoretical ethos of the MDT. Whilst medical staff often chair meetings and take a dominant role, this is not always by force, but due to other professionals deferring to the medical model (Gair & Hartery, 2001, Atwal & Caldwell, 2005). Atwal and Caldwell found a gender effect; male nurses felt more able to express their opinions to doctors than female nurses, and the one female medical consultant in the study contributed less than her male counterparts. It also noted that the majority of those in therapist or nursing roles were female, and the majority of medical staff were male. Whilst the study did not examine other facets of diversity, such as race or class, it could be hypothesised that at a subconscious level, when a team member belongs to a traditionally dominant or oppressed group this may interact with perceptions of power and status within professional roles. This is important to consider, as in my experience of working in NHS trusts in London
there are often class, gender and race trends across certain professions, e.g. psychologists and therapists have tended to be white, and nursing staff black. This may be more damaging when one professional opinion has precedence.

Factors hailed as positive by some teams are found to be lacking in others. Improved communication might only occur when MDTs are able to meet regularly, not when members rely on clinical notes or messages between professionals (Caldwell & Atwal, 2003). Even in MDTs that reported good interprofessional communication, duplication, too many meetings and bureaucracy were reported as problematic (Abbott et al, 2005). The same study noted that it is often expected that specific MDT tasks are added to existing workloads due to a lack of protected MDT specific space. Whilst the staff interviewed in this study felt that their workloads had not increased significantly, there remains a risk of this happening.

Blurred boundaries and roles are frequently commented on in MDTs. As there is greater potential for skill sharing in mental health than physical health (Winton & Robinson, 2005), this is particularly pertinent in teams psychologists may work in. Brown and colleagues (2000) reported that workers in three multidisciplinary CMHTs described blurring as both progressive and leading to an amalgamated approach to clinical thinking, and as a problematic intrusion into each professional’s identity. One interviewee described taking on another discipline’s work as “meddling”. In teams where staff remained uncertain about their roles, this lead to uncertainty about where their responsibilities lay, and confusion about who they should contact if they felt their workload was excessive. It was beyond the remit of the study to explore why workers viewed it in such different ways. One might hypothesise that role blurring is perceived more favourably in teams where staff are able to practice their specialist skills in addition to generic tasks, and are not fearful of their specialist remit being removed.

It would appear that the impact of MDT working on staff is dependant on the particular MDT. This is explicit in Molyneux’s (2001) account of her MDT, where staff members gave positive accounts of their experience, but also stated how dissimilar it was to other MDTs they had worked in, which they perceived more negatively. Staff members felt confident in their own roles and thus were not threatened by other professionals, and all staff prioritised weekly case conference meetings (unlike their prior experience of meetings). Notwithstanding that this qualitative project was conducted by a staff member of the same team (which may
have lead to staff offering biased accounts) the evidence reviewed in this section would suggest that when MDTs work well, they can be very positive experiences for staff. However, this state of affairs certainly does not apply to all, therefore despite the claims of the Mental Health Commission (2006), MDTs do not always lead to a happier and more effective staff group.

The advantages and disadvantages of multidisciplinary teams for clients

Reviewing findings from the 1990s, the Mental Health Commission (2006) claimed that multidisciplinary mental health teams reduce bed use, increase contact with services after discharge, and are viewed positively by clients. However, whilst I was not able to access all the literature cited in the report, two papers I accessed did not appear to focus on MDTs specifically or had flaws – one compared an MDT community service with an inpatient service (an unfair comparison), and the other focused predominantly on case management (Dean et al., 1993; Ford et al., 1995). Therefore these cited findings should be viewed with some caution.

In services for disabled children, parents prefer collaborative inter-professional working providing it is effective and sufficiently coordinated by a consistent staff member of the MDT or an external party. In one service, the MDT helped parents feel valued as equal partners in care planning for their children (Carter et al., 2007). Not all MDTs use a care coordinator model, and as MDTs can have many professionals involved, clients and carers may be intimidated or confused by contact from multiple professionals if there is no coordinator. MDT working should enable salient client information to be shared, leading to comprehensive understanding of the client by professionals, which in child services is vital to child protection (DES, 2003). However, a disadvantage of this is its impact on confidentiality. In some child services there is reluctance to share information due to such concerns e.g. social services not having access to health databases (Frost & Robinson, 2007). Looked-after children report confidentiality to be important and reassuring, and have criticised professionals for sharing all the information obtained in an interaction by recording it in shared notes (Munro, 2001). In my current child and adolescent placement in a social services setting, psychology notes are kept separate for this reason, although basic overviews and any information regarding child protection issues are shared with the MDT. Information sharing and confidentiality can both have a positive impact on client care, but they are most useful when they are balanced. A potential problem to this approach is that whilst legislation can make recommendations about what the confidentiality balance should be, final decisions
will lie with staff members who may have conflicting opinions on the matter, leading to inconsistency from the client perspective.

For clinical diagnosis and outcomes, there is some evidence to suggest that MDTs may improve services for clients. MDTs have been more able to make differential diagnoses in dementia than unidisciplinary teams (Wolfs et al., 2006). Borrill and colleagues’ review of 400 MDT primary care teams suggested that they lead to increased access to services for clients and improved outcomes for intervention and follow-ups (Borrill et al., 2002, cited in Sloper, 2004). A review paper by Simmonds and colleagues (2001) summarised that clients of multidisciplinary CMHTs were less dissatisfied with treatment, spent less time in hospital, were less likely to drop-out of treatment and were less likely to commit suicide or die in suspicious circumstances, compared to those in standard services. However, this review only examined five studies, and the authors noted that care should be taken when generalising the results as the teams evaluated had a level of enthusiasm that might not be characteristic of teams in general.

As clients with schizophrenia have been reported to prefer holistic treatment that does not predominantly focus on a medical model, MDTs have the potential to offer such a service (Winton & Robinson, 2001). In theory, MDTs enable differing professional viewpoints about a client’s treatment to be voiced, so that important decisions do not lie with one professional. Gair and Hartery (2001) found that in two MDTs with responsibility for discharging older adult clients from hospital, over a third of discharges proposed by medical staff were disagreed with, and sometimes this disagreement lead to the client remaining in hospital for their safety. This shows how a wider perspective may lead to otherwise overlooked issues being highlighted and acted upon, in the client’s best interests. However, whilst it is positive that professionals are able to challenge a fellow professional when they think it is in the best interest of the client, a downside to too many conflicting views might be that fewer decisions are made on behalf of the client, leading to care stagnating through indecision.

The prior section concluded that an MDT is only as effective as its team dynamics. When teams experience communication difficulties as a result of team conflict, this can negatively influence the quality of communication - both between professionals regarding the client, and to the client (Caldwell & Atwal, 2003). In addition, when teams are dominated by the medical model, the social and functional needs of
clients may be overlooked in preference to their medical needs (Atwal & Caldwell, 2005). Client needs may also be overlooked for staff convenience. In a study examining a unidisciplinary nursing team, nurses appeared to prioritise relationships with their colleagues at the expense of what might be best for the client. This was manifested by staff members following a care plan even if they had strong reservations about it, not offering a second opinion through fear of undermining their colleagues, and not making commitments on behalf of colleagues (Griffiths and Luker, 1994). Whilst this research is not directly about MDTs, it could be hypothesised that when MDTs are not characterised by high levels of conflict and professionals wish to maintain good relationships with colleagues, then similar processes may occur. Furthermore, when professionals have less knowledge about the remits of their colleagues' professional work, this may magnify these issues. In my experience, the MDTs that have worked well with each other have communicated more effectively with clients, and clients have appeared to be more engaged. When teams I have worked in have not worked well together, at its worst it seemed as though the client's care took second place to personal issues between clinicians.

As noted previously, there are different models of MDT working. A client-centred, collaborative multidisciplinary service in Sweden for adults with psychosis has a philosophy of "horizontal expertise", proposing that all involved - multidisciplinary professionals, clients and families - have equally valid knowledge and opinions. Clients and families can take an active role in care planning, and is reported to foster trust, honesty, client satisfaction and participation (Piippo & Aaltonen, 2004). Clients reported strong benefits to this particular MDT approach. The inclusion of the client's social network enabled treatment to be more integrated and reflective of the client's perspective, increasing professional understanding of their situation. Clients felt more comfortable when making contributions, and the meeting process was described as more beneficial than when they met with only one professional at a time. Clients also noted that they found it helpful to hear different points of view within the meeting (contradicting the beliefs held by nurses in Griffiths and Luker's study that clients preferred a united front), and the process felt more collaborative. This suggests that some models of multidisciplinary working can have clear benefits for clients; however, the service is rather unique and probably expensive, and therefore cannot suggest that MDTs in general will benefit their client groups.
There is some evidence to suggest that MDTs are beneficial for their clients. However, the effectiveness of MDTs remains dependent on how strong team dynamics are. As previously stated, many MDTs function in far from ideal conditions. Therefore in many cases, the advantages of MDTs for clients may not be evident in practice. Evidence that MDTs lead to better client outcome remains limited, and in Sloper's review paper (2004), the author remarks that many of the studies have methodological difficulties, and often attempt to gain insight into a client perspective through interviewing staff members. It is noteworthy that literature on the impact of MDTs on clients seems more limited than literature on the impact on staff, particularly as MDTs are recommended so frequently in government policy for the benefit of clients. Whilst there appears to be more evidence suggesting MDTs benefit clients rather than disadvantaging them, this may possibly be due to researcher/publisher bias. It may be unlikely that a quantitative study directly examining the potential negative outcomes of MDTs would receive funding or that a service evaluation would wish to take such a stance. Likewise, quantitative studies that fail to find significant results may be less likely to be published in peer reviewed journals (Rosenthal, 1979). Therefore this may make it difficult to fully explore whether MDTs can have a negative impact on clients.

What can a Clinical Psychologist do to foster effective multidisciplinary work?
The prior two sections suggested that MDTs can sometimes have difficulties functioning smoothly, which can impact negatively on client care. However, when MDTs function well, there are positive outcomes for clients and staff. Therefore if teams can run effectively there is less chance of the disadvantages of MDT teamwork outweighing the advantages. Alongside their fellow professionals, Clinical Psychologists should use their specialist expertise to help the team run as optimally as possible.

To lessen some potential disadvantages of MDTs (e.g. predominance of the medical model), New Ways of Working (NWW) (DOH, 2007) proposed changes to MDT structure and functioning. It proposes that rather than one profession within the team taking a leadership role, different professions should take the lead in specific areas dependant on their expertise, and how that fits with the expertise of the team. So a Clinical Psychologist may take a leading position in the realm of psychological therapies, but not necessarily if another team member has greater expertise in that area. Increasingly, other professionals within the mental health MDT practice Cognitive Behavioural Therapy (CBT), therefore competence in
psychological therapies may be a shared multidisciplinary skill in some teams (Winton & Robinson, 2005). In one MDT I have worked in, a Community Psychiatric Nurse was trained in CBT techniques and the Specialist Registrar had a psychotherapy qualification. The Clinical Psychologist in this team primarily used CBT, so theoretically the psychologist could provide consultation and CBT for more complex cases, the CPN could provide CBT for less complex cases and the Senior Registrar could offer psychotherapeutic work and consultation subject to their level of qualification. If a team uses such a model effectively it may maximise staff expertise and encourage staff members to develop skills that they would have previously considered to be outside their remit. This may lead to increased staff satisfaction. However, it may also lead to confusion and, in teams where there is already a high degree of negative conflict, competition and rivalry.

It has been recommended that clients should have more access to evidence-based psychological therapies (Layard, 2005). However, since Agenda for Change (DOH, 2004), Clinical Psychology is perceived as a relatively expensive resource compared to other professions, and if other professionals have psychological therapy skills, psychology may be seen as too expensive to offer therapy in less complex cases. This has lead to assertions that Clinical Psychologists should take more consultative and supervisory roles in regards to psychological therapies (BPS, 2007). However, whilst this is a tenable way of working for experienced Clinical Psychologists, I wonder what difficulties may be raised for newly qualified psychologists consulting to experienced individuals from other professions, who may not have more experience of psychology, but may have many more years experience of working with clients. Such a situation may lead to interpersonal difficulties such as resentment and awkwardness. In addition, good supervision is dependant on reflecting on rich personal experience. Whilst a newly qualified Clinical Psychologist would have a minimum of three years experience, expecting them to take a supervisory role soon after qualification may place them in a difficult position.

The British Psychological Society’s document on New Ways of Working has this to say on the subject of a psychologist’s role in an MDT.

“Psychologists have important roles to play in achieving improved outcomes from teamworking. These include helping to achieve optimal team design and
operation, effective involvement of users and carers, teaching, training,
research evaluation and development" (BPS, 2007, p21)

To achieve this, a need to be innovative in working methods to meet team
challenges is stressed, and increased integration within the team is recommended,
with the proviso that psychologists should be able to maintain their individual
professional identity. Previously, many Clinical Psychologists have been more
removed from the inner core of the MDT than other professions (Gelsthorpe, 1999)
so for some teams, this may be a very different form of working that might take
some adjusting to.

NWW (BPS, 2007) also asserts that teams need to assess themselves as to how
they meet the requirements of their clients and carers, and that psychologists are
useful in this process. A psychologist's ability to frame things in a systemic way and
to impart those ideas can be useful in helping a team greater understand a client in
a way less potentially challenging to alternative professional clinical models (Vetere,
2007). Systemic ideas may help explore how a client's social network influences
their perception of services, as well exploring how the team's own interactions
impact upon the client. Vetere describes how from a systemic point of view, a team
might recognise how they play out roles with the client and influence them e.g. in
recreating destructive interpersonal patterns in the client’s life, by contributing to the
client feeling persecuted by services (leading to their own withdrawing) and buck
passing. Such an understanding may enable a team to engage best with their
clients and to prevent prior mistakes being remade. Clinical Psychologists can take
this expertise further by using systemic ideas to explore team dynamics when there
is a high level of conflict between staff, or other difficulties. A systemic approach to
understanding team processes is valuable when changes are made within the team
to improve outcomes, and a Clinical Psychologist with an understanding of systemic
issues may be particularly suited to take the role of exploring this (BPS, 2007). A
systemic approach would see interpersonal difficulties within the MDT as a result of
the particular systems in place in that team - and the external and internals
influences on staff members - rather than a sign that an MDT will never work in that
particular setting, or with those particular staff members. Of course, in an
environment where professionals are already unnerved by change, voicing these
systematic observations may not be an easy task, and psychologists should be
mindful that such a process may stir anxieties and defensive feelings in other
professionals.
More traditionally, a Clinical Psychologist’s role is to impart a psychological viewpoint as an alternative to other models - if they dominate the team - and to help form a biopsychosocial model (Gelsthorpe, 1999). Whatever ideas a psychologist is imparting, a distinction can be drawn between the interaction within the team being facilitative (i.e. encouraging and fostering psychological thinking in other team members) and consultative (offering a psychological opinion more directly) (McCourt, 2002). Both are useful depending on the details of the situation, e.g. how the team functions, and the subject to be explored. However, it is important to consider the possible negative implications of both. McCourt suggests that a risk of consultation work is that consulters can feel self-important. Following this, care must be taken to not appear self-important to other team members, as this may lead to resentment, and resultant difficulties in team functioning. A facilitative role may be easier in some teams than others, and might work best in teams with a positive attitude to psychology and confidence in using psychological ideas. However, in teams that normally have a limited explicit psychological repertoire, more subtle facilitative techniques might be more powerful than direct consultation. This is because ideas could originate from psychologically sceptical team members giving them ownership, rather than from a psychologist who could be accused of enforcing their views on other team members. In my experience, psychological ideas are alluded to by non-psychology professionals in teams, but are not always seen as being psychological ideas. A facilitative approach might work well in such a team.

Conclusions
In summary, despite the good intentions behind MDTs, when they are put into practice they do not always reflect the ideal. This leads to MDTs being difficult places to work in for staff, which may impact on clients. Proponents for MDTs may suggest that it is not the idea of the MDT that is flawed, but how they are practiced in the real world. My response is that this would be acceptable if MDTs were confined to the world of ideas, but as they are designed to be practical clinical applications, their potential flaws need to be recognised within policy. There also needs to be more research directly looking at client’s views and qualitative experiences of MDTs, which may highlight both advantages and disadvantages for clients. NWW does appear to be a response to some of the difficulties that hinder MDTs from working optimally, but as with any new initiative, it may make staff workers worried, which may impact on its effectiveness. However, there are several roles that a Clinical Psychologist could take within a team to aid its functioning, both
in regards to clinical work and exploring team dynamics. Systemic ideas are likely to be prominent. Finally, a Clinical Psychologist must also consider how best to impart their specialist expertise in their specific setting.
REFERENCES


"The relationship to change."

Problem Based Learning Reflective Account

March 2007
Year 1
Group processes
At the end of my first day of training I found myself in a room with strangers, a title, vague instructions and a huge uncertainty of where things were to lead. The facilitator appeared to be the only one with a clear idea of how things were going to progress, and confusion and awkwardness abounded. Certainly we attempted to turn to our facilitator in this first session (much more than in later sessions) for direction, for guidance and for security. This is probably not dissimilar to a client attending therapy for the first time, particularly groups; the uncertainty of “how is this to progress?” “What is expected of me?” and “what do I expect?” It’s a disconcerting position to be in, and an important one to place oneself in, as an aid to empathy in clinical settings. This was a quick lesson on the importance of transparency in therapy and why it is important to articulate its predicted structure. The more that was explained about PBL, the more comfortable things felt.

Our sole instructions were our title “The Relationship to Change”, a limited amount of information on Problem Based Learning, and the instruction to assign certain roles in our group (chair and scribe). I offered to be scribe as I had a laptop (making note dissemination easier). In retrospect it may have been because it gave some clarity of purpose, and when this is lacking it is tempting to grab any idea of purpose to hand. Again, this is important to keep mindful of in therapy when you’re explaining models and clients are potentially eager to please, and want to feel they know what is going on.

The group therapy comparison continued after we had grappled with the question and decided to see what could be generated from our own personal experience. How much of myself did I want to give? Would it match what the others wrote? Would I disclose too much or too little of myself? Would I look like an idiot? It’s one thing talking about yourself in front of strangers, it’s another doing so in a group you’ll have regular contact with for a long time. For me this was particularly relevant as my immediate response was to explore my own personal and psychological growth in the face of prior emotional problems. Whether this is right or wrong, I have the perception that to open up to prior emotional difficulties in such a setting, particularly at such an early stage, would make me look like a neurotic trying to deal with their own pain by becoming the healer of pain. Therefore there was a desire to come across as myself, but also not to expose myself too much and lead to a negative impression of me being formed. And this wasn’t therapy, just a task orientated group! This initial reluctance to open up struck me as important to remain
mindful of in future clinical work. This actually marked the beginnings of conflict – as some accounts had more “personal” reflections one group member commented that they felt quite exposed relative to the others.

This conflict continued with debates on whether people do change as entities or just develop. There was also lesser conflict over the need for a more formal structure and how much we should worry about the ever-decreasing time to the deadline. Despite this conflict some people were able to draw parallels between other people's accounts and their own experience, despite the fact that they were very different. This shows how selective people’s memories can be, also a sign of the originality all group members bring to the process. But by end it felt a bit like people were grasping for straws. Whilst one group member came up with an articulate paragraph that was seized, generally everything seemed utterly fragmented and frustrating at this point, with no sense of cohesiveness. The desire to have structure and a plan was striking.

Then came resolution along with a bombshell. Two significant events occurred – a group member left, and a feasible idea was generated. I am uncertain to whether they were connected, but it is possible that the shock of the former made us more willing to seize the latter. The group dynamics started to work better at this stage – conflict lessened, and an attitude of purpose and confidence characterised us. I feel the surprise of losing a group member made people want to pull together. From then on the group moved forwards into working with each other with mutual delegation, enthusiasm, and praise for each other’s contributions.

In retrospect, the stages our group went through reflect an observed series of group dynamics referred to as “forming, storming, norming and performing” (Tuckman, 1965). Forming, characterised by the construction of groups and tentative exploration of group boundaries, was reflected in our case by dilemmas referring to how much personal information to give, attempted dependence on the facilitator, and by our attempts to create structure. The storming stage was the most obvious stage, characterised not only by arguments over content but also organisational issues (such as what time the group should meet). Its resolution by two coinciding incidents complicates the interpretation of what pushed the group into the norming stage (where the group becomes coherent in its working together towards its goals). However, whilst this made it a more comfortable group to work in, comfort can lead to stagnation (as referred to in Tuckman's work), or at least lack of challenge. When
there are 6 people who are entirely for an idea, who is there to spot the potential flaws, both before and after the performance stage? As explained in the second section, perhaps our joy of finding an idea prevented us from exploring our chosen model further, leading to us using an older version. If there had been more debate at this point, this may not have happened.

**Presentation content**

The core idea of the presentation was to present the five stages of change (precontemplation, contemplation, action, maintenance and relapse) according to the Transtheoretical Model of Behaviour Change (Prochaska & DiClemente, 1983), but also to model how not to be a therapist in a humorous way, by way of a spoof of a television programme. I wonder if group members wanted to add a humorous edge to the presentation whilst they could, aware that training would get harder and may not offer such opportunities for creativity again. The presentation could even be seen as reflective of trainees' own process of change – of starting a demanding endeavour and perhaps another stage of life or adulthood, and thus desiring to exploit light heartedness whilst still possible. However, a point made by humour is not necessarily any less important and incisive. After all, effectively applied humour in therapy is thought to increase client self-understanding and reduce fears, and act as a protection against burn out for therapists themselves (Franzini, 2001). Satire is an extremely powerful way of making incisive points through humour, and whilst our presentation was hardly Jonathan Swift, I feel the use of the “therapists” had greater impact than if we had employed a straight therapeutic model.

One of our debates was whether to just have one psychological theory as part of our presentation, or a few. The decision to only have only one was made in order to not confuse an audience by being overly complicated. Looking back, I wonder whether it was left too simple, too blunt, and not nuanced enough. Sometimes complexity is not needed to make an important point. However, I wonder whether it would have had more depth by having a more complex theoretical grounding. It can be a difficult balance to obtain in a time-limited presentation. As mentioned before I have the perception that once an idea had been generated it was seized – perhaps this limited other possible avenues we could have explored. However, regardless of whether more theoretical grounding might have added something, I think our presentation worked. The idea of keeping things simple is something which we have also been told numerous times to take into the therapy room and one which through
my clinical practice I am beginning to observe. Don’t introduce too many concepts at once as there is often little to be gained.

Our therapists (based on TV’s Trinny and Susanna of “What not to Wear”) were scripted on the principles of how a therapist should not act. They possessed no empathy or listening skills. Their questions were closed or leading in the extreme, and they passed personal judgement on the client. They remained stuck in their own perspective/agenda and were unable to see that of others, making them dismissive of the client’s desires. In fact there was absolutely no attempt to enter the client’s world and work with it. Whilst it was a caricature it contained important lessons. The leading questions highlighted very visually for me quite how annoying, confusing, manipulating and potentially demoralising they can be. Their client became more withdrawn and alienated as the “therapy” continued.

Trinny and Susanna also demonstrated what happens when the “therapists” bring too much of themselves into the therapy process, leading to them making assumptions regarding what should happen and where the client should end up. This is pertinent as it is possibly something we have a greater chance of slipping into. It’s potentially the easiest thing in the world to look at someone and make your own value judgements about what might be beneficial to change in that person’s life. This can come from issues relating to diversity and what one culture or person considers important. Whilst considering this, we should not assume that diversity is not an issue when clients “match” us in certain areas (e.g. race, gender, sexuality, disability status). To use systemic terminology, just because two individuals look similar on paper does not mean that their family scripts are the same. Part of the problem our “therapists” found was that their priorities did not match the client’s. However, value judgements regarding priorities also can come from us being in a different position to the client due to our training and knowledge of models, and conversely our comparative ignorance of that client’s life. When faced with various different areas of distress or co-morbid diagnoses it can be quite tempting to tackle either everything that could be defined as a problem, or what your formulation identifies as a central factor. However, the client may expressly state they wish to go no-where near this. This last part provides more of a dilemma as if the client strongly avoids something entirely central to the overall problem, perhaps it would be equally unethical to not even mention your perception of its importance, to see if the client might reconsider examining the issue. However, such decisions must be
made on a case by case basis, and at the end of the day, the decision of what to work on should be the client's.

When researching the Transtheoretical model we found various different versions. Later versions have no relapse stage and a determination stage (Prochaska et al, 1992). By using the older version of the model our presentation used out of date information, which is an important criticism. In hindsight this is something I would have changed. However, in my observations of this model being used by other professionals, the stages considered most noteworthy were precontemplation, contemplation, action and maintenance, and our presentation described all four. As a learning experience for our colleagues, it at least offered an introduction to some of the main ideas of the model.

Finally, perhaps things could have been improved upon, but then things can always be better, and indeed, perfectionism has been indicated as bad for one's mental health! (Dunkley et al, 2006). Overall I think our presentation and our experience as a group was both meaningful and enjoyable. A good starting point for three further years of clinical training, I think.
REFERENCES


"The Stride family: Issues relating to learning disabilities, parenting and professional intervention."

Problem Based Learning Reflective Account

March 2008
Year 2
When reflecting on how we responded to this Problem Based Learning (PBL) task, it seems appropriate to compare it with last year’s. Then, my group were virtual strangers, tentatively picking our way around a task defined only by a title. The initial meetings were characterised by uncertainty, frustration and some conflict. One year later, the atmosphere was strikingly different, showing greater cohesiveness, confidence (within ourselves and with each other), and the ability to sit comfortably with the uncertainty that characterises the beginning of a loosely defined task. Perhaps it was our year of clinical experience and teaching, the fact this was our third PBL task, or that the task was a clear vignette rather than just a title, but we felt like a team of professionals working together on a clinical task rather than a group of strangers scrambling for ideas. This felt like a stronger, more secure starting position.

That is not to say there was no indecision or initial difficulties. We started with an outline of the Stride family; a couple with learning disabilities (LD) with twin 3-year-old girls, who were on the Child Protection Register under the categories of Emotional Abuse and Neglect. There were several obvious starting points for discussion in the vignette. One was the domestic violence between Mr and Mrs Stride, and the reflection that the male relationships in Mrs Stride’s life (partners, family and professionals) appeared to be characterised by absence, power or bullying. Another was whether certain parents may find themselves more likely to be in the spotlight of social services than others. Whilst the idea of people with LD raising children has become more acceptable to professionals and public in recent years, there remains a perception that they simply cannot parent without professional intervention (May & Simpson, 2003). However, the Strides had difficulties that might benefit from intervention, and this led to discussion about what was a sufficient level of parenting: Could the Strides reach these standards with sufficient professional assistance? In what ways might their current level of assistance be inadequate? e.g. their family support worker had no training in working with people with LD. However, we found it difficult to feel connected with the vignette, or the task of making the problem into a presentation, because the outline seemed dry and impersonal.

This disconnection inspired our first task. We each selected a member of the Stride family and wrote a personal account of their perspective; Mr and Mrs Stride, their daughters, and each paternal grandparent. It became apparent that to create a rich personal account, we would have to creatively expand upon the information
included in the vignette - particularly in the case of the grandparents (about whom little was written). As Trainee Clinical Psychologists we realise it is important to make as few assumptions as possible - in both tasks using clinical vignettes and in our clinical practice - so as to not misrepresent or misunderstand somebody's experience. Therefore, it felt uncomfortable to work against that principle, and we could be criticised for doing so. However, our method can be justified as whilst we were writing these accounts we aimed not to be professionals assuming what a client might be feeling. For the exercise we were the clients and their family, trying to make their position our own, and writing how we'd imagine the situation to be. None of us had been in a similar situation, so it was a creative exercise rather than a factual account; as childless people without LD our accounts were limited by our very different experiences, and thus based on a combination of clinical knowledge and imagination. However, forming hypotheses about a person's situation by placing yourself within that role is subtly different from making assumptions about a person's experiences, as long as it is remembered that hypotheses remain just hypotheses. Also, trying to empathise and hypothesise how a client feels is a necessary part of clinical work when considering what intervention might work well for them, and how they might be feeling as the recipient of services. However, our hypotheses must remain tenuous, and we must remain aware of how people's diverse experiences will add dimensions that we can easily risk overlooking by assuming that our own experiences are universal.

The task's outcome was to make the Strides feel more like living, 3-D people. It focused our attention on the family as individuals and highlighted that when personal accounts are added to descriptive clinical information, the perspective of clinicians discussing the case can be changed, i.e. by increasing personal empathy. We therefore formed an idea of staging a professionals' meeting where professionals discussed the family in very detached tones, before contrasting this with a highly personal account from the Strides addressing fear, loss and how they could only try as hard as they could with the resources at their disposal. Its aim was to bring the Strides' humanity into a discussion that they were removed from.

Our next task was to decide which professionals should be present at the meeting and what they should say. We did not have sufficient group members to include everyone in the professional network, and our exclusions were influenced by whom we considered most essential in the Strides' care. Our Chair was to be the Clinical Psychologist in the role of Expert Witness responsible for completing a risk
assessment. Other professionals we decided to include were the Social Worker, the LD Psychologist, the Health Visitor, the Child and Adolescent Mental Health Team (CAMHS) worker, and Mrs Stride’s Community Psychiatric Nurse. We excluded the Foster Parents and the Guardian, which on reflection may have made the discussion group too focused on paid professionals. However, as our primary message was to show how professionals can forget the personal when they are making such decisions, this was justifiable. We wanted to highlight areas where multi-agency coordination does not run smoothly, in addition to the problem of clients slipping in between services due to gaps in service criteria. Therefore, we wanted to show professionals disagreeing along professional lines leading to conflict and indecision, services passing the buck to one another, and the problems that occur when allocated caseworkers could not attend meetings and instead send poorly informed colleagues. These are things that we all reported as having experienced in our professional lives so far, and we felt them important to communicate; given that the professionals were so strongly scrutinising the Strides, it was only fair that the professionals should be scrutinised in our presentation too!

As for deciding what position our selected professionals would each take, this was when our group had our most poignant learning experience. Our aim was to address some of the more pertinent issues we had already discussed in our group by the professional characters debating the best course of action. Thus we would be able to show arguments both for and against removing the children and placing them into care, with one professional discussing the negative effects of domestic violence on children (e.g. difficulties in emotional competence and adjustment, Katz et al, 2007), and another pointing to evidence and government policy stating that children should remain in the family home whenever possible due to the potential negative outcomes of care (DES, 2006). Our original characters were created from our preconceptions of each professional stance, therefore the Social Worker was orientated towards preventing the worst case scenario, the LD Psychologist was progressive in their approach, the Health Visitor was kindly but a bit “mumsy” etc. It was not until we had created our professionals’ viewpoints and characters that we realised we had stereotyped our depictions, and that the most positive, progressive characters were the two psychologist roles. This discovery was quite a revelation to us, and we spent time discussion it’s implications regarding how we perceive other professionals and how they perceive us. Why did we show such positive bias towards the psychologist roles and more negative, stereotyped depictions of the others? How would we as Clinical Psychologists have been presented by another
group of professionals? Would we have been characterised as stuck up, well paid and with a tendency to refuse primary case responsibility? Does this mean that we will always feel distanced from other professionals compared to other psychologists, and view ourselves more positively compared to other professionals (and them to us)? Turner and colleagues' Social Identity Theory (1979) would suggest so. It states that group members gain self-esteem from viewing their group positively, by looking for discrepancies/differences that show their group in a positive light compared to alternative groups around them. This leads to biased perceptions and evaluations of other groups, and thus biased behaviour. The discussion helped us reconsider the characters we had subconsciously stereotyped, as well as times when similar group processes may have led us to form similar views of other professionals. As a result, we decided to be much less stereotypical in our portrayal of different professionals, and valued the discussion as a learning experience that will remain with us in our professional futures.

Our final presentation had the following structure; a 10 minute professionals meeting speaking about the family in detached tones, a 5 minute video of the Strides giving their personal option, and then 5 minutes for professionals to change their opinions as a result of the personal insight being injected into proceedings. After the presentation we discovered that an Expert Witness would not hold such a professionals meeting and would instead meet professionals individually, but as the meeting was more a forum for discussing which issues we considered pertinent than an accurate representation of what exactly might happen, I feel artistic licence is justified. To highlight the difference a personal perspective can (and should) make, our Social Worker changed his recommendation that the children should not be removed from the parents, due to becoming aware of their frustration at being offered services they could not use, their underlying motivation (which was previously overlooked), and of the ethical implications of negative personal judgement by professionals, not just as parents but as people. In clinical work I have witnessed how parents can be ignored as people and just seen as deficient parents, and when professionals are ultimately focused on the good of the children, this perhaps is an easy oversight to make. I hope that our presentation highlighted the problems this causes and the potential limits it places on interventions and outcomes. Of course, this is not to say that in all child protection cases such a personal look at the parent's world would lead to a similar change of opinion – child protection ultimately places the child's needs first, and sometimes it is the right
decision to remove them. One criticism of our presentation is that it may have downplayed this.

When we started the PBL exercise we felt distanced from the family, and thus the exercise. However, as the process continued and our presentation started taking shape, so did our impression of the Stride family. Once the video had been recorded, they almost felt a part of our group. From the feedback at the presentation, I hope that our audience also shared this impression of the family. My own personal learning highlight will remain the discovery of how easily we caricaturised our fellow professionals in the multidisciplinary team. Whether it was the task that squeezed our preconceptions into the roles we produced, or whether it was reflective of our own subconscious prejudices is uncertain, but it highlighted to me why the role of the reflective practitioner is so essential; not just in terms of how we reflect on our own individual practice, but how we interact with our fellow workers. Likewise, perhaps mental health workers as a whole should be aware of how these group processes may contribute to workers and clients being differentiated as two very different groups, and create the sense of extreme difference between the two groups whilst ignoring areas of similarity.
REFERENCES


“Older Adult PBL exercise – the case of Mr Nikolas.”

Problem Based Learning Reflective Account

February 2009
Year 3
Task outline
For my final Problem Based Learning (PBL) exercise, my group was comprised half of members belonging to my case discussion group (trainees in my year who I had regularly met with over the course of training) and half members of the year below. We were given an outline of the difficulties of Mr Nikolas; a gentleman aged 69 years old experiencing possible memory problems. This outline included information from his family and new partner. His eldest son believed his new partner was exploiting him financially, his ex-wife had become involved with his finances, and the new partner wanted to spend her life with Mr Nikolas whilst retaining some independence. Our task was to work together to explore the issues raised, and address these in a group presentation.

Group experience and progression
The group was constructed from people I knew well and those I did not. I initially wondered if this would divide the group. In my experience, when faced with new challenges, people form alliances with those that they know or perceive they have something in common with. In my clinical experience, some multidisciplinary teams with difficult dynamics have split along lines of profession, or between older and newer staff. As this is an uncomfortable and damaging dynamic, I was keen for this not to occur. Thankfully, I sensed that my group members felt similarly. Two factors that protected us from forming two groups within the larger one were thus; having one relatively clear task (despite initial uncertainty on how to proceed) and sharing a professional identity. A minimal divide occurred. For example when we had to write two scripts, each year group wrote one between them. However, this was for practical reasons such as scheduling meetings around timetables.

During our initial meeting I was aware that my year had completed three prior PBL tasks and the year below had only completed two. My confidence has grown considerably during training, both clinically and academically, and taking a leadership role in initial discussions was something that I felt confident to do. As we had no formal facilitators, if I could use my extra year of experience to help facilitate the group, this could be positive.

However, I did not want to be too dominant in the group along with my third year peers. Members of a group perceived to have a dominant role run the risk of taking over proceedings (Marchington, 1994, cited in Hartley, 1997). Whilst us third years were not dominant in an explicit hierarchy, our extra experience and confidence at
PBL exercises may have placed us in a position where we could have easily taken a
dominant role. I felt this happened during the initial meeting; having clearer ideas of
what we would like to examine was a consequence of greater confidence. Our first
homework task (to write personal accounts for the main characters in the case
scenario) was suggested by the third years, after the success of doing this in a prior
PBL task. However, in sessions afterwards, this dominance disappeared. It was a
second year that thought of the main idea that we worked on, and contributions from
group members were approximately equal. Any subsequent dominance in
discussions related to personality rather than academic year. Also, the second
years may have also had the potential to dominate due to their larger numbers (we
numbered three, whilst they numbered four).

Initially I felt our group took a relaxed pace. We discussed the case without making
clear decisions for the first two meetings, which were scheduled relatively far apart.
Whilst I had confidence from prior PBL presentations that we would complete the
task on time, I was somewhat anxious before the third session as to when we would
decide upon an idea to work on. However, unlike my last PBL exercise there was a
new group to adapt to, which takes time. In his equilibrium model, Bales (Bales &
Strodbeck, 1951) suggests groups go through three stages; orientation, evaluation
and control. He also states that group discussion alternates between instrumental
(task-focused) and expressive (interpersonal needs focused) talk. Whilst the three
stages are linear, instrumental and expressive discussion continues in varying
proportions throughout the process to maintain balance. The group was new, so as
we defined and explored the task (orientation), we also used communication to
facilitate social bonds. This may have slowed the process somewhat. We then
discussed what points we wanted to address in our presentation; i.e. what values
we shared (evaluation), a process that involved expressive as well as instrumental
discussion, as our values are personal. Finally, our conversations became more
instrumental as we worked on precise solutions (control), although expressive
conversation remained important when allocating tasks. Whilst we broadly moved
through these three stages in order, the theory misses an important fourth stage –
reflection. At our conclusion we reflected both on the group approach to the task
and our individual responses to it. Also the stages did not seem as linear, as
discussions in the evaluation and control stage could lead us back to the orientation
stage to outline the task in a slightly different way, and our personal values were
important from the beginning.
Decisions and political and social issues

We started discussing the scenario as a case discussion, noting what was missing and forming hypotheses based on available information. In earlier PBL tasks I found it uncomfortable to hypothesise formulations if there was missing information, due to fear of making assumptions. This time I felt more comfortable making tentative hypotheses, albeit remembering to change these in light of new evidence. This may reflect increasing clinical ability to create initial formulations based on limited information. This can be necessary if initial assessments are subject to time constraints or if information from other informants is limited. Whilst it remains important not to make assumptions, keeping a variety of theories in one's head can be helpful, as long as one remains vigilant to information supporting or contradicting them.

As this first session progressed we talked less about Mr Nikolas and more about his systemic network, particularly things that seemed odd to us, like his ex-wife's control of his finances. We also discussed his son's (Alexander's) behaviour. It seemed Alexander was not just concerned for his father, being motivated by resentment towards the new partner. The group formed negative feelings towards Alexander. Issues about possible family gender scripts were discussed, and we reflected on the absence of certain family members' opinions, wondering about what stories there may be outside the case outline. With hindsight, we spent much of this initial session talking about the other individuals in the system and little time discussing Mr Nikolas, our client!

By writing personal accounts for the main characters we helped bring each person in the system to life. This exercise highlighted the multiple perspectives involved; for example, Mrs Nikolas and his new partner had different perspectives on Mr Nikolas as a person. We realised this focus on multiple realities had been relatively absent from our initial discussion, as it can also often be missing from clinical case discussion in professional settings. These personal perspectives helped us to remain more open minded about what each person in the system felt. In professional life, this can be achieved by interviewing multiple members of the system when appropriate, and if not remaining mindful that there will be alternative outlooks.

1 Whilst assumptions should not be made in clinical work, we creatively expanded upon information in the scenario due to the academic nature of the exercise
Mr Nikolas' account caused us to shift our focus back towards his personal experience, and I felt particular sympathy for his situation. We reflected that there was something about the case – the predominance of Alexander’s perspective and the continued control of the ex-wife – which made it difficult for Mr Nikolas’ voice to be heard. We conceptualised this as part of the trend towards devaluation of older people in the UK. We felt that there was insufficient evidence in the scenario for a substantial memory problem, despite it being the assumption of many in the system. Whilst the risk of dementia increases after 65 years of age, between the ages of 65-69, the risk is small at 1.4% (Jorm et al., 1987). We wondered if this assumption of dementia and the removal of Mr Nikolas’ voice would occur if Mr Nikolas were younger. Due to medical and social beliefs surrounding aging, cognitive disabilities associated with dementia may be viewed as something occurring universally to older people and a reason to disregard their concerns (Stirling, 2004).

This was our inspiration for how to present the issues discussed, by creating two role-play scenarios. One would reflect the case scenario as it was written and the other with one main difference – the characters would be 20 years younger. We thus explored how Mr Nikolas’ own perspective was ignored, both by his family members and by professional services, in the older scenario but not the younger one. We also explored how Alexander’s personal reactions to seeing his father with another woman were ignored in the older scenario, but viewed as his main difficulty in the younger one (when Alexander was a young adult). The outcome in the younger scenarios was family therapy rather than cognitive assessment. We also examined the roles of the ex-wife and current partner in both scenarios, and the missing voices; not just Mr Nikolas’ but of absent members of the system.

**Unconscious processes, critique and lessons**

We only became aware of having initially ignored Mr Nikolas’s perspective in hindsight. As a trainee due to start my older adults placement, this is a salient warning of how this happens in services and families in real situations. It was concerning how easy it was to forget the central person in the scenario when the other voices were louder. This is why people who are relatively voiceless within society (including older adults, people with learning disabilities or people with chronic mental health difficulties) may have experiences of services that at best do not meet their needs, and at worse are abusive. As both a professional who wants to hear these voices, and as a feminist aware of how women suffered this same
difficulty until relatively recently (with some still suffering), it is alarming to lose curiosity in this way. However, we realised our mistake during our second meeting, and therefore focused on the issue of Mr Nikolas' lost voice in the presentation. I would imagine that no professional is ever free from this potential problem, but constant reflective practice is one way of protecting oneself from it.

Towards the end we became aware we had scapegoated Alexander as the bad person in this story. Within our group, some members had the experience of parents finding new partners in their adulthood, or family members dying of dementia. My own father died of dementia and my mother since settled with another partner, so this was especially pertinent for me. My own experience of accepting my mother's new partner as an adult was that whilst I had conflicted emotions and difficulties, I worked through these away from her, and was glad that she was happy. Other group members felt similarly. This may explain the reaction towards Alexander. It is common for group members to project hidden, unbearable feelings onto another member of the group, so as to disown them and retain intrapsychic and interpsychic balance (Gemmill, 1989). Whilst we did not do this to a group member, we did it to one of our characters. The parts of us that would feel/have felt angry, confused and betrayed by a parent taking a new partner (the parts we did not want) were projected onto Alexander. Again, it is disquieting that we were not aware of this until the end, when we reflected on the task. However, as above, being a reflective practitioner should help us increase awareness of when our own personal projections affect our clinical work. This was a powerful lesson about projection in small groups that will not be forgotten, with the advantage that it was not a real group member who suffered from being scapegoated.
REFERENCES


"Case Discussion Group Process Account Summary 1."

July 2007

Year 1
In the account, I described the usefulness of discussing cases in this format. Our group meetings were unstructured, with our group facilitator taking less of an organisational role than appeared to be the case in other groups. Group members appeared considerate of each other, and shared the space to discuss cases. The lack of structure created a light atmosphere, possibly assisting bonding, but sometimes time was managed poorly, and client discussions were not satisfactorily resolved.

I felt increasingly able to participate in the group as my clinical confidence and familiarity with group members increased. Initially I was reluctant to speak due to low confidence. I felt reassured when another group member admitted she too felt unconfident, and was pleasantly surprised when she described perceiving me as knowledgeable. The experience of starting such a novel task, with the perceived possibility of negative judgement from others, was compared to how our clients might feel when starting therapy.

Regarding my clinical development, the group assisted me in reconceptualising clients or issues, and widened my perspective on various professional issues. Discussions admittedly were not always helpful. However, mostly they were. I particularly valued a discussion on self-disclosure, given that I had different views to my then supervisor, and did not feel I could debate and develop my thoughts on this subject in supervision. The group was a perfect format to discuss it within, as varying peer opinions led to lively discussion where ideas could be explored.
"Case Discussion Group Process Account Summary 2."

July 2008

Year 2
I reflected upon the increasingly supportive role of our discussion group, and my increased ease within it. I felt this perception was shared, as group members appeared more willing to discuss various difficulties within the group, e.g. difficulties within placement settings. Occasionally group members discussed stress arising from course pressures. I presented a client who I perceived as being treated unjustly by external agencies, but with whom I had concerns regarding whether personal experiences were influencing my perspective. It felt validating when group members shared my concerns, and allowed an exploration of the emotions and issues raised.

On several occasions, my group considered why our social dynamic was conflict free. One suggestion was our relative stability of membership. However, because less stable group membership can encourage reflection on group dynamics, we, in our stability, may have not been so observant. I questioned the necessary existence of conflict stages in linear theories of group processes. Wheelan (1994) suggested that group members' initial dependence on more powerful group members lessens when mutual trust is acquired at later stages. This might have explained why certain group members were more vocal in the first year, whilst contributions were more equally balanced in the second year. However, Wheelan argued that conflict is required to enable group members to create shared goals, values and procedures. I observed that we completed this process, moving to a position of mutual trust and shared understanding, without conflict. This may be partly due to professional homogeneity.
CLINICAL DOSSIER
"Overview of placement experience."

July 2009

Years 1, 2 & 3.
Adult Mental Health Placement: Twickenham CMHT
During this initial, year long placement, I was primarily based within the multidisciplinary CMHT. Additionally, I worked one session a week in primary care at a GP's surgery during the first half of placement, and a session a week in an Eating Disorders Service during the second half. The primary model of therapy used in all three settings was CBT, with some psycho-educational work. At the Eating Disorder Service, I gained experience of motivational interviewing. I had contact with individuals from a range of cultural and class backgrounds, in addition to varying mental health issues. Therapeutically, I worked individually with individuals experiencing difficulties associated with depression, panic disorder and agoraphobia, body dysmorphic disorder, extreme low self-esteem and low moods, psychosis, eating disorder not otherwise specified, and assertiveness difficulties. I worked with an asylum seeker, which gave me some insight into certain immigration related experiences. In addition to clinical interview, in assessments I used standardised tests and semi-structured interviews. I completed two psychometric assessments. One used the WAIS-III, the WMS and a battery of executive functioning tests, to obtain baseline measurements for a woman considered at risk of dementia. I presented this assessment at a local psychology meeting. I helped organise and co-facilitated an open, discussion based Hearing Voices group, loosely based on the philosophies of the Hearing Voices Network. I completed a week long training course on family interventions for psychosis, and started co-facilitated work using this approach with a son and his mother. I also took part in a service audit of NICE guidelines, and presented findings back to the service.

Child and Adolescent Mental Health Placement: Sutton CAMHS and Joint Adolescent Service (JAS)
This six month long placement was divided between a multidisciplinary CAMHS service and a social services led agency, designed to intervene in families with teenage children at risk of systemic breakdown. At CAMHS, I worked with children aged between four and fifteen years old, for difficulties including sleep problems, separation anxiety and panic attacks, OCD and depression. Therapeutic models used were CBT, solution focused family therapy, and indirect behavioural interventions with family members. I also was jointly involved in an ASD and ADHD assessment with my supervisor, and a further ADHD assessment alone. For the purposes of assessment I used a variety of projective tests, child specific standardised measures and psychometric tests, in addition to observation and the gathering of information from various sources, including children, parents, teachers
and educational psychology. At JAS I worked more intensively for four to five months with two pre-adolescent girls in difficult home circumstances. These interventions were less structured, using projective techniques and drawing to facilitate emotional expression, in addition to counselling skills and systemic formulation. I regularly met with one of these girls in a school setting, and met with her and her mother at their home for a consultation session using solution focused family therapy. I attended CORE group and child protection meetings for both of these clients, increasing my experience of interagency working. I also gave a presentation and facilitated a discussion on self-harm at a parents’ support group via JAS.

Learning Disabilities Placement: Joint Croydon Learning Disability Team (JCLDT)
My learning disabilities placement was based within a multidisciplinary team of health and social services staff. During the six month placement I worked directly with clients with a range of intellectual abilities and indirectly with staff, at clients’ homes and outpatient settings. I often thought and worked creatively, being theoretically informed by systemic and behavioural theory, and when appropriate, literature relevant to the individual client’s difficulties (e.g. ASD or attachment literature). For one client I created my own assessment tools by making photo stories to discuss, which I used alongside established tests. I worked jointly with my supervisor to assess whether a referred individual met the service criteria for having a learning disability, and an ASD. Other assessment experiences included two dementia assessments and a challenging behaviour assessment, involving gathering information from residential staff via interview, semi-structured interview and formal measures, and client observation. One intervention, for complicated grief and adjustment difficulties, involved life story work directly with the client and indirect behavioural work with the client’s main carer. I also co-facilitated a women’s health and safety group with a specialist community nurse and a counselling psychologist, and attended a Safeguarding Adults meeting regarding another client.

Advanced Competencies Specialist Placement: Brief Psychodynamic Therapy at Kingston’s Psychological Therapies in Primary Care.
The setting for this six month placement was a primary care service offering a range of psychological therapies. During this placement I worked in the psychodynamic model only, for a maximum of fifteen sessions. I worked with adults of working age across a variety of cultural and class backgrounds. Whilst most clients had
difficulties broadly conceptualised as depression or anxiety, individual formulation, informed by psychodynamic theory, suggested a wide range of differing issues. This was a challenging placement, as it involved me working in a new model in which precise technique is difficult to outline, and thus is largely learned through experience. However, by the end of the placement I felt that my new skills were beginning to consolidate. Whilst on this placement I attended a conference on intensive short-term dynamic therapy, and subsequently presented this model to the service in a team meeting. Due to changes at the national and local level, the service had recently become a joint venture with a third sector service. Whilst I was on placement various procedural changes were piloted, e.g. telephone triaging, and the service received feedback regarding a bid for IAPT funds. This gave me insight into how services are affected by changing government policy, as well as issues surrounding the introduction of stepped care within an established service.

**Older Adults Placement: Richmond Older Adults CMHT and Barnes Hospital**

My final six month placement involved community and inpatient work. I co-facilitated an open psychology discussion group at an inpatient ward with two other trainee clinical psychologists. Through the CMHT I had direct contact with a variety of clients for assessment and treatment. Therapeutically I primarily used the CBT model, but also used solution focused therapy (both individually and as a couples intervention), grief counselling, and schema therapy. I worked for a session at week at a physical health rehabilitation service, where I offered briefer interventions. Referrals were primarily for low mood and anxiety, with underlying issues relating to loss of social roles and adjustment to disability. I used CBT and narrative therapy techniques, both integratively and separately, and additionally was theoretically informed by health psychology theories of chronic illness and disability. After individual CBT with one client, I worked directly with his wife and himself, integrating CBT and systemic techniques. I presented at the rehabilitation unit’s group for clients experiencing chronic airway obstruction. I also co-presented a talk on the role of clinical psychology in the NHS, career paths and formulation, to teenagers on a work experience week. I supervised an honorary assistant for CBT based work.

*At the time of writing this portfolio, the placement is still ongoing and further experiences will be updated.*
CASE REPORT SUMMARIES
“Psychometric assessment of a woman in her late 50s with recently emerging depressive episodes and a family history of dementia.”

Adult Mental Health / Psychometric Assessment Case Report Summary

May 2007

Year 1
Susan Johnson was referred for psychometric testing by the consultant psychiatrist of the CMHT, to help inform diagnosis and obtain baseline measurements of cognitive functioning. This followed an episode of severe depression and staff reports of physical rigidity, reduced arm swing, staring gaze and tremor. Susan's sister presented similarly before being diagnosed with frontotemporal dementia; her father and paternal aunt were also suspected to have had dementia. Susan had no history of depression until five years previously. She found school academically difficult, and left aged 15-years-old with no qualifications, subsequently working in jobs including domestic and care work. At assessment Susan reported her depression as having disappeared, and had a tremor.

The case report reviewed cognitive profiles for Alzheimer’s disease, frontotemporal dementia, dementia with Lewy bodies, Parkinson's disease and depression. Three general domains of functioning were assessed using the following tests; general intelligence (WAIS-III, and NART for estimated premorbid intelligence), memory (WMS) and executive functioning (Hayling and Brixton, Trail Making Test, and the FAS). Susan appeared motivated during testing but showed perseverance. Results suggested that Susan’s language functions and delayed recall remained at premorbid levels, but there were deficits in working memory, immediate recall, shifting cognitive set and response suppression. Susan's neuropsychological profile most matched frontotemporal dementia or dementia with Lewy bodies, although this was not exact. Susan was informed results were inconclusive, but dementia was a possibility. Recommendations included referral to neurology and further neuropsychological testing to assess change. Test choice and issues of informed consent were reflected upon.
"Cognitive behavioural therapy with a man in his mid-late 20s for body dysmorphic disorder."

Adult Mental Health Case Report Summary

July 2007
Year 1
Mark Withers was referred to psychology within the CMHT due to low mood and extreme distress regarding his appearance, diagnosed as dysmorphic disorder (BDD). During assessment, Mark described his father as belittling and later absent, but felt close to his mother and sister. Throughout his teens Mark experienced low mood, abused illegal drugs, and attempted suicide on three occasions. Subsequently he moved to Thailand, initially experiencing emotional stability, but increasingly becoming preoccupied with his appearance.

Measures assessing depression, anxiety and BDD related obsessions and compulsions were completed. Mark's difficulties were formulated using Phillip's (1996) CBT conceptualisation. Emotional abuse/neglect from his father, perfectionism and development of acne in Thailand were hypothesised as causal factors. Self-critical thoughts, checking behaviours, reassurance seeking, mirror gazing and mirror avoidance were conceptualised as maintaining factors. CBT was chosen as the literature base most supported this approach.

I offered Mark sixteen sessions, using the following techniques in order; response prevention, cognitive restructuring, behavioural experiments, and exposure. Mark's mood worsened during our first few sessions, so the initial focus was on risk management. During therapy Mark reduced checking, reassurance and avoidance behaviours, and acknowledged attractiveness was subjective and that his own appearance-based self-evaluations might be harsher than other people's. By session fourteen, Mark reported reduced preoccupation with his appearance, and whilst he still believed he was unattractive, the impact of this had reduced. All outcome measures indicated improvement. Areas not covered in the intervention, i.e. social anxiety and guilt, were reflected upon in the critique.
"Solution Focused Family Therapy with an 11-year-old boy for school refusal, separation anxiety and panic attacks."

Child and Adolescent Case Study Report

April 2008
Year 2
Simon Jones was referred to CAMHS for panic attacks, school refusal and separation anxiety. Simon had periodically experienced these difficulties previously, but they had intensified since moving to senior school. There were no evident risk issues. During assessment, projective assessments and network diagrams were completed by Simon, and information was gathered from Simon, his parents and his school. Simon's elder brother was killed in an accident, Simon only had one kidney, and his younger and older sisters had physical health difficulties and behavioural problems respectively. These experiences, along with family scripts regarding closeness in Simon's maternal family, were conceptualised as having understandably led to parental overprotectiveness. Problem-maintaining patterns were described within a systemic formulation.

Solution focused therapy was selected because numerous "exceptions" to the problem, which could be explored, were indicated. Family intervention was chosen due to its effectiveness for anxiety problems and ability to address systemic factors. Simon, his parents and his younger sister attended. Each had differing levels of engagement; Simon was the least engaged. Four sessions were offered, the first session using the miracle question. The family were increasingly able to recognise exceptions to problems, their own contributions to these, and possible solutions. Simon became more engaged, and started attending school regularly. All family members acknowledged Simon's achievements, and reported improved family interactions. As I had never used solution focused family therapy before, I reflected on challenges in learning a new approach, in addition to managing conflict and differing levels of engagement between family members within sessions.
"Rule formation with a man in his 50s with a learning disability and autistic spectrum disorder, for theft of bicycles."

Oral Presentation of Clinical Activity / Learning Disabilities Case Study Summary

September 2008
Year 2
Cyril Smith, a man with a diagnosis of learning disability and suspected autistic spectrum disorder (ASD), was re-referred to learning disability services by residential support staff, after incidents of Cyril taking bicycles not belonging to him. Staff previously assisted him in buying his own bicycles, but Cyril discarded these shortly afterwards. Resultantly, staff were reluctant for Cyril to purchase new bicycles. Previous obsessive interests were reported by staff and in Cyril’s Psychology file.

An early hypothesis was that Cyril could not imagine the impact of bicycle theft on owners, due to theory of mind difficulties. Individual assessment with Cyril used theory of mind tests and a photo story of bike theft to assess this hypothesis, which was supported. Cyril’s ASD related difficulties were incorporated into a behavioural formulation. Drawing upon ASD literature regarding difficulties in rule generalisation, the intervention aimed to teach Cyril specific rules, using repetition of picture stories, so he would only use his own bicycle and not discard it. Ongoing assessment suggested Cyril had little concept of ownership, so specific rules regarding ownership were included.

Cyril appeared to increasingly understand these specific rules. He retained his own bicycle for two months, and took no other bicycles during this time. Unfortunately, towards the end of the intervention a new issue arose; Cyril’s bicycle, and subsequently purchased bicycles, were taken from him. A referral was made to Safeguarding Adults, and residential staff were instructed to continue using the picture stories with Cyril to continue specific rule acquisition.
"Brief focused psychodynamic psychotherapy with a young man who hides his true self away from others."

Specialist Placement Case Report Summary

April 2009
Year 3
Benjamin McMillan, a 20-year-old white British homosexual student studying drama, was referred for therapy within primary care. He had a pattern of “destructive” relationships, a feeling he was not coping with life, difficulties relaxing and a history of alcohol abuse that had temporarily resurfaced. By the time of assessment matters had improved, but he still found life difficult and wished to explore issues.

During the assessment Benjamin spoke of being close with his mother to the exclusion of his father, until she sided with his father after discovering Benjamin’s sexuality. He was unpopular throughout childhood and adolescence but distained his peers. Historically he sought intense dyadic relationships in which he suppressed his own needs and self, resultantly being mistreated. I thought Benjamin had a degree of false self as well as a degree of narcissism. I also thought Benjamin used the defences of denial, reaction formation, rationalisation and intellectualisation. CBT was considered inappropriate because of the latter two defences; it would repeat his existing way of conceptualising life.

Benjamin was offered twelve sessions of brief focused psychodynamic psychotherapy. Within this we explored why Benjamin did not allow others to see aspects of his self (i.e. vulnerability and anger) and over time, he started showing these sides of himself to others. I conceptualised Benjamin’s desire for dyadic relationships as due to Oedipal dynamics, although Benjamin was uncertain. Benjamin attended eleven of the twelve sessions and reported finding life easier to cope with by the end. He improved on all outcome measures.
"Audit of Post Traumatic Stress Disorder service provision in adherence with NICE guidelines, in Community Mental Health Teams and a specialist service."

Service Related Research Project

September 2007
Year 1
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ACKNOWLEDGEMENTS

I wish to thank Sue Thorpe, Vicky Vidalaki and Jane Street for their supervision and support, and in the case of the latter two, their work helping organise the overall wider project. I also wish to thank Claire Alexander and all others involved in the organisation of the wider project. Finally I would like to thank the specialist PTSD service and the various CMHTs involved in the project for allowing their services to be audited.
ABSTRACT

**Background:** In 2005, the National Institute of Clinical Excellence (NICE) published guidelines for treatment of Post Traumatic Stress Disorder (PTSD), so services can offer standardised evidence-based care.

**Objectives:** To investigate adherence to NICE guidelines for PTSD within a specialist PTSD service and across Community Mental Health Teams (CMHTs), as part of a larger trust wide audit of NICE compliance.

**Participants and setting:** 20 service users from the specialist service, and 8 service users from CMHTs referred between January-December 2006 were included in the audit. The 8 CMHT service users came from 5 CMHTs.

**Measures:** A PTSD specific audit tool based on NICE guidelines was created by a clinical psychologist working within the specialist service. A generic audit tool was created by trust employees, and was further refined through pilot study and discussion with researchers.

**Procedure:** For each service user, the audit tool was completed via review of clinical notes and communication with service users' care-coordinators/therapists.

**Results:** The majority of service users from both types of service were offered trauma-focused CBT, access to an interpreter when appropriate, and were asked about time since trauma and severity/duration of symptoms, as consistent with NICE guidelines. Medication was commonly prescribed prior to trauma-based CBT being offered, and CMHTs provided service users with less written information on PTSD compared to the specialist service.

**Conclusions:** The services assessed are largely NICE adherent, although exceptions and implications for the service are discussed. Criticisms regarding assumed universal application of NICE guidelines for PTSD are noted.
INTRODUCTION

Post Traumatic Stress Disorder (PTSD) is a psychological condition arising after an individual having been subjected to trauma, features symptoms related to their traumatic experience. The DSM-IV and the ICD-10 stipulate that for diagnosis to be appropriate, individuals must have experienced a traumatic event characterised by a severe threat of physical harm and/or intense fear and vulnerability, and must repeatedly relive aspects of the experience. Avoidance is also commonly featured (although only essential for DSM-IV diagnosis) and the ICD-10 stipulates symptoms must occur within 6 months of the trauma. (American Psychiatric Association 2000; World Health Organisation, 1993). Typical traumatic events include violent crime, war, accidents, disasters and traumatic childbirth.

There appears to be limited information on prevalence rates in the UK. Most studies focus on specific populations (e.g. rape victims) rather than overall prevalence. In the USA, lifetime prevalence has been suggested to be 7.8% (Kessler et al, 1995). PTSD is more common in economically developing countries than developed countries, and is particularly common in refugees. Across a variety of Western and non Western world populations, women typically have higher rates of PTSD compared to men, although this is not always the case, particularly in military populations (Keane et al, 2006).

Clinical guidelines summarise the findings of evidence-based practice to advise health care professionals of which treatments are effective, in order to improve outcomes for clients (Gray, 2005). The National Institute of Clinical Excellence (NICE) guidelines for children and adults with PTSD were published in March 2005 (NICE, 2005) and offer treatment guidelines for primary care, generic mental health services and specialist services. In adults, “watchful waiting” is recommended for individuals with mild PTSD symptoms up to one month after the traumatic event with the exception of severe symptoms (although “severe” is not defined). 8-12 sessions of trauma-focused Cognitive Behavioural Therapy (CBT) or Eye Movement Desensitisation and Reprocessing (EMDR) should be offered to individuals who experienced their trauma more than 3 months ago. Trauma-focused CBT and EMDR have been suggested to have equal efficacy to each other (Seidler & Wagner, 2006). PTSD specific pharmacological treatment should not be prescribed before psychological therapy is offered as a treatment.
The guidelines note that many individuals residing in Britain with PTSD come from different cultural and ethnic backgrounds. They recommend that bilingual therapists and translators should be used when appropriate and cultural differences should be explored. This is important, as numerous difficulties have been highlighted in psychotherapeutic work for PTSD when the client is a refugee from a different cultural and linguistic background from their therapist and the country of residence. (Nicholl & Thompson, 2004).

To ensure guidelines are being met (and to highlight where they are not), clinical audit is an essential tool for ensuring quality in the NHS. An audit evaluates performance in comparison to set standards, with the aim of improving services where standards are not met (NICE, 2002). The audit cycle stipulates that once an area has been identified and standards set, data are collected and compared to standards, leading to the implementation of change. Repeated audits identify whether changes implemented are maintained.

The aims of this audit were to determine how fully a London NHS trust adhered to the 2005 NICE guidelines for PTSD, as part of a larger scale NICE audit. The specialist PTSD service audited is a psychotherapeutic service offering evidence-based interventions on an outpatient basis. Due to its status as an audit, the project did not require ethical approval.
METHOD

Setting and participants
The audit took place in a Mental Health NHS trust as part of a larger audit spanning 5 London boroughs. Community Mental Health Teams (CMHTs) and specialist care settings were audited. In total 11 CMHTs, 7 adult and child specialist services (including a PTSD service) and an unspecified number of child services were audited. The clients whose data was used in the audit were all referred to the service between January and December 2006.

For the purposes of this audit, data were collected on 20 clients from the specialist PTSD service, and 8 clients with a PTSD diagnosis from 5 CMHTs.

Measures
An audit tool was created by trust employees based on the relevant NICE guidelines. The audit tool for PTSD was created by a Clinical Psychologist working within the PTSD specialist service (see appendix A). A more generic audit tool was created by other trust employees (see appendix B). The generic audit tool was further developed after a pilot study and consultation with data collectors. Alternative audit tools were created for depression, obsessive-compulsive disorder (OCD), schizophrenia, bipolar and eating disorders (ED) using similar methodology.

Procedure
Several researchers were involved in the audit, each focusing on a specific NICE guideline. A pilot audit was completed by two of the audit leads and the results were used to refine the audit. Researchers audited two or three teams each.

For each CMHT, a list of 25 clients was made. Auditors collected data on 20 cases for each team (allowing for difficulty in gaining access to notes, etc.) using the relevant audit tool. The audit tool was completed through review of client notes and consultation with the clients’ key workers. In the case of the specialist service, there was also some consultation with the service lead regarding cases. The author collected data from one CMHT and the PTSD specialist service.
Using the generic audit tool, data were collected on:
- Diagnosis
- Gender
- Ethnicity
- Age
- Whether English was spoken as a first language
- Whether they were offered an interpreter
- Record of treatment in primary care
- Risk assessment
- Receipt of information about condition

Using the PTSD audit tool, data were collected on:
- Information gathered and disseminated at initial assessment
- Watchful waiting
- Psychological treatment
- Pharmacological treatment

Items on the PTSD audit tool and some items on the generic tool (i.e. English as first language/access to interpreters) were directly based on the PTSD specific NICE guidelines.

After data collection, auditors distributed data amongst themselves so each auditor collated the data relevant to their specific guideline. Data were inputted into SPSS and analysed using descriptive statistics. Chi-square analysis was considered unsuitable due to the small sample size, as category frequencies were often <5.

\[2\] The generic audit tool also included information on care plan status, contingency planning, receipt of vocational assessment/physical health checks/information on medication, and information regarding carers. Due to the report word limit, these variables were considered less relevant to the specific PTSD NICE guidelines and documented issues relating to PTSD care, and have been excluded from the analysis.

\[2\] The specialist audit tool contained items on effectiveness of medication (items 4.3-4.5). As the specialist service does not take responsibility for medication apart from in rare circumstances, the information was not available, therefore these variables were also not included in the analysis.
RESULTS

Overall the results suggest partial adherence to NICE guideline recommendations. The variables described in the method section were analysed descriptively and are presented using graphs with data labels (percentages). The number of cases described in each variable is stated in each title graph.

Initially demographic variables are described, before variables relating to assessment and treatment.

Demographic variables (gender, ethnicity, age)

![Graph showing percentage of clients by gender](image)

*Figure 1.1: Percentage of clients by gender (n=28)*
**Figure 1.2: Percentage of clients by ethnicity (n=28)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Mean age</th>
<th>Standard deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD service</td>
<td>37.9</td>
<td>12.3</td>
<td>22-62</td>
</tr>
<tr>
<td>CMHTs</td>
<td>37.88</td>
<td>13.72</td>
<td>22-59</td>
</tr>
</tbody>
</table>

*Figure 1.2: Mean age (n=28)*

**Interpreter requirements and access**

*Figure 2.1: Percentage of clients speaking English as a first language (n=28)*
All clients from the specialist service who spoke English as a foreign language were offered access to an interpreter (100%/n=10). All clients from CMHTs who were known to speak English as a foreign language (60%/n=3) were also offered access to an interpreter, as shown in figure 2.2.

![Graph showing access to interpreters](image)

*Figure 2.2: Percentage of clients not speaking English as a first language offered an interpreter (n=15)*

**Record of treatment in primary care**

Whilst 50% (n=4) of CMHT clients did have a record of primary care, only 20% (n=4) of those with the specialist service had such a record (see figure 3.1 below). Of the 80% in specialist services with no primary care record, 93.8% (n=15) had a record of secondary care, and 6.3% (n=1) had a record from another specialist service. Of the 37.5% of cases in CMHTs with no primary care record, 33.3% (n=1) had a record from another secondary service, although it was not known in 66.7% (n=2) of cases.
The majority of clients had an up-to-date risk assessment.

Figure 4.1: Percentage of clients with completed risk assessments (n=28)
Information received

Figure 5.1: Percentage of clients receiving information on condition (n=28)

Figure 5.2: Percentage of clients receiving written information on condition (n=28)
Information gathered at initial assessment

![Bar chart showing the percentage of clients asked about time since trauma, severity and duration of symptoms](image)

**Figure 6.1: Percentage of clients asked about time since trauma, severity and duration of symptoms (n=28)**

**Treatment**

All cases from the specialist service and 87.5% (n=7) from CMHTs were assessed more than 3 months after index trauma (the remaining case remains uncertain, although it is probable that they too were assessed more than three months after the trauma). Therefore items relating to watchful waiting have been excluded due to irrelevance.

The percentage of clients offered trauma-focused therapy is shown in figure 7.1. The majority of clients from both types of service were offered trauma-focused CBT. In the specialist service, the 10% (n=2) not offered trauma focused CBT were offered more generalised CBT to enhance coping skills, before commencing trauma-focused work. The remaining 5% was not offered trauma-focused CBT at the time of audit due to the client receiving an ongoing assessment arising from complexities in presentation and immigration status. The 12.5% (n=1) from CMHTs who were not offered CBT did not speak English as a first language. This may be why they did not receive therapy.
Figure 7.1: Percentage of clients offered trauma-focused therapy (n=28)

Figure 7.2: Service from which trauma-focused therapy was provided (n=24)

Of those not receiving medication in the PTSD service, all were all in receipt of medication for comorbid difficulties. This has not been included as a variable as it was only categorised as such by the researcher auditing the specialist service, and thus is not comparable with cases from CMHTs.
Figure 7.3: Percentage of clients offered medication (n=28)

Figure 7.4: Percentage of clients offered medication before trauma-focused therapy (n=13)
Figure 7.5: Service from which medication was offered (n=13)
DISCUSSION

The results indicate that both CMHT and specialist services are NICE compliant on most variables. The findings are discussed in detail below.

The vast majority of clients for both specialist services and CMHT were offered trauma-focused CBT, consistent with NICE guidelines. In the case of the specialist service, this is perhaps not surprising given its status as a psychotherapeutic service. The reason only one CMHT case was not offered therapy may have been their limited English. This is worth highlighting as it directly contradicts NICE guidance on service provision for those without English as a first language. Otherwise there was a very high rate of offering an interpreter (with the exception of a quarter of CMHT cases being unknown). As half of specialist and CMHT cases, and half of CMHT cases where language of origin was known to the auditors did not speak English as a first language, it is an important that interpreter services are being offered at this rate.

In the specialist service, two clients were offered generalised CBT to increase coping skills, as clinicians felt that starting with intensive trauma-focused work would be too destabilising to have therapeutic merit. This is non-compliant with NICE guidelines, which stipulate trauma-focused therapy as a front line treatment. However, as argued by Dorahy (2006), trauma-focused CBT/EMDR may be insufficient and/or inappropriate for complex cases, as NICE’s conclusions were drawn from a small number of short-term trials on clients experiencing single traumatic incidents. Therefore it is not certain how appropriate the guidelines are for those with more complex trauma histories. The majority of individuals in the specialist service share complex and long-standing trauma histories, often associated with political conflict, and many were also subject to stressors associated with immigration (e.g. economic and social isolation). Psychological intervention for PTSD with this client group should address issues arising from these other factors in a holistic fashion (Nicholl & Thompson, 2004). Whilst the NICE guidelines state individuals should not be refused access to treatment due to linguistic and cultural differences, there is no guidance for how refugees’ specific trauma experiences may need a more complex treatment package.

In the majority of cases, the index trauma(s) occurred before the NICE guidelines were written. This may explain why there were no details available on assessment
within one month of trauma. It may also explain why all clients with the specialist service in receipt of PTSD medication, and a third of clients with CMHTs, were offered medication before they were offered trauma-focused therapy. Whilst this would appear to be NICE non-compliant, it was rarely stated when individuals were first prescribed medication, which may have been pre-guidelines. Also, according to the service lead, the specialist service prescribes medication very rarely, thus medication had been prescribed by other services before the referral. Therefore, whether medication has been prescribed or not appears to have little to do with specialist service involvement.

The majority of clients with the specialist service were in receipt of medication for comorbid difficulties. The results not only indicate that it is common practice for clients to receive pharmacological treatment for comorbid disorders, but also that the group examined is highly complex, which may have an impact on other areas of care. Unfortunately, as this information was collected as an addition to the audit tool, there is no comparison data with the specialist service.

The majority of clients had completed risk assessments. As the risk of suicide for individuals with PTSD may be 6 times that of demographically matched controls (Kessler, 2000), it is an important that risk is attended to. However, whilst CMHTs used formal risk assessment tools, specialist services referred to risk as part of written reports. Whilst a higher proportion of clients were reported to have completed risk assessments with the specialist service than CMHTs, it is possible that references to risk in CMHT reports were not included as formal risk assessments, thus the two results may not be comparable.

Half of referrals to the CMHT had a record of treatment in primary care, compared to 20% of referrals to the specialist service. This is likely due to different pathways to care, as individuals are referred to the specialist service from other mental health services. As referrals had not come directly from primary care, then it is perhaps unrealistic to expect there to be a record from primary care. Incidentally, there was a record of care from the referring agency.

All clients with the specialist service received information on their condition; the service lead described this as an integral part of the service. In CMHTs only half definitely received information (unknown in 3 cases). This may be an expected
difference between specialist and generic services, as one would expect specialist services to have more access to such material.

A major limitation of the audit is that sample size was small, especially for the CMHT group. This was a result of there being few individuals with PTSD referred to the service within the time criteria specified. The small sample size meant that statistical testing using chi-square was not possible. It also means that generalisations across all CMHTs must be made with care, if at all. Increasing the inclusion criteria (i.e. the period of time in which eligible clients were referred to the service) may have partly counteracted this. However, as the guidelines were only introduced in March 2005, the earlier date of inclusion could not have been earlier than this.

It is questionable that the generic and PTSD specific audit tools were entirely suitable for auditing the specialist service, e.g. variables relating to the success of medication were excluded from this analysis due to an absence of information (due to the service being primarily psychotherapeutic), and a record of primary care was often only available if the referring CMHT included it. Also, whilst auditing the specialist service, the researcher created additional categories (e.g. medication prescribed for comorbid conditions). This made some direct comparisons with the CMHTs problematic, as data was collected by other researchers not using these extra categories.

Finally, in 5 specialist service cases, it was not possible to talk to the responsible therapist, therefore information on these cases has only been obtained by notes, and therefore are potentially incomplete.
IMPLICATIONS/RECOMMENDATIONS

Results will be disseminated to the NHS trust as part of a presentation of the wider project. This should enable trust-wide communication of which areas are NICE adherent or not. The trust may need to address further why medication is often prescribed before trauma-focused therapy is offered.

CMHTs should be encouraged to give written information about PTSD to clients and further exploration of this area is recommended, the outcome of which would have implications for future directions. If there is a lack of appropriate information, then responsibility may lie with higher management, with the impetus being to create and/or distribute relevant information. If such information is available, then interventions at CMHT level may be more appropriate.

However, it is important to retain discussion of whether the NICE guidelines are appropriate to every client referred to the service. Whilst guidelines try and ensure a standard level of care, criticisms of NICE do exist. If there is a chance that strict adherence to guidelines may have negative consequences (i.e. in offering trauma-focused therapy to an individual who first requires work on coping skills), then these issues should be noted.
REFERENCES


Appendix B: PTSD specific audit tool

Post Traumatic Stress Disorder (PTSD)
Management of PTSD in Adults

Date of Index Trauma (mm/yyyy).............

<table>
<thead>
<tr>
<th></th>
<th>Standard</th>
<th>Valid Exceptions</th>
<th>Met (Evidence in Case-notes)</th>
<th>Met (Following conversation with the care co-ordinator)</th>
<th>Not Met</th>
<th>N/A</th>
<th>Other Comments</th>
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<tbody>
<tr>
<td>1.0 Initial Assessment</td>
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<td>1.1.1 Time since index trauma</td>
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<td>1.1.2 Severity of PTSD Symptoms</td>
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<td>1.1.3 Duration of PTSD Symptoms</td>
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<tr>
<td>1.2 The initial assessment indicated that the service user was given written information about the symptoms, treatment and prognosis of PTSD, including the natural course of symptoms after trauma and the need for follow-up in the months immediately after a trauma.</td>
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<td>2.0 Follow-up (Watchful Waiting)</td>
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<td>2.1 Has the service user been assessed less than 3 months after the trauma?</td>
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<td>If 'yes' the service user was offered a follow-up appointment within 4 weeks (watchful waiting) as a way of managing their difficulties. Please note where this was offered</td>
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<td>The service user is unable to attend within 4 weeks due to personal or practical reasons.</td>
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<td>The follow-up appointment was in:</td>
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<td>□ Primary care</td>
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<tr>
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<td>4.2.1 Paroxetine or Metoxetine (general use)</td>
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<td>Standard</td>
<td>Valid Exceptions</td>
<td>Met (Evidenced in Case-notes)</td>
<td>Met (Following conversation with the care co-ordinator)</td>
<td>Not Met</td>
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| 4.3      | *Has the service user responded to the prescribed PTSD medication?*  
  4.4.1 If yes, the treatment has been or will be continued for 12 months  
  4.4.2 If no, another antidepressant has been prescribed or Olanzapine has been added | | | | | |
| 4.4      | *The choice of which medication to prescribe has been discussed with the service user.* | | | | | |
| 4.5      | *There is evidence that the service user has been counselled on discontinuation/withdrawal symptoms* | | | | | |
Appendix C: Generic audit tool

### NICE Baseline Clinical Audit Tool – Adult

**Clinical Audit Methodology**
- Request new referrals and re-referrals accepted for care between 1st January 2000 and the 31st January 2005.
- Select cases where the service user diagnosis is covered by the NICE guidelines and who have had at least two-three months care.
- Audit 20 cases per team (from a pool of 25) – Maximum 10 depression cases, Minimum 5 psychosis (Schizophrenia/Bipolar Disorder), Remaining 10 Eating Disorders, PTSD, OCD or additional schizophrenia/bipolar disorder. (Select the audit tool according to primary diagnosis. This should be recorded in the initial assessment letter or discharge summary).
- For each case complete the generic information pages as completely as possible.
- Initially collect the data from the service user’s case-notes. Where evidence is not located, seek evidence from the client’s care co-ordinator.
- Where there is ambiguity, make a written record of the information available in the notes for discussion.

<table>
<thead>
<tr>
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<td>CMHT/Team</td>
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<td>Gender:</td>
<td>Age:</td>
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<td>Ethnicity:</td>
<td>Referral Date:</td>
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<td>Service User details continued:</td>
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<td><strong>Is English their first language</strong></td>
<td>Yes</td>
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<tr>
<td><strong>Where appropriate, the service user has been offered access to an interpreter</strong></td>
<td>Met</td>
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<td><strong>There is a record of the treatment given in primary care</strong></td>
<td>Met</td>
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<td><strong>If met, record treatment received:</strong></td>
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<td><strong>Is there an identified carer?</strong></td>
<td>Yes</td>
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<tr>
<th>Met</th>
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<td>The service user has an up-to-date care plan</td>
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<td>Met</td>
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<td>The care plan includes an advance decision or contingency plan, detailing the service user's treatment choice in the event of an acute episode of illness?</td>
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<td>Met</td>
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<td>There is an up-to-date risk assessment</td>
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<td>Met</td>
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<td>Has the service user received: (Please tick)</td>
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<td>Occupational/vocational assessment</td>
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<td>Physical health checks</td>
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<td>Information about their current condition?</td>
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<td></td>
<td>Information about medication, how to take it, side effects?</td>
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<tr>
<td>Met</td>
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<tr>
<td>The carer has been offered an assessment of their needs</td>
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“Documented evidence of dissemination of findings to the service.”

Service Related Research Project

September 2007
Year 1
To whom it may concern;

Please accept this letter as verification that Martyn Bignold, Fay Coster, Gemma Ellis and Anna Preston, Trainee Clinical Psychologists, each presented their Service Related Research Projects on September 14th 2007. The CMHTs enjoyed the feedback and it sparked an interesting discussion around NICE guidelines and other related projects in the Trust. Their contribution both through the projects and their presentations, was very much appreciated.

Yours Sincerely

Jane Street
Consultant clinical psychologist
“Trainee psychologists' perceptions of spirituality and the integration of spirituality and therapy.”

Qualitative Research Project Abstract

May 2007
Year 1
ABSTRACT

Background: In recent years, literature regarding the integration of religion and spirituality into therapy has increased. However, spirituality is rarely addressed in therapy or therapist training programmes. When therapists do address spiritual issues within therapy, it appears to be driven by their own personal attitudes regarding spirituality.

Objectives: To explore how clinical and counselling psychology trainees view spirituality and therapy, their understanding of spirituality, and how they understand their own spiritual beliefs as influencing ideas of integration.

Method: Participants were recruited via an email, sent to first year clinical and counselling psychology trainees. Of the 15 respondents, 4 participants were purposively selected so as to represent a variety of spiritual attitudes (evangelical Christian, “spiritual”, Buddhist and atheist). Participants were then interviewed using a semi-structured interview. Interviews lasted approximately 20 minutes each. Data were analysed using interpretative phenomenological analysis.

Results: Participants perceived the term spiritual as having both positive and negative connotations. Despite differing personal beliefs, all participants felt it important to integrate client led spirituality into therapy as part of a commitment to valuing diversity, although those who were spiritual themselves believed this more strongly. Participants, however, were uncertain how to integrate spirituality into therapy.

Conclusions: The study suggests that trainees think an awareness of their clients’ spiritual beliefs is important, but do not feel that training focuses on helping them to integrate these. Recommendations as to how clinical and counselling psychology training can address this are suggested, including peer discussions.
"Reductions of Eating Disorder Symptoms during Pregnancy: An Interpretative Phenomenological Analysis."

Major Research Project

July 2009
Years 2 & 3
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ACKNOWLEDGEMENTS

I wish to thank Dr Laura Simonds and Dr Vicki Mountford for their greatly valued supervision and support. I also wish to thank South West London and St Georges NHS trust, Eating Disorder Service, and the Beating Eating Disorders charity, for allowing me to recruit through their organisations. Finally, I would like to thank my participants for taking part.
ABSTRACT

Background: Eating disorders predominantly occur in young women of childbearing age, some of who become pregnant. Previous research suggests many women with eating disorders experience reduced symptomatology during pregnancy. Various explanations have been proposed. However, variability remains within individual experience, unaccounted for by existing theory.

Objective: To explore the experiences of women with reduced eating disorder symptomatology in pregnancy and their explanations for this, within a broader context of identity and perceived relationships.

Method: Two participants with diagnoses of Eating Disorder Not Otherwise Specified (EDNOS) were recruited from a London NHS Trust Eating Disorder Service. A case study approach was used. Semi-structured interviews were analysed using Interpretative Phenomenological Analysis.

Results: A table of themes was created for each participant. One participant's account was characterised by the concept of respite (from expectations of slimness) throughout pregnancy and of increased interpersonal support, with eating concerns disappearing. Whilst the other participant referred to respite, more central to her account was perceived, self-motivated challenges to eating disordered behaviours, motivated by responsibility towards the foetus. Similarities and differences between accounts are examined.

Conclusions/implications: Results were discussed in relation to locus of control, reduced expectations during pregnancy, relational selves and social support. An integrated perception of the self as socially connected and as having positive personal attributes may be implicated in recovery. Further research on perceived control and relationship to the foetus is suggested. Clinically, suggestions are made regarding identity change and the role of social support outside therapy.
1. INTRODUCTION

This introduction will define and outline possible causes of eating disorders. It will then summarise literature relating to fertility, prevalence of pregnancy in women with eating disorders and obstetric complications, before exploring how pregnancy affects eating disorder symptomatology, and body image in women with and without eating disorders. Identity changes in pregnancy are explored before the research rationale is outlined.

1.1 Description of eating disorders

The Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV: APA, 1994) specifies three diagnoses of eating disorder; anorexia nervosa (AN), bulimia nervosa (BN) and eating disorder not otherwise specified (EDNOS).

1.1.1 Diagnosis

The DSM-IV (APA, 1994) stipulates the following diagnostic criteria for AN. Individuals must be extremely fearful of gaining weight, despite weighing less than 85% of expected weight for age and height. Perceived body shape/weight is distorted, low body weight is denied, or weight/shape is overly important in self-evaluation. Postmenarcheal women experience amenorrhea. There are two subtypes of AN: Binge-purge type features regular binges and self-induced vomiting or abuse of laxatives or diuretics, whilst restrictive type only features food restriction and not bingeing or purging.

For DSM-IV diagnosis of BN, individuals must engage in recurrent binge eating. A binge is an episode where much larger amounts of food are consumed than most would eat in comparable circumstances, accompanied by perceived loss of control. Individuals engage in compensatory behaviours, including self-induced vomiting, laxative, diuretic or other medication abuse, food restriction or excessive exercise. Symptoms must occur at minimum twice a week for 3 months or longer, and should not only occur within AN. BN is divided into purging and non-purging subtypes. Individuals with purging subtype regularly self-induce vomiting or use laxatives, diuretics and enemas, whilst individuals with non-purging subtype use alternative compensatory behaviours. Individuals usually weigh within normal range.

EDNOS is diagnosed if symptoms are of clinical significance, but criteria is not met for AN or BN. Individuals may almost meet criteria for AN or BN, have mixed
symptoms, or binge without purging (Binge Eating Disorder not yet being a diagnostic category, Fairburn & Bohn, 2004). It is suggested that despite symptom differences, all eating disorders feature over-preoccupation with shape and weight at their core, and should be conceptualised transdiagnostically (Fairburn et al, 2003). However, this conceptualisation is not universally shared. Birmingham and colleagues (2009) assert the three diagnoses do not meet rigorous criteria for common causality, and EDNOS is best conceptualised as a mixture of AN and BN.

**1.1.2 Prevalence**

Whilst eating disorders can affect anyone, most reported cases are young women (Royal College of Psychiatrists, 2000). For young women in Western countries, estimated prevalence of AN is 0.3%, the most at risk group aged 15-19 years old, and prevalence of BN is 1%, the most at risk group aged 20-24 years (Hoek & van Hoeken, 2003). This may be an underestimate as many people do not report to services, particularly those at subclinical levels. Community studies using questionnaires as initial screening often have poor response rates (Hoek & Hoeken, 2003). There are few prevalence studies for EDNOS, although approximately 60% of individuals in eating disorder services may be given this diagnosis (Fairburn & Bohn, 2004). In Portugal, a prevalence of 2.3% was found in a community sample of teenagers, accounting for 77.4% of girls with eating disorders (Machado et al, 2007). Eating disorders may affect 4% of women of childbearing age in a London community sample (King, 1989, cited in Turton et al, 1999).

In Europe, eating disorders are diagnosed more frequently in women than men (Hoek & van Hoeken, 2003). Incidence of AN in Europe increased until the 1970s, and then stabilised (Hoek & van Hoeken, 2003). BN diagnosis in primary care increased until the mid 1990s and then decreased, although this may represent GP awareness rather than true incidence (Currin et al, 2005). Eating disorders are more common in Western countries (Makino et al, 2004) and higher socioeconomic groups in the UK (McClelland & Crisp, 2000), although incidence in non-Western countries and lower socioeconomic groups is increasing (McClelland & Crisp, 2000; Makino et al, 2004).

**1.2 Causes of eating disorders**

Eating disorders appear complex and multi-factorial in aetiology and maintenance, and numerous theories have been proposed. Biological, psychological and socio-cultural models will be examined, before integration of models is considered.
1.2.1 Biological causes

Familial incidence of eating disorders is frequently observed, although the nature/nurture debate remains. Bulik and colleagues' (2000) review of twin studies suggests additive genetic factors, alongside unique environmental factors, are conducive to development of BN, with shared environmental factors being less significant than genetics. Due to fewer twin studies on AN, the authors’ conclusions are limited, although familiality is noted. Serotonin is implicated in eating disorders (Bailer et al, 2007), as well as personality traits such as perfectionism, a desire for order and sensitivity, described in part as genetic (Wade et al, 2008). However, if eating disorders are primarily genetic, this would not explain increased prevalence over the 20th century. Increased incidence in Western countries is also difficult to explain from biological perspectives, unless certain ethnic groups have higher genetic vulnerability. Suggestions that non-Caucasian ethnic groups exposed to Western values through immigration or Westernisation have increased prevalence of eating disorders, and “cultural clash” can increase vulnerability (Shuriquie, 1999; Nobakht and Dezhkam, 1999) contradict this.

1.2.2 Psychological models

1.2.2.1 Psychoanalytic

Bruch (1974) observed individuals with AN have overprotective or controlling mothers, and resultantly feel ineffective in taking control of their lives. They may lack identity or self-direction, and experience difficulties recognising somatic or emotional internal states. Resultantly, Bruch argues adolescent conflicts of increasing autonomy from parents are insurmountable in anorexic individuals, because they do not feel sufficiently autonomous to cope with independence. Food restriction provides required feelings of mastery and control. Approaching sexuality may be another conflict. Not eating may defend the self from being overwhelmed by the “other” (Morais, 2002). Clinton (2006) draws on object relations and mentalisation. Difficulties in regulating affect, stemming from insufficient affect mirroring from caregivers in infancy, lead to individuals feeling uncertain who or where their desires originate from, or mislabelling them. Individuals thus have difficulties in separation, focusing on the desires of others rather than their own, or difficulty in recognising their own desires/internal states, including differentiation of physiological desire from psychological. Therefore overcoming feelings of hunger through food restriction is used to control a painful psychological world. The psychodynamic theories reviewed do not address why eating disorders are more common in women. Neither do they
address environment outside the family, i.e. societal values, or explain greater prevalence in certain cultures and socioeconomic groups, However, Bruch (1974) notes dieting often precipitates AN and can be triggered by social pressure, suggesting some acknowledgment of wider social factors.

1.2.2.2 Cognitive behavioural
Cognitive behavioural models of eating disorders have evolved over time. Emphasis is primarily on maintenance, rather than aetiology. Early conceptualisations of BN (Fairburn & Garner, 1986; Fairburn et al, 1986) suggested shape, weight and eating become the primary ways of evaluating self-worth. Food restriction is used to slim. Bingeing, sometimes triggered biologically to rectify negative energy balance, is also caused when rigid dietary rules are broken. Feeling out of control, individuals temporarily and dramatically abolish restriction attempts. Purging and further food restriction attempt to compensate for binges, maintaining a cycle, whilst concerns regarding capability to control eating, weight and/or shape increase (Fairburn et al, 1986). Additionally, perfectionism, persistent low self-esteem, interpersonal difficulties and mood intolerance are implicated. The first three contribute to self-criticism and perceived failures in alternative areas, thus motivation to gain self-worth through food restriction increases. The latter allows strong emotions to be avoided, primarily via binging (Fairburn et al, 2003). Fairburn and colleagues (2003) propose BN has similar causal routes to AN and EDNOS, and note individuals often change diagnosis over time (e.g. AN to BN), therefore eating disorders are best viewed transdiagnostically. When applying their model to AN, starvation syndrome is suggested as maintaining, and binging and purging are removed as maintenance factors from AN restrictive type. The transdiagnostic model is criticised for not acknowledging unique pro-anorexia beliefs in AN (Schmidt & Treasure, 2006), and because eating disorders may not have common causes (Birmingham et al, 2009). Schmidt and Treasure (2006) primarily conceptualise AN as "motivated eating restraint" rather than over-concern with shape/weight/eating. Initially, restraint is interpersonally and intrapersonally reinforcing – individuals are praised for weight loss, and feel euphoric, successful and in control. As AN progresses, not eating becomes negatively reinforcing as eating physically feels unpleasant. Food rules are strongly adhered to as individuals with AN are frequently perfectionist, fearful of making mistakes and obsessive. Food becomes the primary focus due to starvation; similar preoccupations were observed in men on restricted diets (Keys et al, 1950; cited in Sassaroli et al, 2008). Subsequent emotional numbness is negatively reinforcing for individuals who tend to use avoidance, also
common in AN. Interpersonally, sympathy is positively reinforcing, whilst when frustrated loved ones react by criticising the individual with AN, the individual withdraws defensively into AN.

Cognitive behavioural therapy (CBT) has been rigorously evaluated and is the treatment of choice for BN (NICE, 2004); however, research regarding treatments for AN is relatively scarce, CBT being one of several suggested psychological interventions. Cognitive behavioural models refer to biological factors (starvation effects) and social factors (cultural attitudes to weight), although position problems within individuals rather than wider systems. Considering gender and cultural trends in eating disorders, cognitive behavioural theories may attend too little to wider social factors. CBT does not help all individuals in treatment; therefore consideration of wider factors may be beneficial. Also, by mainly being maintenance models, they could lack preventative ability.

1.2.2.3 Family/systemic
Systemic models suggest eating disorders are caused and maintained by interpersonal family dynamics, rather than cause being located within individuals. Structural interpretations (Minuchin et al, 1978) suggest anorexia occurs in a specific type of “psychosomatic family”, where enmeshment, overprotectiveness, rigidity and difficulties in conflict resolution are common. The overprotected child becomes highly focused on parental approval, feeling interpersonally ineffective in families where conflicts are not addressed. By not eating, the child communicates feelings they feel unable to communicate directly in the family. When anorectic symptoms emerge, families focus on this whilst other difficult family dynamics are continually avoided, thus providing reinforcement. Milan-Strategic explanations (Selvini-Palazzoli, 1978) suggest family members find personal responsibility difficult, thus blame-shifting is frequent, especially in parental dyads (as both parents perceive themselves as self-sacrificing). To hide inter-parental conflict from wider systems, parents recruit individuals within the family as allies, this often being the individual who develops AN. This places them in an ambiguous position of mediation. The self-sacrifice of not eating matches dynamics of perceived self-sacrifice within the family. Women with BN describe their parents as having more difficult martial relationships and relationship with themselves compared to controls (Dolan et al, 1990). Family therapy is frequently effective for adolescents with AN (Fishman, 2006). However, systemic theory continues to develop. Some family therapists, to avoid blaming discourses, are not concerned with aetiology, noting
cause is rarely evident. Instead they focus on maintenance factors, to help families identify more helpful solutions (Lackstrom & Woodside, 1998). Older theories of aetiology are criticised as potentially blaming, and inaccurate, as eating disorders themselves can cause family reorganisation, avoidance, rigidity, resentment and parental splitting (Whitney & Eisler, 2005). Also, the older theories describe nuclear families where parents are still a couple. Whilst they might describe common trends, they ignore those outside the described pattern.

1.2.3 Socio-cultural/feminist models

Whilst some other models acknowledge societal background as contributing to eating disorders, Bordo (2003) argues cultural factors are predominant in their cause, noting high prevalence in women, recent increases in prevalence and comparisons to Victorian concepts of hysteria as suggestive of this. Many "faulty" cognitions, perceptions and beliefs in AN or BN reasonably match societal perceptions of female body ideals, and biological necessities of weight restriction. Criticisms that socio-cultural models cannot explain why only some women develop eating disorders are based on assumptions that all women have identical socialisation experiences (Bordo, 2003). Orbach (1993) suggests AN is an extreme manifestation of the dilemmas most women face. Women experience alienation/emptiness and feelings that their needs and desires are wrong, caused by their positioning in society. Whilst thinness is culturally encouraged for women and is the claimed aim of the anorexic, anorexia's core relates to self-denial of food, and by extension self-denial of other needs and the self. This achievement leads to self-esteem in consumerist societies, where women receive constant messages regarding body perfection. Malson (1998) argues thinness is portrayed as infantilised sexualised femininity. Women should be child-like through passivity and dependency, and women with AN take this to the extreme, being thin and "ill". However, it can also signify rebellious rejection of these ideals, by parodying them and thus rejecting traditional femininity. Whilst Bordo (2003) acknowledges women have different experiences of socialisation, all outlined theories imply women experience similar oppressive experiences on some level, and do not explain what protects most women from developing eating disorders, or why men develop eating disorders. While they attend to wide social experiences, they do not sufficiently explain individual difference.

1.2.4 Integration of ideas

The described models do not sufficiently explain why some groups are more likely...
to develop eating disorders but why only some individuals within those groups do so. Integration of models could solve this. Several models refer to similar concepts; e.g. psychodynamic, systemic, cognitive behavioural and feminist models all refer to perceived control, so similar ideas may already be proposed in differing conceptualisations. Integrated theories could further identify why specific individuals in certain cultures are at higher risk of developing eating disorders.

Raphael and Lacey (1994) propose an interesting integration of biological and social-cultural ideas, with some focus on psychological factors. Biologically, women experience pregnancy and men are never guaranteed of genetic fatherhood. Cultural pressure thus emerged to control female sexuality, originally via religion. As religion in Western societies became less powerful and women gained greater autonomy, if beliefs still exist that women need controlling, “it falls to women to control themselves to avoid total disaster for society” (Raphael & Lacey, 1994, p 149). Women thus control themselves and their sexuality through dieting. However, biologically food restriction is difficult, and starve-binge cycles begin. Family dynamics (e.g. poor parental relationships), life events (e.g. break-up of first sexual relationship) and intrapersonal coping mechanisms (i.e. possessing other self-control mechanisms) determine which women develop eating disorders. Whilst the authors’ ideas could focus more on individual psychological factors, it could explain increased prevalence in women whilst acknowledging why only some succumb. Psychodynamic approaches could be incorporated to help explain individual vulnerability.

1.3 Eating disorders and pregnancy

Pregnancy places biological demands upon mothers-to-be, including greater nutritional requirements, and can impact on individual psychology, e.g. identity changes (Smith, 1999). It changes expectant mothers’ immediate systems, and as pregnancy is solely a female experience, is associated with gender roles. As weight gain is anathema to individuals with eating disorders and occurs in most pregnancies, pregnancy could be traumatic for women with eating disorders. This potential impact will now be examined.

1.3.1 Fertility

Eating disorders are associated with reduced fertility. For formal diagnosis of AN in postmenarchal women, amenorrhea is required. Whilst this is not necessary for BN or EDNOS diagnosis, the menstrual cycle can experience irregularities (Pinheiro et
al, 2007). However, women with eating disorders can become pregnant. Crow and colleagues (2002) reported that over 10-15 years, women with bulimic symptoms became pregnant at rates comparable with the general population, despite greater menstrual irregularity. Women with AN only have reduced fertility whilst they are actively anorexic, and can become pregnant despite amenorrhea (Leonard & Mahler, 2001, Namir et al, 1986). Therefore it should not be assumed by clinicians that women with eating disorders will not become pregnant during recovery, or even whilst still symptomatic.

1.3.2 Prevalence of eating disorders in pregnancy

Equally, some pregnant women will have eating disorders, either at levels of clinical significance or subclinical levels. In a community sample, 4.9% of pregnant women scored above the cut-off signifying eating disorder symptomatology on the Eating Attitudes Test (EAT), and 10% of the sample experienced eating disorder symptomatology two years prior to pregnancy (Turton et al, 1999). EAT scores are not sufficient for diagnosis, but authors estimated 2.4%-3.3% suffered an eating disorder. One third of women with previous eating disorder symptoms reported symptoms remained in pregnancy. In a community sample of pregnant women in China, 9.8% experienced eating disorder symptomatology (Lai et al, 2005). Whilst generalising these findings to British samples is problematic, statistical analysis examined other variables. Lai and colleagues (2005) found associations between eating disorder symptoms and traditional gender roles, body dissatisfaction and “drive for thinness”. Whilst partner support and maternal-foetal attachment were not associated with eating disorder symptoms, desire for thinness was associated with poor partner support, difficulties in maternal-foetal bond were associated with poor body image, and partner support and good maternal-foetal bonds were associated with traditional gender roles.

1.3.3 Impact of eating disorders on foetus

There is conflicting information regarding how expectant mothers’ eating disorders may affect their unborn children. Some studies suggest complications with pregnancy, birth and foetal development occur, whilst others find no or minimal impact. One study showed that whilst the majority of women with eating disorders during pregnancy had full term pregnancies and healthy babies, over a quarter required caesarean section (Franko et al, 2001). Women with eating disorders in remission gained more weight in pregnancy and had higher birth weights and Apgar scores than women remaining symptomatic (Stewart et al, 1987). A meta-review
suggests women with AN and BN have higher rates of caesarean section and miscarriage (Michell-Gieleghem et al, 2002). Low weight at conception and lesser weight gain during pregnancy are also associated with lower birth weights and increased chance of congenital malformations, and stillbirth, breech births, cleft palate and low Apgar scores are risks associated with BN and AN. However, details are not given regarding inclusion criteria for studies. Lacey and Smith (1987) reported that out of 20 mothers with BN at conception (but who mostly experienced reduced symptoms during pregnancy) one experienced premature birth; their baby weighed 950g and died at 29 weeks. The participant had a history of drug and alcohol abuse although it is uncertain whether this was active during pregnancy. The others were full term, weighing between 2500g-3700g, although one had a cleft palate and another a cleft lip. There were nine cases of hypertension, two cases of pre-eclampsia and eight breach births.

Rocco and colleagues (2005) noted few complications in their sample, with one premature case in their group with subclinical eating disturbance (n=37), and none in their eating disordered group (n=11). However, unlike some other studies, individuals with histories of substance addiction were excluded. A Norwegian longitudinal study showed that whilst women with Binge Eating Disorder tended to have heavier babies and caesarean section, women with AN and EDNOS purging type did not differ significantly to controls for birth outcomes (Bulik et al, 2009). However, woman with diagnoses of AN six months prior to conception were placed within the AN group, despite symptom level during pregnancy. It is possible that women whose symptoms reduced even before conception were placed within this group. This contrasts to Franko and colleagues' study (2001), which assessed symptoms at conception. It is uncertain why women with eating disorders have higher rates of caesarean section, although this may be due to inadequate nutrition during pregnancy, and foetal abnormalities or malpresentation (Mitchell-Gieleghem et al, 2002).

Sample sizes are relatively small for all original studies described, and excepting Bulik and colleagues (2009) and Rocco and colleagues (2005), there are no comparison control groups for women with no history of eating disorders.

1.3.4 Symptoms of eating disorders during pregnancy
1.3.4.1 Observed impact

Research suggests that many women with eating disorders experience reductions,
or even total amelioration, of eating difficulties during pregnancy, even if this is not
maintained post partum. In a clinical sample of 20 women with BN, the majority
reduced binging and all reduced self-induced vomiting whilst they were pregnant
by the third trimester (Lacey & Smith, 1987). Three quarters stopped binging in
totality, and all women abusing laxatives stopped in pregnancy. Whilst the majority
experienced relapse of eating difficulties post partum, approximately a quarter
retained gains. Larger quantitative studies suggest similar findings (Crow et al,
2008), increasingly for each trimester (Morgan et al, 1999). Small number qualitative
studies with women with AN and BN found anorexic cognitions and bulimic
behaviours respectively ceased during pregnancy (Namir et al, 1986; Ramachandani
and Whedon, 1988). Lemburg and Phillips (1989) found the majority
of their sample of women with BN, AN and combined symptoms experienced
reduced eating disordered symptoms during pregnancy and over half felt in
remission, although under a quarter remained symptom free a year since birth.
Similarly, Blais and colleagues (2000) reported that whilst anorexic and bulimic
women described reductions in symptoms during pregnancy, this was only
maintained for nine months postpartum. Self-induced vomiting, over-concern with
appearance, compulsive eating and food restriction were also not reduced
significantly. However, the study examined the first trimester, and other studies
suggest reduced symptoms are most pronounced in the third trimester (Lacey &
Smith, 1987; Morgan et al, 1999).

Significant reductions in eating disorder symptomatology do not always occur, and
symptoms can worsen (Stewart et al, 1987). A review paper reports restrictive and
bulimic symptomatology, along with other attempts to restrict eating, such as
smoking, can increase during pregnancy (Mitchell-Gieleghem et al, 2002). Out of six
women with BN, only one woman stopped binging, self-induced vomiting and
laxative abuse completely, and she started exercising for weight control. All women
feared losing control, and two started restricting their food (Lewis & LeGrange,
1994). Whilst half a sample of 129 women retrospectively reported reduced
symptoms, bingeing and purging did not decrease significantly, and a third reported
no change (Crow et al, 2004).

No specific studies were found on negative emotional aspects of eating disorders in
pregnant women, such as shame or guilt. Several studies examining symptoms
more broadly (Lewis & LeGrange, 1994; Lemburg & Phillips, 1989; Namir et al,
1986) describe participants’ anxiety regarding impact of food restriction on the
foetus and weight gain/losing control. Lemburg and Phillips (1989) reported participants felt guilt over weight gain and humiliated at professional weigh-ins. Some did not report their eating disorder to involved professionals, which the authors framed as indicative of guilt and shame.

1.3.4.2 Possible explanations
Several hypotheses are offered for why many women with eating disorders experience reduced eating disorder symptoms during pregnancy. Some explanations are theorised by researchers. Others are suggested by participants themselves, via questionnaires and semi-structured interviews. Fear of harming the foetus, increased psychological stability and support, and physical explanations have all been suggested, although they are not necessarily incompatible with one another.

1.3.4.2.1 Fear of harming foetus
One theory is women reduce eating disorder symptoms due to fear they will harm their unborn child. Several studies describe participants reporting this as a concern (Morgan et al, 1999; Lacey & Smith, 1987; Lemburg & Phillips, 1989). However, women who have not managed substantial reductions in eating disorder symptoms during pregnancy have also reported similar concerns (Lewis & LeGrange, 1994). Therefore uncertainty remains regarding what wider factors enable one woman to substantially reduce symptoms due to fear of harming her baby, whilst another woman is unable to.

1.3.4.2.2 Increased psychological stability and support
Rocco and colleagues (2005) hypothesise women enter a new “psychic dimension” during pregnancy, where the role of impending motherhood and the importance of the foetus takes precedence over previous worries. They suggest not only do pregnant women take more care of themselves during pregnancy, but others also take more care of them (their sample reported higher levels of interpersonal satisfaction during pregnancy), and reduce expectations. Therefore women with eating disorders experiencing further difficulties in everyday life may find it easier to cope within contexts of increased interpersonal support. The authors suggest this greater psychological stability terminates after birth, with the mother finding herself under increased stress. Suggestions that improvements in interpersonal relationships in pregnancy may be correlated to improvement in symptoms are found in other studies. Six women with AN all viewed pregnancy as positive, not
only because it normalised their life, but because they perceived more positive
attention from partners and reduced criticism regarding their eating disorder (Namir
et al, 1986). However, this is described as a by-product of pregnancy, rather than
reason for symptom amelioration, and participants reported continued conflict
regarding eating behaviours with their husbands. Pregnant women with eating
disorders experiencing amelioration of symptoms would be less likely to relapse if
they were in stable relationships (Lacey & Smith, 1987). This is not expanded upon
as a possible protective factor. Likewise, in Lewis and LeGrange’s (1994) study
where the majority of their sample did not experience substantial reductions in
eating disorder symptoms, all participants reported marital difficulties.

1.3.4.2.3 Physical explanations
Physical explanations have been proposed for reductions in bingeing. Bingeing may
be less possible in the third trimester due to reduced gastric volume (Morgan et al,
1999). However, authors note this would not explain experiences of participants
who did not revert to bulimic symptomatology post partum. Whilst pregnancy
temporarily ceased binge-purge cycles, they felt this was for an insufficient time for
lasting improvement. Participants themselves do not state this as a primary reason.
Hormonal effects have been hypothesised. Morgan and colleagues (1999) found
some women retrospectively described reduced symptoms before discovering
pregnancy. They suggest possible hormonal effects, although acknowledge
possible recall bias.

1.3.4.3 Body image
Socio-cultural and cognitive behavioural theories of eating disorders suggest there
is pressure on women to be thin and beautiful in Western society. There may be
less pressure on women during pregnancy, although in women with and without
eating disorders, attitudes towards bodies and pregnancy vary. In a study of fifty first
time mothers, of which approximately half had a history of food restriction and half
did not, the majority of women in both groups had positive perceptions of body
changes (Fairburn & Welch, 1990). The majority of participants perceived their
growing stomach as positive. Attitudes to other areas (i.e. breasts and thighs) were
related to participants’ perceptions of these body parts pre-pregnancy. Davies and
Wardle (1994) found pregnant women correctly perceived themselves as larger than
non-pregnant controls but were more accepting of their body size. Their perceptions
of ideal body shapes had not altered, but increased discrepancy between this and
their new perceived size did not lead to body dissatisfaction. Pregnancy may allow
women to tolerate bodies more removed from ideals. Sociological research suggests women can only be acceptably large during pregnancy (Charles and Kerr, 1986, cited in Earle, 2003).

Crow and colleagues (2004) in a sample of pregnant women with eating disorders reported 43.8% described body satisfaction as decreasing, despite bingeing and purging reducing. This implies body image is not necessarily associated with reductions in eating disordered symptomatology. Whilst the women in Lacey and Smith's (1987) study almost all reported reduced symptoms, a quarter found body changes distressing, whilst an approximate quarter found changes positive. In a Swedish community sample of pregnant women with and without eating disorders, all women reported finding changes to their body positive, although women with eating disorders stopped breast-feeding earlier, and had fewer positive feelings about it. This was suggested as due to poor body image (Larrson and Andersson-Ellström, 2003). Therefore women both with and without eating disorders have differing experiences of body image issues during pregnancy.

Pregnant women without eating disorders have described whilst they might be dissatisfied with parts of their pregnant bodies, in parallel they had respect for its ability to grow and bear a child. Also, they felt released from pressures of thinness and personal body dissatisfaction (comparable prior to pregnancy) whilst they fulfilled a physical and socially accepted function (Bailey, 2001). However, this did not last long after birth, and old pressures took hold again. During pregnancy, women almost felt their body was not their own - either because they shared it with their unborn child, or because they had become "public property", with people asking to touch their bumps. This was described both as intrusive and a positive reduction of personal barriers. Johnson and colleagues’ (2004) study on pregnant women without eating disorders suggested that when women’s individual meaning making is closely examined, body image becomes complex. Participants felt more dissatisfied with their bodies during pregnancy and perceived themselves as less attractive, whilst also framing pregnancy as a temporary retreat from normal standards of female beauty. They also described feeling as though their bodies were public, and medical, property.

Pregnant women without eating disorders described negative perceptions of looking fat rather than pregnant in early stages, and expressed dissatisfaction that society no longer saw them as sexual beings (Earle, 2003). However, looking
pregnant can increase women’s perception of social status, and body changes are viewed more positively when obviously due to pregnancy, the pregnant body being seen as a temporary state to lose once pregnancy is over. Feminist theories suggest that embracing the pregnant body could be seen as resistance against traditional ideals of what women should look like, rejecting sexual objectification. Alternatively, maintaining concern over appearance whilst pregnant might demonstrate resistance towards ideas that women are functional rather than attractive when pregnant (Earle, 2003).

1.4 Pregnancy and identity
Women without eating disorders have described pregnancy as “confirmation of adult womanhood” (Bailey, 2001, p. 116), and a shift in how they saw their gendered identities. It was suggested that in some settings, being visibly pregnant asserted femininity in a positive way. Before pregnancy participants felt conflicted in conforming to gender stereotypes. When pregnant, they felt more feminine and at ease in perceived feminine roles, and found this liberating, although it was acknowledged this could feel restrictive with time. Participants spoke about their bodies no longer being their own, as they felt bodily attached to their baby. However, this was described as empowering rather than as subordination, which they had felt previously in other settings. Nevertheless, there were differences in women’s accounts of self-identity and body changes, with some women dissociating the two, or being worried that their bodies would overwhelm their identities. Femininity was accepted as not inferior, but important in its own respect. As feminist theories suggest negative aspects of femininity being internalised and struggled with cause eating disorders, then a more positive feminine identity could possibly be associated with reduced symptomatology. Women with eating disorders who perceive themselves as failures as women may find this feeling ameliorated by taking on the feminine role of impending motherhood (Lacey & Smith, 1987).

Smith (1999) interviewed pregnant women without eating disorders using IPA analysis. Participants described their identities as relational – their sense of self was closely linked to perceptions of relationships with others. They spoke of being closer to partners, and being recognised increasingly as adults by parents. For three out of four of the participants, there was perceived greater integration between different aspects of themselves and perceived greater similarity between themselves and important others. Smith suggests this interpersonal and intrapersonal integration of the self is preparative of motherhood so the new identity of motherhood is explored.
through the experiences of others. Pregnancy also coincided with increased self-reflection. This study, only having four participants, cannot be empirically generalised to wider populations. However, if it can be theoretically generalised and participants’ experiences seen to suggest something more universal, it might be that some women feel more integrated, both socially and personally during pregnancy. A more integrated psychological experience and increased self-reflexivity could be factors in reducing an eating disorder’s power, by allowing greater self-awareness of genuine needs. Both psychodynamic and socio-cultural explanations of eating disorders suggest individuals’ unawareness of their needs as important in aetiology.

1.5 Rationale for study
It is commonly but not universally observed that women with eating disorders experience substantially reduced symptomatology during pregnancy. Several explanations have been offered. Researchers and participants have suggested concern for the foetus as a primary reason. However, as women who do not achieve symptom amelioration share this concern, this suggests other factors are involved. Possible factors have been speculated, but further research to support these or identify other factors is required.

Rocco and colleagues (2005) suggested improved interpersonal support might reduce symptoms. Social support is somewhat addressed in other studies. In a Chinese study (not cited by Rocco and colleagues), poor spousal support was associated with drive for thinness, which in turn was associated with eating disordered symptoms in pregnancy (Lai et al, 2005). Positive or difficult spousal relationships are described respectively in women whose eating disordered symptoms either ameliorated or did not ameliorate substantially in pregnancy (Namir et al, 1986; Lewis & LeGrange, 1994). However, there are no studies that deeply explore the meaning and significance of perceived interpersonal support for women with eating disorders during pregnancy, in regards to symptoms and their general lived experience. Also, as areas of conflict can exist in contexts of greater perceived support (Namir et al, 1986), the matter may be more complicated than perceived support simply improving.

Body image within pregnancy has also been researched, although experiences of women both with and without eating disorders vary. Studies of pregnant women with eating disorders tend to report body image change in broad terms (i.e. improved or not improved, at most describing how different body parts are perceived). However,
research with pregnant women without eating disorders suggests interpretations of perceived body change are complex, with increased size being disliked, but perceived as socially acceptable (Bailey 2001; Johnson et al, 2004). Maternal-foetal bond is associated with body image (Lai et al, 2005). More detailed exploration of both could suggest why, and could show whether mothers-to-be themselves perceive a meaningful link between the two. Body image is not always associated with binge and purge behaviours in eating disordered pregnant women (Crow et al, 2004). Therefore there is a research need to explore personal meaning making regarding physical changes in pregnant women with eating disorders, with relation to symptomatology.

Existing research has not focused on identity change in pregnant women with eating disorders and how this might relate to symptom amelioration. Identity changes in pregnant women without eating disorders are observed in a previous study exploring participants’ phenomenological experience (Smith, 1999). Exploring identity in pregnant women with eating disorders may help explain why some women overcome eating disorders and not relapse after pregnancy. Whilst many women revert to eating disorder symptoms after pregnancy, a substantial minority do not (Morgan et al, 1999). This lasting change may be indicative of identity change during pregnancy.

Therefore the aim of the current study is to explore women’s own explanations of their subjective reduction of eating disorder symptomatology, and their lived experience of pregnancy, with a broad focus on identity (including body image) and relationships. Such research, focused on participant’s phenomenological experience, could complement existing research by supporting or adding complexity to previous assertions. It could highlight previously unexplored experiences that could inform larger-scale research. In addition, as close examination of an individual’s phenomenological experience would explore emotional experience, it could allow closer examination of negative and positive emotions felt in pregnancy.
Whilst the study uses a qualitative methodology so as to remain open to new insights not featured in extant literature, it also has two broad hypotheses derived from the research literature outlined in this section. These are as follows:

1) women experiencing a reduction of eating disordered symptoms during pregnancy will also perceive increased social support from others throughout their pregnancy, and will personally value this.

2) women experiencing a reduction of eating disordered symptoms during pregnancy will experience some change in their perceived identity over the course of pregnancy.
2. METHOD

The study aims to explore experiences of women during a specific time in their life (their pregnancies) describable as life changing, in relation to perceived reduced eating disorder symptomatology and broader lived experiences. The rationale of using Interpretive Phenomenological Analysis (IPA) and my position as researcher will be explored, before procedure is outlined and the approach considered critically.

2.1 Rationale for IPA
IPA’s epistemological assumptions derive from roots in critical realism (Bahskar, 1978; cited by Fade, 2004). Whilst acknowledging a stable reality beyond human perception and conceptualisation, it postulates people have a complex, meaningful relationship with the world and therefore cannot examine “reality” from removed, objective positions. Perhaps viewed best as a perspective than a strict analytic stance, it claims an individual’s inner world can be somewhat known by how they relate to the outer world, because they are a “person-in-context” (Larkin et al, 2006). Therefore it is possible to know something about a person’s inner world in relation to specific experiences, recounted at certain times, in certain situations, through language used and descriptions given. However, true understanding can only ever be partial, and accounts are never purely “first-person”, being constructed by both participant and researcher. Analysis involves both attention to participants’ own expressed meanings of experiences (the phenomenological) and tentative exploration of deeper meaning not explicitly expressed (the interpretative) (Larkin et al, 2006). Due to epistemological assumptions that individuals are an inclusive part of reality rather than objectively removed from it, analysts’ interpretations are coloured by their own subjective reality. There is also commitment to the idiographic analysis of individual experience (Smith, 2004).

Possible reasons for reduced eating disorder symptomatology in pregnancy have been suggested. These include concern for the foetus, increased interpersonal support and greater acceptance of body image. However data can be conflicting, suggesting individual experience is complex and multi-faceted. Relationships are suggested as important but have not been examined in great detail. Research with pregnant women without eating disorders has suggested body image and identity are complex when participants’ subjective experiences
are closely examined. IPA allows for participants' own theories as to why their eating disorder symptoms decreased, in addition to broad issues of identity and relationships, to be examined within their own meaning making.

As this study was interested in exploring participants' perceptions of a transformative experience rather than constructing inductive theory, IPA was chosen rather than grounded theory (Payne, 2007). More fundamentally, grounded theory was designed to explore and explain social processes. When applied to phenomenological experience, it can be limited to describing aspects of experience rather than saying something meaningful about them (Willig, 2008). IPA is often chosen for studies exploring transformative experiences because it attempts to explore individuals' perceived realities rather than describing them objectively (Smith & Eatough, 2007). Discourse analysis was rejected as the research aimed to explore subjective experiences of individuals. Discourse analysis focuses on public "reality" constructed by language (Coyle, 2007). An epistemological assumption was that something meaningful about a person's subjective experience could be accessed from how they described it in language, rather than their perceptions being constructed or limited by their language. I could have used narrative analysis, as this approach is interested in individual's personal meanings. However, narratives are useful for exploring individual's meaning making of disruption and restoration of stability (Murray, 2008). As my research question was interested in transformative experiences that were not necessarily disruptive, and that could lead to positive change rather than returned stability, IPA remained the best choice.

2.2 Position as researcher

Due to epistemological assumptions regarding how the world can never be objectively observed, it was important to reflect on my own experiences and values, to know how this could affect my interpretations. I am a white, female Clinical Psychology Trainee aged 30 years old, with an interest in eating disorders, the consideration to work in the area after completion of training, and experience of working with two clients with eating disorders during training. I had my own eating difficulties in my teenage years that were of clinical severity but which I received no treatment for. These difficulties remitted by my early 20s, largely due to personal attempts to overcome them. I also have female friends with similar histories. When starting the research process I saw little comparison with these experiences and those of the women I wanted to interview. However,
on reflection I may have an interest in "spontaneous" remission or lessening of eating disorder symptomatology, due to factors outside therapy. I am not a mother and have never been pregnant, so I would not take personal experiences of this with me. However, as a woman who eventually wants children and who hopes pregnancy will be a positive experience, it was important to be aware of my possibly romanticised views on pregnancy.

I consider myself a feminist, and my interest in eating disorders stems partly from it being a condition predominantly affecting women. My own aetiological perspective is cross theoretical, merging aspects of cognitive, systemic, biological, psychoanalytic and feminist theories, but incorporates ideas regarding pressure on women to look beautiful and the construction of femininity in patriarchal society. I also believe there are mixed messages in my society about motherhood, e.g. respected nurturer verses subservient domestic "servant", and the various debates in the media about stay-at-home verses working mothers.

Due to the interpretative aspect of IPA, my own position will impact on interpretive processes, e.g. in observing themes I consider important within the data. I may be more aware of socio-cultural aspects of participant's experiences. Also I have worked primarily in cognitive behavioural models clinically. Therefore I may be more likely to interpret data within feminist or cognitive behavioural frameworks. Whilst I will endeavour to describe participants' subjective experience as accurately as possible, IPA acknowledges total neutrality is neither possible nor desirable. It justifies this by being explicit in its use of double hermeneutics, analysis being both an attempt to reflect participants' worlds and an act of interpretation by researchers.

2.3 Sampling

The study was interested in women who experienced subjective reductions in eating disorder symptoms whilst pregnant. Therefore the research question required a homogenous group. IPA frequently uses purposive sampling to ensure research questions are meaningful to participants (Smith & Osborne, 2003). Sample sizes are small due to IPA's idiographic stance that analysed experiences should not be generalised empirically, although relating psychological concepts within analysis allows theoretical generalisability. Whilst five or six participants has been recommended for student research (Smith & Osborne, 2003), case studies can be used, and are particularly suited for IPA.
because of its idiographic nature (Smith, 2004). Case studies offer context-dependent accounts that help fully understand behaviours, enriching social science because human behaviour cannot be seen as purely rule based (Flyvbjerg, 2006). Case studies become theoretically generalisable by supplementing, informing or contradicting existing hypotheses (Flyvbjerg, 2006). Whilst originally five to six participants were desired, only two participants were recruited. Therefore the study followed a case study approach.

2.4 Rationale for semi-structured interviewing

Semi-structured interviews were used so participants could bring their own stories and agendas to one active listener, who remained sensitive in adapting the interview schedule to follow participants' needs. This included encouraging participants to continue talking about arising meaningful but unexpected areas not covered by the interview schedule.

2.5 Interview schedule

The interview schedule (Appendix B) was constructed following Smith and Osborne’s (2003) recommendations. Funnelling was used so initial questions were general, referring to participants' overall experiences of pregnancy and their explanations for symptom amelioration. Subsequent questions explored areas of interest. To prevent participants being led, numerous questions were phrased broadly, with prompts if needed.

It is important in interview not to explicitly seek confirmation of existing ideas in the literature. However, to obtain meaningful data comparable to existing literature, to address gaps in the literature that inform research questions, and due to practical restraints such as obtaining ethical approval, an interview schedule somewhat influenced by existing literature was necessary. After reviewing literature outlined in the introduction and consulting with project supervisors, questions were asked relating to two broad areas. These were identity and inner experiences (including body image), and perceived relationships (including maternal/foetal bond). Further questions were asked about participants' experiences after birth, so to explore what happened afterwards, and finally participants were asked if there was anything important that had not been discussed. For ethical purposes, after recording was finished, participants were invited to reflect and talk through any issues that might have arisen.
After the first interview, one question asking about the participant’s relationship to their eating disorder was removed, as it did not make intuitive sense to the participant. Also it was decided the main (recorded) interview required detailed exploration of what happened to symptoms, rather than this just being discussed in the initial, unrecorded interview, used to assess for criteria.

2.6 Ethics

2.6.1 Ethical approval
Ethical approval was sought and awarded by Charing Cross Hospital REC (Appendix C) and the University of Surrey Ethics Committee (appendix D). The R&D department at South West London and St George’s NHS trust (SWAG) approved the project, and Beating Eating Disorders (BEAT), the national eating disorders charity, gave permission for the research to be advertised on their website.

2.6.2 Ethical considerations
I did not make initial contact with participants unless they had given permission via their care workers/therapists, who informed them of the project. Otherwise potential participants contacted me via advertisement. This aimed to reduce pressure to take part and to avoid unintentional upset by contacting individuals with no introduction, potentially making them question service confidentiality. Where possible, potential participants were given a choice of interview location.

Potential participants were given written information (Appendix F) relating to the project, and participants gave written consent before the main interview. They were informed they could withdraw from the project at any time, that confidentially would be kept and pseudonyms used when reporting findings. They were informed the exception to this would be if the interview led to serious concerns about their safety or the safety of another person, in which case their GP would be informed. Participants were informed their GPs would be told they were taking part in the research and sent a copy of the Participant Information Sheet after agreement to take part, before the main interview. Participants were offered feedback after the analysis.

One concern was whether participants might experience distress by reliving experiences, especially if there were complications in pregnancy, or if
participants were more symptomatic at the time of interview than during pregnancy. To minimise potential consequences, each interview finished with an unrecorded "debriefing", inviting participants to discuss any difficult emotions that arose from the interview. Participants were also given telephone numbers to the BEAT helpline, the Samaritans, and NHS participants were given their trust Crisis Line number.

2.7 Recruitment
Participants could be recruited through two pathways; via the Eating Disorder Service at SWAG or the BEAT website. Due to these two recruitment pathways, potential participants were alerted to the research in different ways.

Participants were recruited from SWAG via:
- a) posters and leaflets in a waiting area and day hospital; and
- b) clinicians informing clients who appeared to meet research criteria.

Participants were recruited from BEAT via advertisement on their website.

Both participants for this study were recruited through SWAG.

The following inclusion criteria were adhered to. Participants had to:

a) be 18 years old or over;

b) have experienced pregnancy to term within the last 2 years (pregnancy lasting at least 35 weeks);

c) have a diagnosis of a clinically significant eating disorder prior to pregnancy and at conception;

d) speak English; and

e) feel the symptoms of their eating disorder reduced in some way during the course of pregnancy.

The age limit was to avoid further ethical considerations of acquiring informed consent from minors. So that participants could recall experiences of pregnancy clearly, it was stipulated that pregnancy should have occurred within two years. The stipulation of pregnancy lasting 35 weeks was two-fold. Firstly, gestation of less than 35 weeks is associated with neonatal morbidity and mortality (Lams et al, 1996); this was a measure to reduce potential for distressing mothers in interview
who experienced obstetric problems. Secondly, as women with eating disorders who experience reduced symptoms during pregnancy have this happen increasingly over pregnancy (e.g. Rocco et al, 2005), it was considered ideal to have participants experiencing full or almost full term pregnancy. Being able to speak English was necessary due to interpreters not being financially possible and difficulties associated with using interpreters in IPA (Smith, 2004). Diagnosis prior to pregnancy and reported reduced symptoms ensured participants had experiences relevant to the research question.

2.8 Procedure
The procedure involved two interviews. An initial interview, lasting up to 20 minutes, for potential participants could be held over the telephone, in their home, or for SWAG clients, a clinic room. This was to check criteria, for them to ask questions about the research, and to acquire/more fully discuss informed consent. If consent was given and criteria were met, the main research interview was arranged in the client’s home, or (for SWAG clients) a clinic room. One participant (Charlotte) elected to be interviewed by telephone and then at her home, the other (Aleksandra) chose to be interviewed both times at a clinic room.

Data were then transcribed and analysed using the guidelines outlined. Participants were offered feedback after the write-up. Respondent validation was methodologically rejected, for the following reasons. Participants may have different, individual priorities to researchers, it can be time consuming for participants, and if researchers resultantly remove their own interpretations and only describe participant’s interpretations, this can be collusive (Barbour, 2001). As IPA is an explicitly interpretative approach using double hermeneutics, respondent validation is even less appropriate.

2.9 Participants
Two participants were recruited from SWAG. Another potential participant did not meet criteria as her pregnancy was 10 years past. Demographic data for both participants are below. Aleksandra (the primigravida) reported eating approximately 600 calories a day pre-pregnancy, and ate at least three meals a day during pregnancy. Her diagnosis was EDNOS with prior diagnosis of AN (as well as recurrent depression), and she reported changing presentation over the years, with periods of bingeing and purging. Charlotte was already a mother to two children. Due to treatment with the Eating Disorder Service she had been eating regular
meals for the previous three months, but described this as extremely distressing and guilt provoking. These difficult emotions disappeared during her pregnancy. After discussion with project supervisors, it was decided that as the project was concerned with subjective reductions of symptoms (and had not specified behavioural symptoms), she met criteria. Prior to this, Charlotte reported food restriction interspersed with several binges a week, compensated for by further restriction, exercise and occasional self-induced vomiting.

Table 1: Participant characteristics

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Charlotte</th>
<th>Aleksandra</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>40 years</td>
<td>40 years</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White British</td>
<td>White Polish</td>
</tr>
<tr>
<td>Diagnosis at conception</td>
<td>EDNOS</td>
<td>EDNOS (previously AN)</td>
</tr>
<tr>
<td>Length of eating disorder</td>
<td>3-4 years</td>
<td>22 years</td>
</tr>
<tr>
<td>Length of pregnancy</td>
<td>38 weeks</td>
<td>38 weeks</td>
</tr>
<tr>
<td>Time since birth</td>
<td>7 months</td>
<td>10 months</td>
</tr>
<tr>
<td>Method of birth</td>
<td>Elective caesarean</td>
<td>Induced labour, caesarean</td>
</tr>
<tr>
<td>Previous pregnancies</td>
<td>2 (2 live births)</td>
<td>None</td>
</tr>
<tr>
<td>Marital status</td>
<td>Married</td>
<td>Married</td>
</tr>
<tr>
<td>Level of education</td>
<td>Degree level</td>
<td>A-Level</td>
</tr>
</tbody>
</table>

I had previously worked with Charlotte clinically. Possible implications are explored in the discussion.

2.10 Data collection
Interviews lasted 40 minutes and were recorded on a digital recording device and transcribed verbatim. Pseudonyms were given to protect confidentiality.

2.11 Analysis
Guidelines for analysis were taken from Smith and Osborne (2003); the process is outlined below.

The first transcript was read several times to become familiar with its content and to offer opportunities for new insights to emerge on multiple readings. Initial comments were made in the left margin, drawing out what I found interesting or significant. These comments broadly were summaries, associations, initial tentative interpretations, and comments about consistencies throughout the
account. Once I felt this process was completed to a sufficient level, I used the right margin to note wider themes at more abstract and interpretative levels, using psychological ideas when appropriate, whilst ensuring emerging themes were still grounded in data. Themes were listed and organised into clusters according to meaning and connections between them. The original text was referred to throughout this process to ensure emerging clusters made sense. Clusters were given summary names to represent superordinate themes.

The second transcript was analysed using the same method. I was careful not to let the previous analysis determine what I saw, but it did help me consider similarities and differences in the accounts. A table of superordinate themes was created for each participant.

2.12 Evaluation
It is debated whether qualitative research should be evaluated using quality criteria or whether that imposes an incongruent positivist paradigm (Dixon-Woods et al, 2004; Pope & May, 2000). A researcher’s position partially depends on their philosophical stance regarding the nature of realism. Pope and May (2000) refer to “subtle realism”, i.e. an underlying reality can be represented through subjective accounts, although not overall “truth”. IPA’s epistemology assumes individuals’ subjective worlds are measurable, within particular contexts, by how they relate to the world (Larkin et al, 2006), which fits this meaning of subjective realism.

One problem with guidelines for qualitative research is they assume homogeneity in methodology and theoretical position that does not exist (Dixon-Woods et al, 2004). These authors argue the theoretical model must be considered when critically examining qualitative research. I have been unable to find specific guidelines for IPA research. Dixon-Woods and colleagues offer more generic suggestions, describable as areas to consider rather than clear guidance (see Appendix H for guidelines). The following is an assessment of the research according to those criteria, which also considers Yardley’s (2008) suggestions on evaluating qualitative research.

Research questions must be clear and suitable for the type of analysis used. IPA is appropriate as the study aims to understand subjective experiences of individuals during a specific, transformative period in their life, and their own
meaning making of their experiences.

Sampling, data collection and the analytic process are clearly described, with reference to suitability for the research question. Such transparency is beneficial to good qualitative research (Yardley, 2008). A purposive sample, focused on examining homogenous groups of individuals with similar experiences, is appropriate due to the aim of exploring experiences of women experiencing reductions of symptoms in pregnancy. Semi-structured interviews allow the interview to be flexible so newly emerging areas can be followed. IPA analysis is appropriate for this research question as it pays attention to participant’s own perceived meanings, whilst also being observant of deeper, less explicit issues. Reported themes are grounded in data, and interpretation is supported by quotes. There is integration of data, interpretation and conclusion. To ensure sufficient grounding in data, one of my project supervisors scrutinised my codings and tables of themes. Having another researcher assess a researcher’s coding ensures interpretations are not just observable to original coders (Yardley, 2008). However, as interpretative analyses contradicts strict reliability checks (Yardley, 2008) and as the study is a doctoral dissertation, this was limited to assessing whether interpretations were sufficiently grounded.

Finally, the research brings new perspectives to the evidence base, by offering detailed analysis of subjective experiences and personal meanings of women specifically experiencing reduced eating disorder symptoms. This compliments both previous qualitative studies initially highlighting areas further explored, and quantitative studies providing data on trends by offering individual context. Whilst findings are not empirically generalisable, findings may be theoretically generalised, with context specific insights that might apply for individuals in similar circumstances (Yardley, 2008).
3. RESULTS

As the study features two case studies the results section will first explore Charlotte’s story, before moving on to Aleksandra’s story, and finishing by exploring similarities and differences between the two accounts.

3.1 Charlotte – the experience of RESPITE

Table 2: Themes for Charlotte

<table>
<thead>
<tr>
<th>Superordinate theme</th>
<th>Subordinate themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incongruence</td>
<td>Inconceivability of having ED in pregnancy</td>
</tr>
<tr>
<td></td>
<td>- physical constraints</td>
</tr>
<tr>
<td>Uncertainty</td>
<td></td>
</tr>
<tr>
<td>Forces</td>
<td>Pregnancy as overtaking force</td>
</tr>
<tr>
<td></td>
<td>Eating disorder as external control</td>
</tr>
<tr>
<td>Connections to other women</td>
<td>Weight concerns</td>
</tr>
<tr>
<td></td>
<td>Connection with another via pregnancy</td>
</tr>
<tr>
<td>Appearance and identity</td>
<td>Ambivalence towards ED</td>
</tr>
<tr>
<td></td>
<td>Importance to identity - prior</td>
</tr>
<tr>
<td></td>
<td>- during pregnancy</td>
</tr>
<tr>
<td>Respite</td>
<td>Freedom from weight constraints - own</td>
</tr>
<tr>
<td></td>
<td>- others</td>
</tr>
<tr>
<td></td>
<td>Help from others</td>
</tr>
<tr>
<td></td>
<td>Increased social ease</td>
</tr>
<tr>
<td>Therapy</td>
<td>Support</td>
</tr>
<tr>
<td></td>
<td>Preparation and continuation</td>
</tr>
<tr>
<td>Future orientation</td>
<td>Uncertainty</td>
</tr>
<tr>
<td></td>
<td>Hope for self-development</td>
</tr>
<tr>
<td></td>
<td>Return of weight concerns</td>
</tr>
<tr>
<td></td>
<td>Negative emotions</td>
</tr>
<tr>
<td>Movement into domestic sphere</td>
<td>Movement towards family</td>
</tr>
<tr>
<td></td>
<td>Inward focus (self and baby)</td>
</tr>
<tr>
<td></td>
<td>Positive emotions</td>
</tr>
<tr>
<td></td>
<td>Consideration of unborn child</td>
</tr>
</tbody>
</table>

3.1.1 Incongruence

Charlotte described her eating difficulties throughout pregnancy as “non existent”, and her story suggested perceived *inconceivability of having an eating disorder*. 
in pregnancy. Describing how she could not conceive of anyone wanting to diet or self-induce vomiting in pregnancy, she described the two as “mutually exclusive”. Despite in her initial interview describing huge guilt and negative feelings associated with eating that disappeared in pregnancy, in her main interview she described herself as broadly recovered at the point of conception, due to behaviourally eating regular meals as part of therapy. She encapsulated her belief that pregnancy was incongruent with an eating disorder by saying:

“it’s odd that you can’t get pregnant when you’ve got an eating disorder because you don’t have periods so it’s kind of nature’s way”

Related to this was her perception that physical issues discouraged eating disordered behaviours. She referred to feeling “pretty hungry” which made restriction impossible, and discounted self-induced vomiting as making a physically challenging and potentially unpleasant experience even worse.

“it’s really not very nice being pregnant anyway so making yourself sick as well would just be so grim”

However, uncertainty in the very beginning was acknowledged, with Charlotte feeling unsure whether her feelings and urges related to her eating disorder would remain.

“I wondered whether even in pregnancy I would still feel huge guilt or the need to binge or god forbid to vomit”

However, the phrasing of “even in pregnancy” suggests a pre-existing belief that pregnancy could be a potential break from eating concerns.

3.1.2 Forces
Related to Charlotte’s perception of incongruence, she described experiencing her release from guilt and worry in the terms of pregnancy as overtaking force, controlling her in a positive way. She described that when she was pregnant “something takes over”, and used metaphor to attempt to explain this experience.

“There’s some kind of machine inside me which is basically programming what I’m doing at what I’m eating”
Whilst she did at times describe herself as recovered from her eating disorder prior to pregnancy due to eating regular meals, she acknowledged this felt forced and emotionally difficult. Pregnancy released her from these negative feelings and allowed her to eat without guilt, although this experience was described as outside her sphere of deliberate control.

"it wasn't like I was trying to be eat well I just ate well because that was the most natural thing for me"

Whilst Charlotte’s perception of pregnancy was described as an internal force taking over, she also perceived her eating disorder as external control. Again, she used metaphor to assert the overpowering and over-controlling experience of being subject to its demands.

"I don’t want it to be all fascist ruining my life"

3.1.3 Connections to other women
Charlotte made connections between herself and wider womanhood in two ways. When referring to weight gains prior to pregnancy, she perceived weight concerns and the desire to be slim as something universal for women.

"slim, which is obviously something every woman wants to be"

However, she did position herself as aside from the common female experience, by describing her own concerns as “more than most”, so the comparison with the wider female group is not total.

Charlotte also experienced connections with another via pregnancy, although whilst her perceived connection with other women through weight concerns was universal, this connection was focused around one important person in her life, her mother. Her description of this connection could be described as almost spiritual.

"probably a kind of funny history repeating itself ... there's this whole symbolic thing of me being inside her tummy and I've got someone inside my tummy ... it's a deeper thing"
Charlotte’s closeness to her mother was an important source of support during her pregnancy, whilst she eschewed groups outside the family that might have provided similar connections.

“there were groups that I could have gone to but I didn’t I didn’t have time you know pregnancy groups and all that kind of stuff”

3.1.4 Appearance and identity

Prior to pregnancy, Charlotte’s desire to be slim and to perceive herself as attractive lead to ambivalence towards her eating disorder. She perceived it as a positive thing in that it led to compliments and social approval, but despite this, she described it as a “false friend”. She later referred to it as the devil (again, using metaphors of external forces), but despite this she also valued perceived benefits.

“feel like calling it the devil, but then again it was great because it meant that I had a nice figure”

In exploring her appearance’s importance to identity prior to pregnancy, Charlotte frequently described it as the central component of her perceived identity. She gained self-esteem from looking good, particularly in contexts of social situations. This suggests a perception of herself as a relational being, whose self-definition is largely constructed through relationships, and how she perceives others as perceiving her. Encapsulating the importance of her slenderness to her self-concept, Charlotte asserted:

“It was my life that I was kind of slim”

During pregnancy however, the fact that her “identity has always been tied up with my weight” caused negative self-perceptions and a sense of loss.

“I just used to take huge pride as I said it was like a triumph it was like a kind of victory and I don’t have that anymore”

Charlotte therefore struggled to redefine her identity according to different criteria, both related to appearance and less tangible qualities, both relating to how others could see her and how she could see herself. She perceived this to be a novel task,
with few foundations to build upon. Whilst she had started the process, she had not yet come to any firm conclusions.

"had to re-evaluate myself shakily and wobbly...I guess there's something about me that's acceptable lets try and find what that is and start from scratch".

Charlotte's self-perception remained somewhat focused on her appearance. Another attempt of redefinition was to discover what apart from her "slimness which people would find attractive". However, she perceived decreased judgement from others in pregnancy regarding concerns of weight, as described below.

3.1.5 Respite
The concept of respite from eating concerns was one of the central themes in Charlotte's interview. Describing her own weight concerns as suddenly "non existent" in pregnancy, she made several references to freedom from weight constraints both in relation to her own and those of others. Regarding her own concerns being relaxed, Charlotte described the experience as "being on holiday", "an excuse to be larger" and as "carte blanche to just be yourself". Again referring to the idea of previously being controlled by eating concerns, she described her new freedom as:

"amazing...let it all hang out on the weight...it feels really nice not to be ruled by this"

Relating to the judgements of others, Charlotte again referred to a function of pregnancy being relaxed expectations and an excuse to be acceptably larger without receiving social disapproval. Encapsulating the idea of relaxed social standards and the impact this had on her, Charlotte asserted:

"you don't need to be going to the gym the whole time...nobody expects you to be fighting fit and trim and all of this was great"

Charlotte's experience of this respite was not just confined to her weight and eating. She also greatly valued what she perceived to be increased help from others. She described this increased help mainly in terms of acquaintances, i.e. teachers and neighbours, perceived it as temporary as the pregnancy, and described valuing and making use of it.
"I milked it for all it was worth because...people see that you’re pregnant they can see that you’re struggling along but once you’ve had the baby they all disappear"

However, Charlotte seemed to say less about increased support from her immediate family. Whilst the closeness of her mother was described earlier, when referring to her husband’s role, she said:

"being close to my husband is a practical thing as well as well obviously he’s my husband but you know I needed support and help"

This appeared an opaque description of her experience of receiving support him, which could indicate an assumption that I would have a common experience of knowing a husband in a similar way, or a reluctance to talk about it in depth in the interview.

Finally, Charlotte reported feeling increased social ease that she attributed to pregnancy, describing it as an automatic topic of conversation in social situations, reducing the pressure she otherwise felt.

"you’ve got something to talk about with everyone"

Subsequent to her daughter’s birth, Charlotte described the loss of this social ease.

"I feel that people can just see through me I feel like I’ve got nothing to say that’s of interest to anyone"

3.1.6 Therapy
Charlotte specifically mentioned her treatment with the eating disorder service as support she felt in pregnancy, describing her therapist and nutritionist as "very supportive and helpful". Further to this however, there was a sense of preparation and continuation from treatment for the pregnancy. Charlotte described her regular eating as being started by therapy, and spoke of this and the weight gain she had thus experienced as helpfully preparative and protective against being traumatised by weight gain through pregnancy, which otherwise would “have been really hard".
"I had three months of ... putting on weight as a result of therapy prior to falling pregnant so I was already I wasn't going from size 8 to suddenly being pregnant"

3.1.7 Future orientation
This theme refers to Charlotte's current circumstances and feelings, and her mixed speculations regarding the future. At the time of the interview, Charlotte had successfully managed to not revert to her eating disordered symptoms. However, she described uncertainty that this would definitely be the case, whilst also hoping that she would not succumb to old behaviours.

"I can't say for definite that I've waved it goodbye I hope I have"

However, even despite uncertainty and difficulty there was hope, and in particular hope for self-development, a process that had already been started within therapy and could continue to be developed to help Charlotte continue the road to recovery.

"I'm not dealing with it very well but I think it's a learning process and I hope to get some strength from somewhere use my resources and try and deal with the situations in the best possible way"

However, when asked what these resources were, Charlotte's reply suggested that the process of discovering them was in its initial stages, initially answering "good god I dunno I wish I knew" before going on to speculate tentatively within the interview after asserting the following.

"obviously I've got some resources but because I'm pretty down on myself and also I feel pretty low then it's hard ... whatever there is you don't know what it is"

Whilst Charlotte had not gone back to her eating disordered behaviours, there was some return of weight concerns, and the idea of weight control being a coping mechanism against life's difficulties.

"I've got fresh sort of challenges ... the whole time I'm thinking god if I just lose some weight it would be really helpful".
Charlotte’s perception of the future was within a context of her currently finding life difficult, with *negative emotions* such as feeling overwhelmed or low.

“I feel like things are always being thrown at me and … at the moment I’m not dealing with it very well”.

For Charlotte, the respite is over, although there remains hope regarding her ability to cope with future challenges.

### 3.1.8 Movement into domestic sphere

Charlotte, whose descriptions of herself pre-pregnancy were of a social being, albeit one with a degree of social anxiety, described a *movement towards her family* as a result of the pregnancy, as well as weight gain prior to pregnancy. This was associated with withdrawal from prior social circles due to a perception of inadequacy and fear of judgement, which occurred despite her assertions explored earlier that in other ways, pregnancy made her social experience easier. However, implicit in her description is an assumption that her family will remain there for her, no matter how "unacceptable" she perceives herself becoming to others.

“I turned to my family more and … I did feel a bit unacceptable to the world and I suppose at least my family love me”

This was in contrast to her experience prior to pregnancy.

“before I was always thinking … can't wait till the kids are in bed and then I can go out and party”

Charlotte also experienced a movement towards *inner focus* towards the baby and herself, describing this using a term often perceived as negative, although without noticeably applying a negative judgement to herself.

“I think I was pretty self-centred you know I was quite fixed on my own pregnancy.”

This connection and movement towards her unborn child can also be seen in the *positive emotions* she felt from the pregnancy.
“Absolutely ecstatic ... tremendous love for the baby”

This was mirrored in her perception of other significant other’s reactions, such as her sons.

“and the boys well they were thrilled that I was pregnant they were just very excited and it was ... a fresh beginning for them”

Charlotte also referred to a consideration of her unborn child as a reason for wanting to eat healthily throughout the pregnancy.

“you’re responsible for this child and if you’re going to start fiddling around with your nutrition ... I suppose you’re afraid of harming the baby”
3.2 Aleksandra – a difficult JOURNEY

Table 3 – Themes for Aleksandra

<table>
<thead>
<tr>
<th>Superordinate themes</th>
<th>Subordinate themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intrapersonal conflict</strong></td>
<td>“Internal battle”</td>
</tr>
<tr>
<td></td>
<td>Self-doubt</td>
</tr>
<tr>
<td></td>
<td>Ambivalent emotions</td>
</tr>
<tr>
<td></td>
<td>Avoidance</td>
</tr>
<tr>
<td><strong>Changing perspectives – the journey</strong></td>
<td>Prior identity</td>
</tr>
<tr>
<td></td>
<td>Shift in focus - self to baby</td>
</tr>
<tr>
<td></td>
<td>- self to social world</td>
</tr>
<tr>
<td></td>
<td>Thwarted fantasy</td>
</tr>
<tr>
<td></td>
<td>Starting position</td>
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<tr>
<td></td>
<td>Respite</td>
</tr>
<tr>
<td></td>
<td>Attribution of weight gain to baby</td>
</tr>
<tr>
<td></td>
<td>Positive outcome</td>
</tr>
<tr>
<td><strong>Self as agent of change</strong></td>
<td>Forcing eating for sake of baby</td>
</tr>
<tr>
<td></td>
<td>Self-talk</td>
</tr>
<tr>
<td></td>
<td>Self-awareness</td>
</tr>
<tr>
<td></td>
<td>Self-care</td>
</tr>
<tr>
<td><strong>Relationship to help</strong></td>
<td>Seeking help</td>
</tr>
<tr>
<td></td>
<td>Importance of professionals</td>
</tr>
<tr>
<td><strong>Relationship to unborn child</strong></td>
<td>Connection</td>
</tr>
<tr>
<td></td>
<td>Desire for companionship</td>
</tr>
<tr>
<td></td>
<td>Planning for arrival</td>
</tr>
<tr>
<td><strong>Connection to others</strong></td>
<td>Self-other comparisons</td>
</tr>
<tr>
<td></td>
<td>Others as information sources</td>
</tr>
<tr>
<td></td>
<td>Others as support/validation</td>
</tr>
<tr>
<td></td>
<td>Improved relationships</td>
</tr>
</tbody>
</table>

3.2.1 *Intrapersonal conflict*

A key theme of Aleksandra’s story was one of internal conflict and struggle, featuring what she described as a constant *internal battle*. Aleksandra would oscillate between feeling distressed about weight gain and thinking she should start restricting her eating again, to continuing her battle against it.
"every week you know I'd have a kilo or something ... I should stop but than I would straight away have the feeling ok it's only for certain amount of weeks left in the pregnancy and I have to eat now she's growing"

Increased physical hunger was connected to this internal battle; despite Aleksandra's attempts to eat regularly, another factor ensuring she no longer restricted was hunger, seen when she exclaimed "I was hungry I just couldn't do it". There were also indications that sometimes Aleksandra's eating disorder won this internal battle, as she admitted that:

"I would go many times ... hungry to sleep because I felt I had enough I wouldn't go and indulge myself completely"

This internal debate, at an early stage in the pregnancy, led to Aleksandra debating whether to continue with the pregnancy, after difficulties with her husband. This dilemma was resolved after seeing the scan (and is explored later).

Aleksandra experienced self-doubt that she would be able to cope with the experience of pregnancy and change. There was uncertainty regarding coping ability when her "eating disorder kicked in", and she described feeling:

"like god suddenly my whole life is going to change how I'm going to be able to cope with it"

She also reported ambivalent emotions that frequently changed and conflicted, such as happiness, unhappiness, resentment and fear. As she sums up below:

"on one level I was happy on the other level I was resentful on a further level I had an enemy in me growing so it was very difficult"

Aleksandra’s described coping style also utilised avoidance, in regards to what might happen to her eating disorder in pregnancy, impending motherhood and interpersonal difficulties. Specifically regarding her eating disorder, she asserted:

"I didn't think really much how I'm going to be about my eating disorder"
This avoidance may represent a temporary reprieve from the internal battle, by not considering contradictory and difficult aspects of experience.

3.2.2. Changing perspectives – the journey
Aleksandra’s resolution of internal battles could be described as a process of shifting perspectives and discovery. Her prior identity revolved around her eating disorder and weight, and her sense of self was as unstable as her weight, altering with weight fluctuations.

“my weight changed so many times from the size 8 to the size of 16 I just never knew who I really was”

Her account suggests a shift in focus in two main areas. There was a shift from self to baby throughout the pregnancy. Aleksandra found this very helpful in no longer “concentrating on myself so much”, and which appears to be of vital importance in overcoming her eating disorder cognitions.

“I could focus on the baby I could focus that I had some future I had some life I had a ... baby forever I will have something in my life not just the battle of losing weight”

Concurrently, there was also a shift in focus from self to others. Prior to pregnancy, Aleksandra stated that she did not rely on others, and her account pre-pregnancy is relatively devoid of interpersonal descriptions. After the initial stages of pregnancy however, her account suggests increased interest in other people.

“When I stopped focusing so much on myself and my eating disorder ... I discovered you know that people can be interested you know I have conversation with people”

Her descriptions suggest this interest in others started after her eating disorder became less of a focus in her life, but then became important in maintaining her reduced focus on her eating disorder. The focus on the baby, however, precedes the reduced focus on the eating disorder in Aleksandra’s perception.
There was reference to **thwarted fantasy** at the beginning of pregnancy about not gaining weight, which Aleksandra appeared dismissive of when recounting it, almost suggesting she considered herself naïve to think it.

> "until 5 months in the pregnancy I had not put any weight on ... so I was thinking whoa this is going to be good maybe I will be one of those women who are not going to put any weight on you know really living in la la land"

Aleksandra’s journey may have started even before conception, as she described finally feeling in a prepared **starting position** for considering pregnancy. Alongside considerations of not wanting to leave pregnancy “too late”, Aleksandra felt:

> "this is the right time because I have some support here I can do this ... this is the place to do it the time"

This is suggestive of preparation, especially when compared to previous thoughts regarding pregnancy.

> "I couldn’t imagine myself going through before the pregnancy I saw women pregnant women and I felt sick"

Aleksandra’s experience also features the concept of **respite**, both in relation to her own perceptions of herself and those of other people. For Aleksandra, as well as the assurance that “people wouldn’t judge me”, there was a specific improvement with her relationship with her body.

> "I liked my body more than before when I was skinny you know for some reason ... I got some sort of peace in some way you know I treated myself better"

This contrasted to perceptions prior to pregnancy. Previously when Aleksandra gained weight, she would not leave her home due to fear of negative social evaluation.

> "I had different ideas how people might think about me ... people will judge me you know that I'm fat or would think oh god those stupid people she stuff herself so much she is so fat"
However, it was important for Aleksandra to reassure herself that weight gain was due to foetus growth, amniotic fluid etc. thus the attribution of weight gain to baby was very important in her continued battle against her eating disorder. The significance of this was to make weight gain more acceptable in her eyes.

“I knew that it's not fat it is a baby there so it's different”

Aleksandra’s journey had a positive outcome at the point of interview, 10 months after the birth. She had not started restricting her eating again and was generally reporting feeling happier and more fulfilled. She described her current experience as “a gradual up”, and asserted:

“I've got life now not the eating disorder I'm living a better life now”

Taken explicitly, this suggests that from Aleksandra’s perspective, pregnancy had a curative effect on her eating difficulties. This may remain the case, although given Aleksandra’s previous use of avoidance, it remains possible that such a positive perspective on outcome is a way of avoiding considering future difficulties and uncertainties. However, Aleksandra’s account does create the impression of a genuine resolution at the end of a challenging journey.

3.2.3 Self as agent of change

Aleksandra’s described experience places her firmly in control of her battle against her eating disorder. Whilst other external events (e.g. connecting with the baby due to scans) might have occurred, she takes the meaning of these events and places the significance within herself and her own actions. One way in which Aleksandra saw herself as an active agent of change was by perceiving herself as forcing eating for the sake of the baby.

“I knew I had to do it I think I had to do it to keep [baby’s name] healthy yeah I did it for [baby’s name]"

Aleksandra also was able to use various strategies to support her efforts. Frequently she described using self-talk, which appears to have had a reassuring and inwardly supportive function. This self-talk would often focus on reminding herself of her motivation (the health of the baby) or the situation being temporary, and helped her explore new perspectives.
“it’s not forever at the moment I have to eat healthily for her because I want her to be healthy ... every negative thought every negative feeling I would try and come up with a positive one”

Aleksandra’s self-awareness in regards to her eating disorder also increased, giving her more control over it, even after her pregnancy had finished.

“I know sometimes when I am going with the eating disorder and I can stop it”

Alongside this, Aleksandra improved her self-care, which in part may have helped her maintain a positive self-image as her previous form of self-definition, her eating disorder, gradually died.

“I indulged myself a little bit instead of in food by buying nice clothes pregnancy clothes I’d have nice new makeup on I will try to do the best with what I could”

3.2.4 Relationship to help

Aleksandra’s account of seeking help both involved contemplation of requesting help and eventually being able to ask for it. Previously, she saw herself as someone who never asked for help, so this signified a shift in self-perception and coping mechanisms. Despite the novelty of seeking help, she found the experience positive.

“I let myself open up to people mostly to my family and admit I was having problems ask for ... I was always very tough never asking for anything suddenly I asked for help and I got the help so the more I was asking for it the more I was getting it so it was very very good”

One wonders whether it was the challenges of pregnancy and the motivation to act responsibly on behalf of the baby that was the further pressure that prompted Aleksandra to take the risk of seeking help.

Aleksandra’s account notes the importance of professionals in several ways. The first help Aleksandra recounted seeking, prior to pregnancy, was professional help
via eating disorder and psychotherapy services, and described it as indirectly an experience that encouraged her pregnancy.

"when I started the therapy here only a few months I met some people which who had children who had very positive experiences and it encouraged me"

In the initial stages of pregnancy, therapy felt like Aleksandra's primary source of support. When asked to describe the most important relationships in her pregnancy, she answered thus:

"I would say here my therapist my group people (Helen) dietician helped me a lot ... I can't say my husband because you know at that point no not at all ... and not my family at that point"

Aleksandra mainly recounted practical help she received from services rather than emotional support, possibly because of her direct, practical style in overcoming her eating disorder and her historical self-reliance. In particular, she found her experience with the dietician and a chart outlining what percentage of weight gain was the baby extremely useful.

"this helped me a lot because I could dissect myself and see this is the baby this is her weight this is the placenta this is the blood this is water everything I could see in my head"

Aleksandra's account suggests that being able to make sense of physical changes so she could visualise the process, alongside reassurance that weight increase was not just her, was extremely helpful.

3.2.5 Relationship to unborn child

Aleksandra's connection with her unborn child was not automatic, and initially she considered terminating the pregnancy. However, seeing the baby on a scan was a turning point that helped her bond with her unborn child, and subsequently moderate her eating on its behalf. Aleksandra explained the impact of the experience on her perceptions of her child.
‘I’m a very visual person with everything helped me a lot seeing the baby there obviously you’ve got arms and legs it’s a living creature ... it helped me a lot because I saw her as a little person already”

When the baby started kicking this was also interpreted as part of the growing bond, and Aleksandra reported it having positive effects on her mood.

A desire for companionship was awakened by the pregnancy, although Aleksandra’s view of the mother-child relationship may have been somewhat idealised, as the following assertion almost mirrors her previous belief that her problems would end if she was thinner.

“when I have a baby my life will change I won’t be on my own anymore I will have the baby”

As the pregnancy progressed, Aleksandra was orientated around planning for the baby’s arrival, and described excitement and looking forward to it.

3.2.6 Connection to others
Aleksandra made some sense of her experiences through self-other comparisons. However, rather than perceiving a sense of connection, she perceived herself as somewhat opposed to other pregnant women, including her sister.

“my sister was pregnant the same time ... she was just all the time on the website mother and baby research and doing this I just didn’t want to do anything”

This positioning of herself as different may reflect Aleksandra’s self-reliance and reluctance to seek help before the pregnancy. However, there were other experiences related to weight that she normalised, suggesting a perceived consistency of experience with others. She referred to her previously fluctuating weight and eating patterns as “the typical yo yo thing” and described weight increase in pregnancy as “a normal part of the course”.

However, as the pregnancy progressed, Aleksandra was able to draw upon others as information sources and a source of help, specifically a friend and her mother.
“my mum obviously was the first port of call for me because she had two kids so I was on the phone many times ... I would call her and get some reassurance”

Aleksandra also noticed others as support/validation. Initially she viewed the eating disorder and psychotherapy services as her only source of support, particularly as she was experiencing marital difficulties. However, as the pregnancy progressed she felt increasingly supported from different sources. She also referred to receiving compliments at the gym that she thought she would not have received had she not been pregnant.

“I got a lot of good comments and positive ... everyone was always so surprised that I was so bloody fit like no one would know I was fit when I wasn’t pregnant”

However, despite referring to positive interpersonal interactions during pregnancy, the following assertion suggests this was not a fundamental way in which Aleksandra made sense of her experiences, perhaps suggesting some continuity from pre-pregnancy.

“some guys maybe were much nicer to me ... more protective you know be careful don’t do this leave that I will help you ... but otherwise treating the same”

However, one significant changing experience for Aleksandra was improved relationships. Perhaps typical for Aleksandra’s perception of herself as an agent of change, regarding the restoration of her relationship with her mother, she describes her own actions as integral in this, as well as the pregnancy.

‘I talked to them I opened up which I didn’t do before ... I never shared my feelings ... I noticed how happy they were that I was pregnancy ... so they were very happy and I felt yes supported”

Aleksandra felt the pregnancy had a restorative impact on her relationships, but that the subsequent support was then welcomed in coping with the pregnancy. She also reported restoration with the relationship with her husband, who she was contemplating leaving at the start of the pregnancy, describing their relationship as “close together again”.
Aleksandra positioned herself as an active agent of change in the improvement of her relationships and any increase in support she felt.

"so the more I was asking for it the more I was getting it so it was very very good"

3.3 Comparisons
In some ways, Charlotte and Aleksandra’s accounts oppose each other. However, alongside differences, there are similarities in their experiences. Both will be outlined below and described in more detail in the discussion.

3.3.1 Differences
The most obvious difference is how each woman perceived being able to create distance from their eating disorder. Aleksandra’s account refers to a fluctuating, challenging but self-directed path to recovery, whilst Charlotte refers to recovery as something automatically happening to her due to the pregnancy.

“I just ate well because that was the most natural thing for me” (Charlotte)

“It was difficult when especially when the weight was going up to stay with the present to stay and just know that this is the baby it not fat and all this mixed feelings the fears” (Aleksandra)

Aleksandra was able to refer to newly discovered resources in her life (e.g. relationships) whilst Charlotte found this more difficult. It may be that whilst Aleksandra has found other methods of self-evaluation, that struggle partially remains for Charlotte. Also, whilst Charlotte’s experience of overcoming her eating difficulties during pregnancy appears easier than Aleksandra’s, Aleksandra appeared to feel more in personal control of the change.

Charlotte’s self-descriptions are grounded in perceptions of herself as a social being, whilst Aleksandra originally appeared to view herself as an individual disconnected from social spheres. Whilst both women make references to the importance of not being judged negatively, Charlotte may be more likely to gain self-esteem through the perceived eyes of others.
“thinking about what I was going to wear to such and such a party ... just planning my wardrobe was so great” (Charlotte)

Charlotte also described greatly benefiting from social support and being able to accept it, which opposes Aleksandra’s descriptions of never asking for help before the pregnancy.

“I feel like I’m a needy person ... so it’s nice for ... people to just be helpful” (Charlotte)

“ask for help which is the other thing I never did I would always be very tough never asking for anything” (Aleksandra)

Charlotte perceived that more social support was offered during pregnancy, whilst Aleksandra described this ambivalently, describing experiences of support and validation but then describing the situation as similar to pre-pregnancy.

Each participant appeared to move towards the other’s original position in redefining her identity. Aleksandra’s descriptions of her improved social relationships also suggest an increased perception of herself as a social being, and recognition of the importance of relationships. Charlotte however was attempting to find a new identity for herself that revolved more around her own individual, personal attributes, and personal belief.

“but I focus on other things ... conversation with people good time fun ... that I didn’t know existed” (Aleksandra)

“I’m quite organised that’s a resource isn’t it and I’m quite you know I try and wear my heart on my sleeve” (Charlotte)
3.3.2 Similarities

Both Charlotte and Aleksandra firmly defined their prior identity as revolving around their slimness.

"I had my whole life about eating and my weight and I was very unhappy with myself" (Aleksandra)

They also described weight concern as a normal female experience, and a connection with other women through this was implied. Both women also noted that pregnancy was a respite from such weight concerns, although this is more significant in Charlotte’s account.

"being pregnant was a bit like being on holiday it was great" (Charlotte)

Both referred to therapy as important in initiating processes of change that they continued themselves. Both women attempted to redefine their identities so they no longer revolve around slimness, although this is completed in different ways and to different degrees, as described above in “3.3.1 Differences”.

Both women regarded increased hunger important enough to recount in the interview, although Aleksandra’s account hints at this being a more difficult experience for her due to her internal battle related to eating.

"I would go many times ... hungry to sleep because I felt I had enough" (Aleksandra)

Both women also mentioned that they believed eating healthily would be best for their developing child. However, this was much more central in Aleksandra’s story, being a key motivating factor for her.

Neither woman referred in detail to their husbands as a source of support. Whilst both husbands were briefly referred to relating to support, participants referred more to their mothers as a significant source of support. Aleksandra explicitly refers to marital difficulties and describes her marriage as problematic until the later stages of pregnancy.
"I can't say my husband because you know at that point no not at all that was a lot of hindrance for me rather than help" (Aleksandra)

At the interview, both women were hopeful that their pregnancies had been curative of their eating disorders, although Aleksandra perhaps felt more hopeful of this.

"it's getting better now and I'm looking forward to the future" (Aleksandra)

"I waved it goodbye or it got put to one side ... I hope it's gone" (Charlotte)
The research aims were to explore participants’ own perceptions of reduced eating disorder symptoms during pregnancy, within a context of identity and relationships. It was hypothesised in the introduction that women with reduced eating disorder symptomatology would perceive a valued increase in social support, and a change in their perceived identity, during pregnancy. The following analyses would support these hypotheses, although both participants perceived their experiences differently, placing differing importance on the role of social support and identity change. I will proceed to discuss results in accordance to these two areas.

4.1 Identity
Both participants appeared to experience some degree of identity change, thus supporting the second hypothesis. For Charlotte this was somewhat temporary, being closely linked to her pregnant state. For Aleksandra, this was more connected to her perception of herself as a social being, and her increasing distance from her eating disorder.

4.1.1 Self-conceptions of personal agency
A difference in Aleksandra’s and Charlotte’s accounts was perception of personal agency in overcoming eating difficulties. Aleksandra perceived herself as autonomously challenging her eating difficulties through self-talk, increased self-care and determination to not harm her unborn child. Charlotte, however, felt a miraculous release from negative emotions regarding eating. She perceived this as arising from an internal force accompanying pregnancy, not within her conscious control. Thus Aleksandra and Charlotte made different attributions regarding personal agency, with different perceptions of locus of control (Rotter, 1954). Locus of control refers to how much individuals perceive outcomes as controllable through their own actions and traits (internal) or as being outside their personal control (external). Aleksandra perceived her battle through an internal locus of control, whilst Charlotte perceived her experience through an external locus of control. Charlotte’s description of her eating disorder as an external force is consistent with her having a primarily external locus of control. It is less certain how Aleksandra viewed her eating disorder prior to pregnancy in regards to personal control, although there are suggestions she felt it controlled her. However, Aleksandra’s accounts of improving her social relationships place responsibility on herself; she started the process by opening up and asking for help. This perception is consistent
with an internal locus of control. Locus of control is usually conceptualised as domain-specific (Grob, 2000), so individuals could have differing loci of control in different life areas.

Perception of control in eating disorders is commonly theorised. Psychodynamic, systemic, feminist and cognitive behavioural models all refer to control to some degree. However, empirical evidence is more limited (Sassaroli et al, 2008). Sassaroli and colleagues found support for theories that low perception of control and desire for high control exist in individuals with eating disorders. This construct was more pervasive than just limited to eating disorder behaviours, applying to external events and internal feelings. Eating disorders are thus attempts to increase overall perception of control and predictability by focusing on the narrow sphere of food and physique. Internal locus of control has also been found in individuals with eating disorders in recovery, although this was described as necessary but not sufficient alone for recovery (Pettersen & Rosenvinge, 2002). Applied to Aleksandra, perceived control in overcoming her eating disorder may have increased her overall sense of control, so she could shift perceived control from food restriction to mastery over her eating difficulties.

Why would this happen during pregnancy? Aleksandra conceptualises this as due to desire to nutritionally sustain her unborn child, supporting assertions from other mothers-to-be who successfully overcome eating disorders during pregnancy (e.g. Morgan et al, 1999). This would suggest that for some women, this motivation may be sufficient to overcome eating disordered behaviours. However, the introduction notes that some women with similar motivations are unable to reduce eating disordered behaviours. Feeling in control of recovery processes rather than seeking perceived control through food restriction might be a factor that enables some women to do this, and others to experience difficulty. It would not explain why Charlotte experienced a radical release of weight concerns during pregnancy without feeling in control of the process. However, if an individual has an external locus of control, they might be more sensitive to perceived expectations placed upon themselves by others, as will now be explored.

4.1.2 Self-definition in relation to physical expectations
Both Charlotte and Aleksandra perceived altered expectations from others, particularly regarding appearance and maintenance of an ideal figure. This was a more central theme in Charlotte’s story, and could be related to external locus of
control. Whilst Aleksandra views her battle against her eating difficulties as arising from her own determination, Charlotte perceives her eating concerns as vanishing, unrelated to self-control, in a context of reduced expectations to be slim. Charlotte’s self-perception may have changed during pregnancy by mirroring her changed perceptions of how she is perceived by others. This could be supported by cognitive behavioural and socio-cultural/feminist arguments regarding the aetiology of eating disorders.

Cognitive behavioural models suggest eating disorders occur when eating, shape and weight primary define self-worth (Fairburn et al, 2003). Both Charlotte and Aleksandra defined their worth like this prior to pregnancy, and moved away from this during pregnancy. If Charlotte sees her behaviour as externally controlled and defines herself in relation to others, she may be more susceptible to perceived changing expectations from others when defining, or redefining, herself. When others allow her to be less focused on shape and eating, then she more easily accommodates this within her self-concept. Bordo’s (2003) assertion that cognitions, perceptions and beliefs in eating disorders represent real societal expectations of the female body supports this. If those attitudes are felt to change temporarily, i.e. during pregnancy, then this could lead to altered self-perception. Therefore it was not Charlotte’s own attempts that enabled her overcome her eating concerns, but a kinder, more accepting social perception that changed her own self-imposed standards. To briefly apply a psychodynamic perspective, this may represent difficulty in separating the desires of others from the desires of the self (Clinton, 2006).

Whilst Charlotte considered this respite from expectations extremely important and positive, she did not herself link this to her perceived incongruence of eating disorders and pregnancy. This incongruence appeared more linked to her self-identity and beliefs as a mother-to-be – she (as a pregnant women) could not conceive of the two existing together. The importance of this self-perception as mother-to-be is also suggested in her perception of differing treatment from others, and her increased social ease, due to her pregnant status. The new self-perception is partly dependent on her appearance as a pregnant woman, therefore self-perception is still connected to appearance, albeit according to different values. Pregnancy may have allowed Charlotte to see herself fulfil an alternative function to the female decorative role, motherhood being perceived by other pregnant women as an alternative physical and socially accepted function (Bailey, 2001). Aleksandra
may have experienced something similar, but her account does not place the same significance on self-perceptions to others as a pregnant woman.

Charlotte did not refer to improvements in body image during pregnancy; her experience mirroring those of pregnant women without eating disorders, who felt fewer expectations to be slim, but remained dissatisfied with their appearance (Johnson et al., 2004). Aleksandra felt she would be less judged on physical appearance when pregnant, but described increased personal acceptance of her physical form during pregnancy. This may be due to Aleksandra excusing her weight gain from pregnancy by attributing it to her unborn child. However, changes in self-perception would also appear to come from new additions to her life, which are explored in the following section.

4.1.3 Broader changes
Aleksandra, whose pre-pregnancy account suggested a self-perception of feeling disconnected from others relationally, saw herself increasingly interpersonally. Her focus shifted towards her unborn child and others from herself and food. Whilst the impact of improved relationships will be later discussed, this section explores her perception of being more socially connected. The perceived impact appears large – Aleksandra described increased interpersonal focus as a key factor in overcoming her eating disorder and feeling more self-fulfilled. Whilst discovering other aspects of life, Aleksandra’s identification with her eating disorder may have reduced as she found alternative ways to define herself (mother and social being). Reduced identification with eating disorders has been suggested as a key recovery component (Keski-Rahkonen & Tozzi, 2005), along with willpower and self-motivation. In Aleksandra’s case, the latter two could be conceptualised as self-determination and internal locus of control. Aleksandra felt more self-aware of her eating disorder processes, suggesting a developing capacity to perceive these as observable thoughts and behaviours, and possibly further reducing identification with eating difficulties. Within cognitive behavioural or feminist frameworks, by focusing on other areas of life, Aleksandra had less need to define herself through weight and shape.

Pregnant women transitioning to motherhood have described feeling closer to partners and perceiving a changing, more adult-to-adult relationship with parents as their own perceived identities changed (Smith, 1999). This greater perceived interpersonal connection enabled impending motherhood to be explored through the
experiences of others. Aleksandra felt her relationships with her parents and husband improved over pregnancy, and she began to view her mother as a resource for understanding pregnancy and motherhood. Charlotte also reported feeling symbolically connected with her mother. Whether Aleksandra maintains her perceived distance from her eating disorder is uncertain, although 10 months after birth, symptoms had not returned, and she remained hopeful they would not. Aleksandra saw her new external focus, which the pressures of pregnancy enabled her to discover, as protective. She also appeared to have greater self-acceptance, which is associated with recovery from eating disorders (Pettersen & Rosenvinge, 2002).

Whilst Aleksandra’s most evident perceived struggle was overcoming her eating disordered behaviours, Charlotte’s perceived struggle was of redefining herself, triggered by therapy and subsequent weight gain. Individuals with eating disorders may lack perceived identity (Bruch, 1974). Charlotte found this greatly challenging pre-pregnancy, not problematic during pregnancy, and post-birth has revisited the issue. As previously suggested, Charlotte may have redefined herself throughout pregnancy as a mother-to-be. However, this was temporary, and her previous task of redefining herself unconnected to shape and eating has re-emerged. Charlotte described attempts to self-identity positive attributes unrelated to appearance to aid this redefinition; as previously noted, perceived distance from eating difficulties is associated with recovery (Keski-Rahkonen and Tozzi, 2005). Whilst Charlotte remained finding this process difficult, she felt more removed from her prior eating difficulties post pregnancy, and was determined, if slightly anxious, to continue the process of redefinition. Possibly the respite of pregnancy, and experiences of perceiving herself as removed from eating concerns, gave Charlotte perceived freedom from weight concerns, and motivation and hope in achieving that again.

Perhaps both women’s newly discovered aspects of themselves; Aleksandra’s increased social connectedness and Charlotte’s search for personal strengths, suggest that integrated self-perceptions of interpersonal connectedness and intrapersonal agency/strength may aid recovery. Such integrated, richer self-perceptions may not need to rely on appearance for self-evaluation, lessening the power of eating concerns. Strengthening less acknowledged aspects of the self may also positively alter more acknowledged aspects, i.e. strengthening interpersonal self-definitions could improve intrapersonal self-definitions, and vice versa. Theories of relational selves suggest perceived identity consists of a myriad of self-other
perceptions based on significant relationships, implying that self-perception is dependent on the quality of these. Andersen and Chen's (2002) social-cognitive model suggests self-other evaluations of significant others, transferred onto lesser relationships through transference, can evolve and change. Positive re-workings of significant relationships could not only impact on perceived identity, but could motivate someone to seek further social relationships beyond significant others, and increase expectations that they can be fulfilling. Aleksandra appeared to experience this. As her relationships with her family improved, she became more motivated to socialise with others. Andersen and Chen's theory acknowledges that alongside alternating relational selves, individuals have a more stable self-perception of competencies, aspirations and values. This is the area in which Charlotte's current challenge lies.

Theories of relational selves could link identity and actual relationships; the latter shall now be explored.

4.2 Relationships
4.2.1 Relationship with unborn child
Both participants reported a strong bond with their unborn child, although Aleksandra's was not immediate. Charlotte felt intense love for the baby, and experienced reduced eating concerns immediately after discovering she was pregnant. Aleksandra struggled with ambivalence, both towards the foetus and her desire to eat well on its behalf. When Aleksandra finally bonded with her unborn child through scans, she felt increased motivation to prevent restriction. Aleksandra's perceived maternal-foetal bonding appears important in overcoming her eating difficulties, and whilst Charlotte did not report this link herself, her ceased eating concerns occurred within the context of a strong bond. Both Charlotte and Aleksandra wished to provide adequate nutrition for their unborn children. Prior research states that mothers-to-be who successfully reduced or ceased eating disorder behaviours perceived this as for the baby's sake (e.g. Morgan et al, 1999), although such intentions are not always sufficient (Lewis & LeGrange, 1994). Perceived maternal-foetal bond may assist that desire to be actualised. Whilst maternal-foetal bond has not been associated with eating disorder symptoms, it has been associated with body image (Lai et al, 2005).

Andersen and Chen (2002) suggest activation of relational selves causes behavioural self-regulation, due to the perceived desires and standards of the other,
in specific relational self-activations. If maternal-foetal bond is viewed as a significant relationship, one where mothers form relational representations based on perceptions of what the foetus needs, then activation of this relational self might cause self-regulation of eating disordered behaviours or desires. Both Charlotte and Aleksandra described perceived relationships with their unborn children, even possibly seen in their description of them as babies rather than foetuses throughout pregnancy. As participants retrospectively reflected on their pregnancies after childbirth, this might be reflective of the temporal context of the interview. However, both (after Aleksandra’s ambivalence had passed) referred to contemplating their arrivals in strongly positive terms.

4.2.2 Other interpersonal relationships

Both Charlotte and Aleksandra perceived improved interpersonal experiences during pregnancy and valued this, supporting the first hypothesis of the study. Whilst Charlotte felt supported in intimate relationships (mother, husband, sons), it is uncertain how much this increased in pregnancy. She described symbolic closeness to her mother, perceived excitement from her children, and mentioned support from her husband. More notably, Charlotte perceived increased support from acquaintances (sons’ teachers, neighbours). Aleksandra perceived improvements in relationships with significant others (parents, husband), in addition to less significant relationships. Both conceptualised these changed relationships in ways broadly fitting prior analysis. Aleksandra interpreted changes as due to her opening up to others, with pregnancy as a catalyst, whilst Charlotte perceived changes as external to her control, arising from her pregnant status. Rocco and colleagues (2005) suggested women with eating disorders might feel life more manageable with increased support in pregnancy, no longer requiring eating behaviours or cognitions as coping mechanisms. However, after childbirth the termination of increased support is stressful. This appears to describe Charlotte’s perceived experience; she was aware increased support would not last after childbirth, but valued it whilst she could. Increased support may also have helped Aleksandra, but she did not conceptualise this as significantly as Charlotte.

Three social aspects identified as definitions of recovery by individuals overcoming eating disorders are good social functioning, perceived assertiveness, and perceived meaningfulness with others and self (Pettersen & Rosenvinge, 2002). The study’s most commonly expressed aspect of recovery, self-acceptance, was further defined to include feeling comfortable around others and the ability to form
satisfactory romantic relationships. From this perspective, Aleksandra’s perception of improved relationships suggests more holistic recovery than symptom reduction. Aleksandra’s interpretation was that due to perceived responsibility towards the foetus, her eating disorder symptoms decreased. Then she could focus on other relationships, giving her an alternative focus to being slim. Improving social relationships and reducing eating disorder symptoms may have worked reciprocally for Aleksandra. Feedback in one area encouraged the other, with her unborn child being the catalyst motivation, and increased interpersonal focus also being a response to new challenges. Additionally, preparing for a significant other entering one’s life may increase reflection regarding existing relationships. Pettersen and Rosenvinge (2002) report participants describing having a child as the significant event spurring recovery (citing experiences of care and responsibility), although did not expand further.

Both participants described practical and preparative benefits of professional contact, particularly valuing information on nutrition and/or foetus development. Neither reported negative experiences with professionals, unlike previous studies (Lemburg & Phillips, 1989). Before Aleksandra repaired her significant relationships, she described relationships in service settings as the most important and supportive. However, participants also felt supported by significant others, albeit later for Aleksandra. Individuals in recovery from eating disorders have suggested that whilst the therapeutic relationship is helpful, important positive, non-professional relationships are vital in providing “unconditional love, support, trust, inspiration, and hope” (D’Abundo & Chally, 2004, p. 1101). These relationships were with parents and partners, although the authors note that difficulties in these relationships can have negative impacts. Charlotte explained her movement towards her family as due to knowing they loved her, possibly suggesting a refocusing from more superficial relationships to deeper ones. Both Aleksandra and Charlotte described their mothers, rather than husbands, as their most meaningful source of support, identifying significance to their mothers’ experience of pregnancy. Both women also saw their joy in their unborn children mirrored in the eyes of significant others. Charlotte referred to the joy of her existing children, and Aleksandra the joy of her parents.

4.3 Summary
The study explores the lived experiences of two women, with similar perceptions of pregnancy being a factor in overcoming eating difficulties, but in different ways.
Charlotte experienced automatic change, whilst Aleksandra struggled, but found pregnancy sufficient motivation to succeed. Their experiences may be influenced by perceptions of control. An integrated perception of self as socially connected and as having positive personal attributes may also help explain their experiences. Both women bonded with their unborn children during pregnancy; when mothers-to-be perceive their unborn children relationally, this might assist regulation of eating disordered behaviours and thoughts. Aleksandra felt the pregnancy was a catalyst for improving significant relationships, and both women specifically referred to their mothers being a positive source of support. The hypotheses that participants would perceive increased and valued social support during pregnancy, in addition to perceived identity change, were broadly supported. However, Charlotte’s perceived changed identity may have been temporally restricted to the state of pregnancy.

4.4 Critique
As a case study perceptive, participants’ experiences cannot be generalised to wider populations. Participants had marked differences in their accounts, demonstrating the unique and individual nature of context-based experience. However, similarities between cases are also supported by existing literature, suggesting theoretical generalisability (Yardley, 2008). These include the importance of perceived support, concern for the foetus, and perceived respite from appearance-based expectations. Their differences are also important as they show similar outcomes can occur via different pathways, which quantitative studies can miss. An advantage of case studies is they are highly idiographic, with detailed exploration of each participant’s experience. Creating a table of themes for each participant rather than merging their experiences to create an overall table of themes allows more richness in the data to be maintained. However, more participants would have enabled me to explore commonalities in Charlotte’s and Aleksandra’s experience in a larger sample, as well as further potential differences.

The study may support Rocco and colleagues’ (2005) hypotheses regarding the importance of interpersonal support and maternal-foetal bond. However, as a qualitative study exploring participants’ phenomenological experience, it cannot make assumptions regarding directionality. Participants’ own theories of directionality (i.e. Aleksandra describing the scans as leading to bonding) are discussed, as integral to their personal meaning making. Exploration of the data attempts to move beyond participants’ explicit accounts, as IPA is interpretive. Whilst this double hermeneutic has been acknowledged, and some interpretations
are linked to existing research to attempt theoretical generalisability, interpretations are invariably influenced by my own perspective as researcher. Therefore the analysis is just one possible interpretation of the data. Coding and themes were checked by a supervisor to ensure sufficient grounding in the text.

The two participants shared some demographic similarities. Both women appeared middle class, were married, white and 40 years old. Voices belonging to younger, unmarried or single, ethnic minority or working class women were not included in the study. Interviewing a wider range of participants might offer different perspectives and highlight alternative challenges. However, existing demographic differences, such as Charlotte's prior status as a mother and Aleksandra being a foreign national primigravida, were not addressed in the analysis because I felt there were more meaningful areas of comparison.

Both women had diagnoses of EDNOS. EDNOS is the largest diagnostic category of eating disorders (Machado et al., 2007), so studies recruiting participants with this diagnosis are important, although rare. As EDNOS includes a wide range of presentations, participants varied regarding symptomatology at conception. Questions assessing this were asked in the initial interview, and in Aleksandra's case (as the second participant to be interviewed), in the main interview. This was reviewed after reflecting that recorded and transcribed data would have been useful for Charlotte, as writing notes during an initial telephone interview lost detail. Given potential variation in EDNOS, the interview schedule should have included questions referring to behavioural and emotional/cognitive symptoms prior to conception.

Non-verbatim recording of prior symptoms was potentially problematic in Charlotte's case. She reported eating regular meals for three months prior to pregnancy due to treatment, and resultantly had stopped restriction, bingeing and purging. Further to this, in her main interview she conceptualised this as recovery. However, in the initial interview she reported high levels of guilt and distress associated with eating and weight gain, and negative evaluations of shape, i.e. her eating disorder cognitions and emotions remained. She described eating concerns as completely disappearing in pregnancy, with eating feeling natural rather than forced. As Charlotte did not show objective reductions in physical eating disorder behaviours from conception to birth, her inclusion could be questioned. This was considered with project supervisors. I justified her inclusion as the study was concerned with
subjective reductions in eating disorder symptomatology, and her remaining
emotional and cognitive symptoms ameliorated. My field supervisor also advised
that individuals must be free of eating disorder symptoms for over three months
before their diagnosis is removed, and Charlotte reported regular eating without
purging for approximately three months. A further issue with Charlotte’s inclusion
was I had worked with her previously in a clinical capacity for treatment of her eating
disorder. This was discussed at a qualitative research discussion group at
university, and a research tutor advised me that her inclusion was acceptable if
possible implications were discussed in my reflections.

4.5 Ethical issues
No ethical issues arose during data collection – participants did not report negative
emotions arising from the interview when debriefing, and both described reflecting
on their pregnancies as enjoyable. No risk issues arose. Participants accepted the
telephone numbers given to them at the end of the interview. One participant spoke
about an issue she did not wish recorded during the non-recorded debriefing. For
their confidentiality, this participant will not be specified. Whilst occupation was
recorded with demographic information, its inclusion was withdrawn, in case this
more specific information reduced confidentiality.

4.6 Reflections
As noted, I had previously worked with Charlotte clinically as her treatment began
with the Eating Disorder Service. This may have influenced my perception of her. I
was genuinely pleased to see her again and it was my impression she felt similarly.
I found it particularly heart-warming to hear how distanced from her prior eating
difficulties she felt, and the interview almost had a parallel feel of a follow-up clinical
appointment. Reflecting on the interviews, I recall feeling more empathy with
Charlotte than with Aleksandra regarding negative aspects of experience. This may
be due to my previous relationship with Charlotte, although it could be due to
Charlotte’s greater uncertainty about the future, or individual counter-transference. It
was also possible that my analysis of Charlotte’s interview would be influenced,
either consciously or subconsciously, by prior knowledge of her. For her clinical
confidentiality I cannot relate the example where I reflected this could have
happened. However, I closely examined her transcript again, and made minor
revisions to the analysis. My prior experience of working with her may have had a
subtle impact on our research relationship and my analysis. However, being explicit
about my position, and acknowledging that qualitative research, particularly IPA, will
always be influenced by the researcher’s experience and contextual factors, reduces negative implications.

I felt connected to each participant, felt honoured to hear their stories, and found myself hoping alongside them that their eating difficulties were over. It felt natural to empathise with participants. I wonder whether if I had explored the experiences of women experiencing a worsening of symptoms whether I would have felt such uncomplicated empathy, due to personal concerns and opinions regarding possible impact on the unborn child.

Regarding how I was perceived by participants, they may have somewhat identified with me based on our shared gender, e.g. Charlotte’s mention of husbandly support possibly assumed shared understanding. However, perceived similarity might have increased difficulties in admitting perceived vulnerabilities, due to negative comparisons. Participants were unaware of my history of eating difficulties or my position as a childless woman, although may have assumed the latter as I have a young appearance. However, if this was assumed, I cannot think of incidences where this may have negatively affected rapport.

4.7 Research implications
The discussion suggests locus of control might be implicated in actualising desires to be nutritionally responsible for the foetus. Locus of control is examined in a limited number of eating disorder studies, but has not previously been linked to eating disorders and pregnancy. Further research could more directly explore perceived control in women experiencing reduced symptomatology during pregnancy. Further work exploring the desire to not harm the foetus as a motivational factor could also be beneficial. Studies exploring the nature of the maternal-foetal bond, or rather the mother-to-be’s relational representation of this, could also further explore theoretical links tentatively made in this study.

The study specifically focused on the experiences of women who showed reduced symptomatology during pregnancy, rather than women who experienced an increase, no change or a mixed group. This was so women, experiencing what could seem a counterintuitive reduction of symptoms, could be the primary focus of the paper. However, similar idiographic qualitative studies exploring the experiences of women experiencing no change or increased symptomatology could help
theoretically generalise why some women experience pregnancy as a break from symptoms, even a cure, and some women do not. Qualitative, and particularly case study analysis is ideal for examining such differences within individual’s personal contexts. When factors are identified, quantitative research could explore between group differences in women experiencing substantial or total amelioration of symptoms, and women who do not.

4.8 Clinical implications
If aspects of pregnancy enable some women with eating disorders to experience symptom amelioration, then identification of those aspects, particularly those transferable to circumstances unrelated to pregnancy, could inform clinical practice. This research offers theoretically generalised support for existing treatments, in addition to suggesting additional areas of focus. All suggestions, apart from those specific to pregnancy, could be applied to the psychological treatment of eating disorders generally. However, as there is little clinical guidance for working with pregnant women with eating disorders, there is a need for evidence-based therapy strategies for this specific client group. Whilst this study is not a therapeutic evaluation study and cannot be empirically generalised due to its small sample size, extant literature is referred to when appropriate to strengthen the study’s ability to theoretically generalise.

Whilst Aleksandra’s primary motivation was pregnancy specific (i.e. harm to foetus), her challenge of her eating disorder could be conceptualised as redirection of internal perceived control from food restriction to fighting her eating disorder. This appeared to maintain motivation, increase perceived control and improve self-esteem. Aleksandra also increased her focus on other areas of life other than food, her descriptions implying that she perceived this wider focus as vitally important in maintenance of gains and recovery. Whilst therapy already focuses on helping clients find alternative ways of perceiving themselves, Aleksandra’s experience suggests this as the major maintenance factor. Charlotte’s experience also suggested redefinition of self was something she struggled with but considered vital for recovery. Therefore the study supports specific focus on redefining identity in therapy. This could be incorporated into existing psychological treatments such as CBT, by clinical psychologists or other skilled clinicians, if and when this focus is appropriate for each client. When clients refer to their eating disorder as an attempt to gain perceived control, explicitly reframing successes in overcoming eating disordered behaviours as a potential shift of perceived control might help some
individuals.

Both participants positively referred to professional support, but also support from non-professionals. Recovery perspectives suggest that non-professional social experience can be more important than therapy, and that clinical treatment should utilise this potential support system more (Pettersen & Rosenvinge, 2002). This study supports this suggestion, and thus provides support for systemic interventions that could help clients improve the quality of these non-professional, personal relationships. If family therapy is not possible, systemic techniques can be used with clients individually; for example, circular questioning can be used with individual clients to help them re-appraise their social networks (Athanasiadis, 2008). Support groups for pregnant women with eating disorders might also create peer-based support systems. Support groups are recommended for treatment of eating disorders (NICE, 2004). However, if there are few pregnant women with services at a given time, numbers may be insufficient.

This study supports the idea that a good maternal-foetal bond may act as a motivating factor in successful symptom reduction. Giving pregnant clients space to reflect on this bond in therapy, working through any negative feelings towards the foetus, might help strengthen it. Systemic interventions that frame the foetus as an existing part of the client’s system, and early referral for neonatal-scans, might also facilitate positive maternal-foetal bonding.

Both participants described practical advice regarding pregnancy, e.g. nutrition and how weight gain is distributed, as very helpful, and specifically mentioned the role of dieticians. This offers some support for pregnancy specific biopsychosocial intervention and the use of multidisciplinary interventions. Whilst some services may be able to offer face-to-face multidisciplinary support, other services may not be so well resourced. Clients may also be reluctant to meet with numerous different professionals. Psycho-educational self-help programmes are recommended for first line treatment of BN and atypical eating disorders (NICE, 2004). Self-help literature focusing on possible biopsychosocial issues for pregnant women with eating disorders, derived from existing research and clinical practice, should be created and used by services as part of treatment of this client group. It may be particularly helpful to add information regarding projected weight gain in pregnancy.
4.9 Conclusion

The study aimed to explore women's own perceptions of why they experienced reduced or non-existent eating disorder symptoms during pregnancy, with a broad focus on identity and relationships. Two participants were recruited and a case study approach adopted. Participants' described experiences had numerous differences, but similarities were observed (e.g. perceived respite from body concerns, concern for and a bond with the foetus, increased perceived support, and improved interpersonal relationships). One major difference in their accounts was one participant's experience of change felt outside their control, as if an internal force took over, whilst the other perceived herself as an active agent in challenging eating disorder behaviours. Findings were discussed in relation to perceptions of control, perceptions of altered social expectations regarding appearance, alternative forms of self-definition, relational selves, including in relation to the foetus, and social support. Clinically, the study suggests explicit focus in therapy on perceived control and personal redefinition may be helpful. It also supports systemic approaches, to help strengthen social support outside therapy and facilitate maternal-foetal bonding, and self-help literature for pregnant women with eating disorders.
REFERENCES


APPENDICES
Appendix A – Protocol

South West London and St George's NHS
Mental Health NHS Trust

Faculty of
Clinical Psychology

Department of Psychology
School of Human Sciences
University of Surrey
Guildford, Surrey GU2 7XH UK

Fay Coster
Trainee Clinical Psychologist
F.Coster@surrey.ac.uk

How do women with eating disorders account for a subjective reduction of their symptoms during pregnancy? An exploration using Interpretative Phenomenological Analysis: Protocol

Theoretical Rationale:
Whilst it is commonly assumed that women with eating disorders have difficulties conceiving, a substantial number do so and continue the pregnancy to term (Morgan et al., 1999). In a community sample, 4.9% of pregnant women scored over the threshold on the Eating Attitudes Inventory (Turton et al., 1999). The effect of pregnancy on women with eating disorders has been researched for the last 20 years, although research remains limited. Many but not all studies suggest that pregnancy is accompanied by an amelioration of symptoms during pregnancy, and a relapse or worsening of symptoms postpartum (Namir et al., 1986; Lacey & Smith, 1987; Lemberg & Phillips, 1989; Blais et al., 2000; Rocco et al., 2005). The reasons for this are less clear. Whilst fear of harming the growing foetus has been suggested as responsible (Lacey & Smith, 1987), as some women have the same concerns but do not show this marked reduction in symptoms (Lewis & Le Grange, 1994) this is unlikely to be the whole story. Both a decrease (Crow et al., 2003) and an increase (Rocco et al., 2005) in body satisfaction has been found to accompany decreased eating disorder symptomatology, and partner support, maternal-foetal bond and depression have been linked to symptom manifestation throughout pregnancy (Lai et al., 2006). Rocco and colleagues (2005) hypothesise that reduction in symptoms may be due in part to sociopsychological issues, such as increased support, increased allowance to self-care, reduced social expectations, and a different "psychic stance" reducing the impact of concerns regarding thinness, body image with pregnancy being removed at birth, post natal depression, mother-child bond and perfectionism have also been associated with this (Lai et al., 2006; Mazzeo et al., 2006).

As eating disorders active during pregnancy can increase complications of pregnancy and birth (Newton & Chizawsky, 2006), and as eating disorders are extremely distressing for those suffering them, research into what may help
recovery from these symptoms (albeit temporarily) is important. Such research could inform psychological interventions for mothers-to-be with an eating disorder. However, whilst several studies examining what happens to women with eating disorders throughout their pregnancy have touched on possible reasons why, there has not yet been a study focusing solely on women who observe an amelioration of symptoms during pregnancy, and their interpretation of this. Quantitative studies that assess reasons for such changes in behaviour only assess what factors the researchers have contemplated as important. Therefore there is a need for a qualitative study exploring the personal experiences of such women, to explore their experiences of pregnancy and the postpartum period, and their meaning making behind their experiences.

Aims, Objectives and Research Question:
The present study aims to explore the individual experiences of a group of women with eating disorders who report a reduction of symptoms whilst they are pregnant. The objective of the study is to add to a body of research in the area by asking what the experiences of these women are, both in relation to their symptoms and in how they view the world and themselves.

Therefore the research question is conceptualised as “How do women with eating disorders explain a reduction in their eating disorder symptomatology during pregnancy?”

Setting:
The research project is being undertaken within the Eating Disorder Service of South West London and St Georges NHS trust. Participants may also be recruited from the Beating Eating Disorders (BEAT) website subject to agreement post ethical approval; the BEAT website advertise doctoral level and professional research and who have a database of approximately 400 research volunteers.

Interviews will take place in participant’s homes, unless they wish the interview to take place somewhere else, in which case therapy rooms at the Eating Disorder Service of South West London and St Georges NHS trust will be used (this option will not be available for participants recruited from BEAT). A telephone interview is offered for the initial interview.

Participants:
6-8 participants are to be recruited from the Eating Disorder Service of South West London and St Georges NHS trust. Posters and leaflets advertising the research will be located in waiting rooms throughout the service’s waiting rooms, with a contact email address and telephone number. In addition, discussions with care coordinators regarding possibly suitable cases will be used to recruit. The BEAT website may also be used to advertise for participants subject to approval.

Criteria are as follows. Participants must:-
  a) be 18 years old or over
  b) have experienced pregnancy to term within the last 2 years
  c) have had a diagnosis of a clinically significant eating disorder prior to pregnancy which remained valid at the point of conception (either diagnosed by the Eating Disorder Service, or in the absence of a clinical diagnosis, retrospectively assessed according to ICD-10 criteria before the research interview). To maintain homogeneity across the sample, only eating disorders with some degree of restriction will be included, and women suffering from Binge Eating disorder will be excluded.
d) speak English. This is due to there being insufficient resources to employ interpreters in the interview and analysis process.

e) have felt that the symptoms of their eating disorder improved during the course of their pregnancy. Due to the focus on participant's individual meaning making of their experiences, the criterion is based on their own perception of improvement rather than a defined objective quantitative measurement. Posters asking for participants will ask for women who felt that their symptoms improved, and discussions with care coordinators will ask for women who were observed to have an improvement in symptoms (the participant's own perception of this will be assessed when they are initially contacted). However, in the initial communications between researcher and participant, participants will be asked what reductions in symptoms they noticed. If according to their self-report there is evidence that there was at least some objective reduction in symptoms to meet the criterion. Due to the possible variation in symptoms and symptom severity, it is difficult to set clear criteria for how much symptoms must be objectively reduced for inclusion in the study. Whilst the study is concerned with women's own interpretations of their experiences, as the study may be used to identify factors that lead to a reduction in eating disordered symptomatology, it is important to ensure that there is at least some objective reduction in symptoms. Potential participants will be asked to provide some description of how their symptoms could be seen to objectively reduce, e.g. allowing themselves to eat 1500 calories per day rather than 1000, reducing binges/purges to twice a week from once a day, etc. Obviously as this is subject to retrospective self-report, it is noted that participants' accounts may not entirely reflect objective reality.

As the study is interested in the experiences of women with Anorexia Nervosa, Bulimia Nervosa and Eating Disorder Otherwise Specified, symptoms may vary between participants. What is considered a reduction in symptoms will therefore be specific to each participant's experienced symptoms. If a participant restricts their eating, then willingly eating more in quantity and/or in regularity is a symptom reduction, as is a reduction in the amount of binges for women for whom bingeing is considered a symptom. Likewise reductions in purge related behaviours (i.e. vomiting, laxative abuse and excessive exercise) are also considered to be symptom reductions.

Procedures:
South West London and St George's clients who have been identified by their care coordinators as potential participants will be informed of the study by their care coordinators/involved staff during clinical appointments. If they express an interest in taking part in the research, they will be asked which of the following they would prefer for an initial meeting with the researcher – i) home visit, ii) telephone conversation, iii) clinic (outpatients or inpatients) appointment. Potential participants who have contacted the researcher directly from advertisement in waiting rooms or on the BEAT website will be given the same choice (those recruited from BEAT will not be offered clinic appointments).

BEAT also can search for potential participants who may meet research criteria within their research database, and contact them with the research details, whilst also informing researchers of the approximate number of potential participants. This is dependent on what personal information is collected for the database.

The initial meeting will involve the following:-
1) assessment of whether the potential participant matches criteria. Potential participants will be asked how they felt their symptoms improved/decreased, how long the pregnancy lasted, what diagnosis and level of treatment they were
receiving prior to conception, age and whether the pregnancy was their first (this is not important for criteria but may be useful to consider in analysis). BEAT recruited participants may also be asked some further questions about their symptoms prior to pregnancy to confirm diagnosis if felt necessary (e.g. self diagnosis), or to categorise them within a diagnosis if no formal diagnosis has been given/the participant was not aware of it.

2) discussion of the research procedure and basic outline of the project, including potential risks and benefits to participants.

3) acquiring informed consent

Those individuals which meet criteria and who give informed consent to take part will be interviewed in their own home using a semi-structured interview lasting approximately one hour, unless they do not wish to be interviewed in their own homes (see “setting”). Individuals will also give consent for the primary researcher to consult with clinical staff and refer to their clinical notes to obtain their official diagnosis at the point of conception (this will not apply for BEAT recruited participants).

To ensure confidentiality for participants whilst ensuring the interviewer’s personal safety, when interviews are to be conducted in participants’ home their address will be given to the project supervisors in a sealed envelope. The researcher will inform supervisors when a home interview is scheduled; after completion the interviewer will collect the envelope and destroy the contents. The interviewer will also prearrange to ring a supervisor when the interview is over.

For reasons of safety for participants, GPs will be informed of the participants taking part in the study once informed consent has been received, and will be sent a copy of the Participant Information Sheet. However, no details of the interviews will be disclosed to GPs or clinicians at the St George’s Eating Disorder Service, unless significant risk to participants or other persons becomes apparent.

**Semi-structured interview:**
A semi-structured interview will be used in the hour-long interviews. Questions are designed to explore participants' experiences of pregnancy and their experience of their eating disorder throughout pregnancy, as well as exploring wider issues relating to identity and social relationships. Due to the nature of qualitative work, there is scope for experiences outside the question areas to be explored if brought up by the participant, to make the interview process meaningful to them. Due to this process, the specific questions asked can evolve slightly over the interview process.

The broad areas of interview are as follows.

**Broad question areas for interview**
What was their overall experience of pregnancy?
How does their eating disorder relate to their experiences of pregnancy?
What explanations do they have for their reduction in symptoms (if any)?
How was their general sense of self before and during pregnancy? (including identity and body image)
What was their experience of their social relationships throughout the pregnancy?
What happened after they gave birth?

**Type of qualitative analyses:**
The study will use Interpretative Phenomenological Analysis (IPA). As the study is concerned with the individual mental experiences of a small group of women and their interpretation of them, and does not aim to propose universal truths about the
nature of pregnancy for women with eating disorders, IPA is the best suited approach. As IPA is invariably influenced by the researcher’s own interpretative stance, the approach uses a double hermeneutic (Smith & Osborn, 2003). Therefore the approach recognises that interpretation of the participants’ stories will be influenced by the researcher’s own values.

Transcripts will be coded in accordance with IPA guidelines to look for psychological processes and general themes arising within individual interviews and between interviews. These themes go through a process of refinement before being written up in the analysis. Quotes from interviews will be used within the write up to demonstrate how themes are grounded in the interview transcripts, with pseudonyms used to protect participants’ anonymity.

**Feedback for participants**
Participants will be offered verbal and written feedback as to the interpretation of their interviews and the overall findings of the project. Due to the ethos of IPA (i.e. that the analysis recognises the importance of the researcher’s interpretation of the participant’s account, using a double hermeneutic), participants’ reflections on the analysis will not lead to its alteration. However, their comments will be considered in the critical evaluation of the project.

**Ethical Considerations:**
Re-living their experiences by talking about them may cause some participants some distress. This may especially be the case if there were complications relating to pregnancy and birth, or if participants are more symptomatic at the time of interview than they were during their pregnancy. To minimise the potential consequences of this, each interview should be finished with a “debriefing” question that asks participants about their experience of discussing their experiences, and invites them to discuss any difficult emotions that may have arisen from the interview if they wish to. In addition, it will be explained to participants that they can drop out of the research at any time, and informed consent will be acquired. As described above, participants will be offered verbal and written feedback.

**Dissemination**
The results will be disseminated in a doctoral level dissertation and will thus be a public document. A version will also be submitted to a peer reviewed journal for publication.

**References**


Appendix B—Interview schedule

General introduction questions/scene setting
How would you describe your overall experience of pregnancy?

What do you feel happened to your eating difficulties whilst you were pregnant?
Prompts—symptoms, feelings, its power

Did you expect this to happen? What thoughts and feelings did this bring up for you?

How do you explain this experience? [question intentionally wide as using funnelling technique]

Identity and inner experiences
I’d like you to think back to before you discovered you were pregnant. [give the participant a moment to do so] How would you have described yourself as a person back then?
Prompts—personality characteristics, roles, self-perception/esteem, what things do you think other people might have noticed about you, ambitions and opinions

Did the way you see yourself change over the course of the pregnancy
Prompt if yes—what changes did you notice? Use prompts for above question as appropriate

As the pregnancy progressed, how did you feel about the physical changes to your body?

What understanding did you have of these changes?

How did this differ from how you saw your body prior to pregnancy?

How important do you think your eating difficulties were in shaping your identity both before and during your pregnancy?

What do you think may have accounted for any changes in how you saw yourself?

What emotions did you notice yourself having throughout the pregnancy?

Person as relational being
What were your most important relationships when you were pregnant?
Prompts—partner, mother, father, extended family, friends

How did you feel people treated you when you were pregnant?
Prompts—differences. Similarities, expectations, support, important relationships and people in general

What impact did this have on you?
Prompts—mood, self esteem, social roles, eating difficulties

Did you notice any differences in how you were around other people?
Prompt – what do you think other people might have noticed about how you were with other people during the pregnancy, what do you think accounted for these differences?

Many women with eating disorders describe their eating difficulties as an important relationship in their life. If this description makes sense to you, what did you notice happening to your relationship with your eating difficulties across the course of your pregnancy?

Maternal/foetal bond
How did you feel about your unborn child when you first discovered you were pregnant?

Prompts – emotions, thoughts, relationship to child

Did this change over time, and how?

Prompts – emotions, thoughts, relationship to child

How much thought did you give to impending motherhood?

Prompts – what it would be like, difficulties, benefits, identity as mother, changes over time

Post birth
We've talked a lot about how you saw things before you discovered you were pregnant, and how you saw things throughout the pregnancy. What happened after you gave birth?

Prompts – eating difficulties symptoms, relationship to eating difficulties, identity, thoughts towards child, social relationships.

How are things for you now?

Anything else?
Is there anything important which you feel relates to what happened to your eating difficulties and symptoms during pregnancy that we have not talked about yet? What is this?

End of tape recording

Debriefing questions

We've talked about a lot of personal things today. How are you feeling now we're coming to the end of the interview?

Is there anything that has distressed you? [with following questions to help the participant talk through any distress]
Appendix C - Charing Cross Hospital Research Ethics Committee approval

Charing Cross Research Ethics Committee
Room 4W/12, 4th Floor
Charing Cross Hospital
Fulham Palace Road
London, W6 8RF
Telephone: 020 8846 7283
Facsimile: 020 8846 7280

Ms Fay M Coster
Trainee Clinical Psychologist
University of Surrey
Department of Psychology
University of Surrey
Guildford, Surrey, GU2 7XH

02 September 2008

Dear Ms Coster


REC reference number: 08/H0711/66

Thank you for your letter of 18 August 2008, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.
Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
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<td>Application</td>
<td></td>
<td>28 June 2008</td>
</tr>
<tr>
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<td></td>
<td>07 June 2008</td>
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<td>Protocol</td>
<td>3</td>
<td>01 August 2008</td>
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<td>Covering Letter</td>
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<td>29 June 2008</td>
</tr>
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<td>Letter from Sponsor</td>
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</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>1</td>
<td>11 May 2008</td>
</tr>
<tr>
<td>Advertisement</td>
<td>1</td>
<td>11 May 2008</td>
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<tr>
<td>Participant Information Sheet</td>
<td>2</td>
<td>18 August 2008</td>
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<td>Participant Consent Form</td>
<td>1</td>
<td>11 May 2008</td>
</tr>
<tr>
<td>Response to Request for Further Information</td>
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<td>18 August 2008</td>
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<td>insurance letter</td>
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<td>24 July 2007</td>
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<td>Key Collaborator CV</td>
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<td>Supervisor CV</td>
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<tr>
<td>Letter to R&amp;D</td>
<td></td>
<td>18 August 2008</td>
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Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.
With the Committee's best wishes for the success of this project

Yours sincerely

Dr Charles Mackworth-Young
Chair

Email: carli.sager@imperial.nhs.uk

Enclosures:  "After ethical review – guidance for researchers"  SL- AR2 for other studies
             Site approval form

Copy to:     Professor T Desombre
Charing Cross Research Ethics Committee

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

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<th>1</th>
<th>Date of issue:</th>
<th>02 September 2008</th>
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<tbody>
<tr>
<td>Chief Investigator:</td>
<td>Ms Fay M Coster</td>
<td></td>
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</table>

This study was given a favourable ethical opinion by Charing Cross Research Ethics Committee on 02 September 2008. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Post</th>
<th>Research site</th>
<th>Site assessor</th>
<th>Date of favourable opinion for this site</th>
<th>Notes (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Fay Coster</td>
<td>Trainee Clinical Psychologist</td>
<td>St George’s Eating Disorder Service, South West London and St George’s NHS trust</td>
<td>Wandsworth Research Ethics Committee</td>
<td>02/09/2008</td>
<td></td>
</tr>
</tbody>
</table>

Approved by the Chair on behalf of the REC:

.......................................................... (Signature of Co-ordinator)

.......................................................... (Name)

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.
Appendix D - University of Surrey Research Ethics Committee approval

Dr Mark Cropley
Chair: Faculty of Arts and Human Sciences Ethics Committee
University of Surrey

Fay Coster
Trainee Clinical Psychologist
Department of Psychology
University of Surrey

13th October 2008

Dear Fay

Reference: 263-PSY-08
Title of Project: How do women with eating disorders account for subjective reductions of their symptoms during pregnancy? An exploration using Interpretative Phenomenological Analysis.

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

Dr Mark Cropley
Dear Fay,

Research Title: How do women with eating disorders account for subjective reductions of their symptoms during pregnancy? An exploration using Interpretative Phenomenological Analysis.

Project ID: PF386

Following various discussions your project has now been approved. This letter ensures that you and the researchers holding a Trust/NHS contract are indemnified by the Trust under DoH HSG (96) 48 (only for non-commercial research). Under your contract of employment you are required to adhere to the Research Governance Framework and Trust research monitoring procedures.

In addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, you need to ensure the following:

- **Patient contact:** Only trained or supervised researchers holding a Trust/NHS contract (honorary or full) are allowed to make contact with patients.

- **Informed consent:** Is obtained by the lead or trained researcher according to the requirements of the Ethics committee. The original signed consent form should be kept on file. Informed consent will be monitored by the Trust at intervals and you will be required to provide relevant information.

- **Data Protection:** All data involving patient data will remain anonymised, where possible, and held on protected systems so as not to compromise the Data Protection Act.

- **Adverse events reporting:** Adverse events or suspected misconduct must be reported to the R & D department, in conjunction with the Ethics committee.
Terms and conditions of Approval

- **Annual review:** An annual review form will be sent to you, which you will be required to complete and return to the R & D Department.

- **Closure Form:** On completion of your project a closure form will be sent to you (according to the end date specified on the R & D database), which needs to be returned to the R & D Department.

- **Publications:** Any publications will need to be reported to the R & D Department. This is vital in ensuring the quality and output of the research for your project and the Trust as a whole.

The R & D Department needs to be informed of any changes to the protocol such as patient recruitment, funding, etc. If any major changes are made to the protocol then this would need to go to the R & D Committee.

If you have any queries regarding the above points please contact Enitan Eboda, R&D Co-ordinator on 020 8725 3463 (St. George's), e-mail: eeboda@sgul.ac.uk.

Yours sincerely,

Dr Andrew Kent  
Acting Chair, Research & Development Committee.
Experiences of women with reduced Eating Disorder symptomatology during pregnancy: Information sheet for potential participants.

I am interested in exploring the experiences of women with eating disorders whose symptoms have improved whilst they have been pregnant. If this experience applies to you and you are interested in talking about your experiences, I would very much like to hear from you. Even if this reduction in eating disorder symptoms was temporary, I would still be very interested to talk to you.

What is the purpose of the study?
Previous research has suggested that many women with eating disorders show a reduction in their symptoms throughout their pregnancy. However, there has been less research looking in detail about why this might be. The purpose of this study is to explore in depth how women who show this reduction in symptoms understand and interpret this experience, as well as exploring their wider life experiences throughout pregnancy. This in turn may influence future research and clinical practice. By understanding what may lead to a reduction in symptoms for some women, it may be possible to help other women in similar circumstances.

Do I have to take part?
No, you do not have to take part unless you want to. Saying no will not affect your care with the South West London and St George’s Eating Disorder Service, or any future care you may receive. If you do agree to take part and choose to withdraw your consent, this is your right and this will not affect your treatment.
What will I be asked to do?
If you would like to take part, there is an initial interview with myself that will last approximately 20 minutes. This will be so I can check whether you are eligible for the study, to explain the research procedure and gain informed consent. From your perspective, this initial interview is an opportunity to ask questions about the research and consider whether you would like to take part. You can choose to be interviewed in person (in your home or in a clinic room at the Eating Disorder Service) or can choose a telephone interview.

If after this meeting you wish to continue and meet the eligibility criteria, then there will be a further interview of approximately one hour. This is the main part of the research, and it will involve you answering questions about your experience of pregnancy. These interviews will be recorded on an audio digital recording device, and you can choose to be interviewed in your home or in a clinic room at the Eating Disorders Service.

I will also require your consent to speak to your main therapist or key worker at the Eating Disorder Service and/or to look at your file, for the purpose of ascertaining your diagnosis prior to conception.

What are the possible disadvantages/risks of taking part?
As the interview addresses emotional issues and will involve talking in part about your eating disorder, you may experience some distress. At the end of the interview I will offer you a chance to talk about your experience of the interview – we can talk through any distress you feel then. I will also provide relevant self-help information and helpline numbers to help you deal with any distress that may emerge. If after the interview I have serious concerns that you or other persons are at a high risk of significant harm, then I will liaise with your key worker or therapist. The research is covered by indemnity insurance held by the University of Surrey.

What are the possible benefits of taking part?
Some people find that talking about their experiences helps them further process and clarify them. Therefore whilst the interview is not intended to be therapeutic in nature, you may find that talking about your experiences helps you in some way. More generally, the study will add to the body of research in the area of eating disorders, and thus may improve clinical practice in the future.

Will my taking part be kept confidential?
The audio recording of our interview will be transcribed into text, and pseudonyms will be given to you and any individuals mentioned in your interview. Audio recordings will be deleted as soon as the interview is transcribed. All information from your interview will be kept confidential from clinical staff and other persons, with the exception of significant risk issues emerging (as described in disadvantages/risks section). If I feel I must break confidentiality for the purpose of yours or others’ safety, you will be informed of this. I will inform your GP that you have agreed to take part in the research and send them a copy of the Participant Information sheet – however, I will not discuss anything you say in the interviews with them (again, with the exception of disclosing matters pertaining to serious risk issues).

For my own safety, if I visit you in your home your address will be placed in a sealed envelope and given to one of my two research supervisors until after the
After the interview has been completed I will collect the envelope and shred the contents.

**What will happen to the results of the study?**
The findings will be written up as part of my doctoral level qualification (PsychD) and will be submitted for publication in a peer-reviewed journal. Selected quotes from the transcriptions will be used in the body of the research write up – however, due to the use of pseudonyms these will be unidentifiable as coming from you. The transcribed interviews will be kept for 5 years in secure conditions to allow for data checking, and then destroyed. If you choose to take part, I will offer you verbal and written feedback as to the interpretation of your own data and an overview of the overall findings. You will not be able to ask for the analysis to be altered but you will be given an opportunity to comment on its interpretation, which will be accounted for in critical evaluation of the project.

**Who is organising the research?**
I am the main researcher and thus the main organiser of the research. However, I am receiving supervision for the project from Dr Laura Simonds, University of Surrey, and Dr Vicki Mountford, South West London and St George’s Eating Disorder Service/St George’s, University of London.

**Who has reviewed the study and given approval?**
The study has been approved by the University of Surrey, the National Patient Safety Agency (National Research Ethics Service) and South West London and St George’s Research and Development Department.

**Contact for further information**
For further information, please contact Fay Coster on 07968 838309 or email edandpregnancyexperiences@gmail.com
Consent form to take part in research

I, ..........................................., agree to take part in the research project conducted by Fay Coster, exploring the experiences of women with reduced Eating Disorder symptomatology during pregnancy. I have read the information sheet and discussed the implications with the researcher, and am thus giving informed consent. I recognise that the interview data will be made anonymous but that sections of the text will be published. I understand that all information will be confidential between myself and the researcher, with the exception of matters pertaining to significant risk to myself or others. I have read the information sheet for the project and have had an opportunity to discuss its implications. I understand that I can withdraw from the study at any time, and that this will not affect any treatment for my eating disorder that I am currently receiving or may receive in the future. I understand that the researcher will have access to my clinical notes and/or will speak to my primary clinician so as to obtain my diagnosis at conception. I understand that my GP will be informed that I am taking part in the research and will be sent a copy of the Participant Information Sheet – however I am aware that they will not be given any details about what I say in the interviews (apart from aforementioned matters pertaining to serious risk).

Name (printed)

Signature

Date
Appendix H – Prompts for appraising qualitative research

- Are the research questions clear?
- Are the research questions suited to qualitative enquiry?
- Are the following clearly described?
  - Sampling
  - Analysis
  - Data collection
- Are the following appropriate to the research question?
  - Sampling
  - Analysis
  - Data collection
- Are the claims supported by sufficient evidence?
- Are the data, interpretations and conclusions clearly integrated?
- Does the paper make a useful contribution?

(Dixon-Woods et al, 2004).
"Research checklist"

Completed over course of training in research projects and practical aspects of research teaching

Years 1, 2, & 3
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<td>2</td>
<td>Formulating and testing hypotheses and research questions ✓</td>
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<td>3</td>
<td>Carrying out a structured literature search using information technology and literature search tools ✓</td>
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<td>4</td>
<td>Critically reviewing relevant literature and evaluating research methods ✓</td>
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<td>5</td>
<td>Formulating specific research questions ✓</td>
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<td>Writing brief research proposals ✓</td>
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<td>Writing detailed research proposals/protocols ✓</td>
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<td>8</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly ✓</td>
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<td>9</td>
<td>Obtaining approval from a research ethics committee ✓</td>
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<td>10</td>
<td>Obtaining appropriate supervision for research ✓</td>
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<td>Obtaining appropriate collaboration for research ✓</td>
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<td>12</td>
<td>Collecting data from research participants ✓</td>
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<td>Choosing appropriate design for research questions ✓</td>
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<td>Writing patient information and consent forms ✓</td>
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<td>15</td>
<td>Devising and administering questionnaires ✓</td>
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<td>16</td>
<td>Negotiating access to study participants in applied NHS settings ✓</td>
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<td>17</td>
<td>Setting up a data file ✓</td>
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<td>18</td>
<td>Conducting statistical analyses ✓</td>
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<td>Choosing appropriate statistical analyses ✓</td>
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<td>Choosing appropriate quantitative data analysis ✓</td>
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<td>Summarising results in figures and tables ✓</td>
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<td>23</td>
<td>Conducting semi-structured interviews ✓</td>
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<td>Transcribing and analysing interview data using qualitative methods ✓</td>
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<td>25</td>
<td>Choosing appropriate qualitative analyses ✓</td>
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<td>26</td>
<td>Interpreting results from quantitative and qualitative data analysis ✓</td>
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<td>27</td>
<td>Presenting research findings in a variety of contexts ✓</td>
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<td>28</td>
<td>Producing a written report on a research project ✓</td>
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<td>29</td>
<td>Defending own research decisions and analyses ✓</td>
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<td>30</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book ✓</td>
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