A Portfolio of Study, Practice and Research.

Submitted for the Doctorate of Psychology (PsychD) in Clinical Psychology

University of Surrey

Impulsive and Compulsive Relationships to Food in Disordered Eating

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Volume One
Introduction to the Portfolio

This portfolio comprises two volumes and each contains a selection of work completed during the Doctorate of Clinical Psychology (PsychD) clinical training course.

Volume 1 comprises an Academic section, consisting of two essays, three problem based learning accounts and two case discussion group process account summaries; a Clinical section, containing summaries of the five placements completed over the three years of the course and summaries of five formal case reports; and a Research section, comprising the Service Related Research Project completed in year 1, an abstract of the Group Qualitative Research Project completed in year 2, the Major Research Project completed in Year 3 and a Research Log Book.

Volume 2 of the portfolio is a clinical dossier containing the five Case Reports, the Placement Contracts, Log Books and Placement Evaluation forms and the two case discussion group process accounts. Due to the nature of the clinical material this volume will be kept within the Clinical Psychology Department of the University of Surrey.

The work presented in each portfolio reflects the range of client groups, presenting problems and psychological approaches covered during the course. Within each volume, the work is presented in the order in which it was completed to illustrate the development of the clinical, academic and research skills during the period of training.
Acknowledgements

A huge thank you to all the people who have supported me throughout my PsychD journey. Thank you to the course team, my inspiring supervisors, and my fabulous cohort. A special mention to Suzy and Nic whose laughter on placement will ring in my ears for years to come, 'stick insects' and 'Grime' will be forever with me!

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Lastly, a huge thank you to Mum and Graham who have been there for me throughout, and whose love and support means the world to me.
Statement of Confidentiality

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Eleanor Evans, 2007
# Table of Contents

**ACADEMIC DOSSIER**

1

## Essays:

2

The Course Team is attempting to involve service users and carers in many aspects of the Surrey Clinical Psychology Training Programme. With reference to the evolving literature on involvement in both training and research, explore ways of involving users and carers in the programme. What issues and dilemmas might such involvement create?

Supervision is seen as an important part of a psychologist's personal and professional development, yet mental health professions are somewhat ambivalent. Critically discuss your own supervision experiences against two theoretical supervision frameworks of your choice, focusing on supervision and learning, and ethical issues including working with difference.

## Problem Based Learning Reflective Accounts:

35

- Relationship to Change
- Child / Learning Disabilities
- Older People

## Case Discussion Group Process Account Summaries:

54

- Account 1
- Account 2

**CLINICAL DOSSIER**

59

## Placement Summaries:

60

- Adult Mental Health
- People with Learning Disabilities
- Child and Adolescent
- Older People
- Specialist Child Eating Disorders

## Case Report Abstracts:

66

- Adult Mental Health 1
- Adult Mental Health 2
- People with Learning Disabilities
- Child and Adolescent
- Older People
vi. Impulsive and Compulsive Relationship to Food Questionnaire 207

Appendix C: Ethical Approval Documentation:
i. LREC Ethics Committee 211
ii. NHS Trust Ethics Committee 214
iii. School of Human Sciences Ethics Committee 215
Academic Dossier

This section comprises two essays, three problem based learning reflective accounts and two case discussion group process account summaries, written over the three year course. This work covers topics pertaining to the core client groups: Adult Mental Health, People with Learning Disabilities, Children and Adolescents and Older People. It also incorporates wider ideas around NHS service development and professional issues.
Service Development Essay

January 2005

Year 1

'The Course Team is attempting to involve service users and carers in many aspects of the Surrey Clinical Psychology Training Programme. With reference to the evolving literature on involvement in both training and research, explore ways of involving users and carers in the programme. What issues and dilemmas might such involvement create?'}
Introduction

The title of this essay appealed to me because it seemed to be a topic that was still relatively in its infancy. Although there is a large amount of information and research dedicated to it, it seemed more challenging because there was scope for exploring new ideas and considering completely new approaches.

My aim when I started to think how I wanted to write it, was to present it in an almost 'structured brainstorming' style. I wanted to have a clear progressive plan, but remain open enough to incorporate my reflections and ideas into the text. Due to this way of working, a significant proportion of the essay is presented in the first person, this does veer away from more conventional academic writing, but I felt this was important in making it comprehensible for the reader.

The first section of the essay begins by briefly thinking about user and carer involvement in the NHS in general, and progresses onto considering it in the context of training and research. I have not specifically focused on user / carer involvement in research (there is a huge array of work that looks at research activity within the NHS), as I consider it integral to the training process, and so have included it in this context. I have attempted to give the reader a flavour of what other professionals are engaging in, in terms of user / carer involvement, and tried to build upon these ideas when thinking about Surrey's position. The second section of the essay concentrates on the barriers and obstacles to user / carer involvement. Due to the scope of the essay, it was not possible to cover all areas, but I feel I have discussed a varied selection of issues. I have used this section to focus more specifically on areas that I am particularly interested in.

Users and Carers in the Programme:

Background and Context

What is meant by ‘user and carer involvement’?

What do we mean by service users and carers?

These terms are difficult to define, as this is an area that has been open to controversy, with some people feeling more comfortable with some definitions than others. However for the
purposes of the essay I feel it is useful to begin thinking about who we are discussing when we use these generic terms. Tew, Gell and Foster (2004) use the description;

the term 'service user' denotes clients, patients, survivors or people with lived experience of mental distress, and the term 'carer' denotes relatives or friends who play an important role in supporting people experiencing mental health difficulties (p.7).

What do we mean by ‘involvement’?
The term ‘involvement’ in relation to service users and carers encompasses a wide area in mental health service provision. A host of national policies (Department of Health, 1998; 1999; 2000) emphasis the importance of user and carer involvement at a variety of levels, including service planning, provision, research and training. The scope of what ‘involvement’ might actually look like is equally diverse, hence the difficulties in implementing effective strategies. This essay will focus on ideas around what involvement could mean in terms of training and research.

What is involvement in the context of training and research?

User and carer involvement in mental health training has gained momentum over the last five years, and is set in the context of specific national policy. The National Service Framework for Mental Health (Department of Health, 1999) states that, ‘service users and carers should be involved in planning, providing and evaluating training for all health care professionals’ (p.109).

Ideally, effective progress towards involvement in training and research should encompass a broad strategy to involve users and carers in all aspects of the educational process. This would mean more than service users being invited to provide a ‘snapshot’ of their experiences to students. Instead it would mean users inputting their opinions and expertise in relation to all core aspects of training. Tew et al. (2004) states these as being;

- direct delivery of learning and teaching
- course / module planning
- programme management
- recruitment and selection of students
- practice learning
- student assessment
In order to achieve this ideal, a major cultural shift would need to occur in educational institutions. A useful way to quantify courses’ progress has been proposed in the form of a ‘ladder of involvement’. This is based on a framework adapted from Gos and Miller (as cited in Tew et al., 2004), which underpins the evaluation processes set out in the National Continuous Quality Improvement Tool for Mental Health Education (Northern Centre for Mental Health, 2003). This is useful when thinking about the stage institutions have reached, and I will refer back to the model when thinking about Surrey University’s progress. Table 1 shows a summary of the model;

Table 1

<table>
<thead>
<tr>
<th>Level 1: No Involvement</th>
<th>The curriculum is planned, delivered and managed with no consultation or involvement of service users or carers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2: Limited Involvement</td>
<td>Service users ‘invited to tell their story’ in a designated teaching slot. Limited input into shaping the course as a whole, except when ‘invited’.</td>
</tr>
<tr>
<td>Level 3: Growing Involvement</td>
<td>Service users / carers have key input into at least two of the core aspects of the course. However representation on all issues is not apparent.</td>
</tr>
<tr>
<td>Level 4: Collaboration</td>
<td>Service users / carers involved as full team members in at least three of the core aspects of the course. Contribution to key decision-making across the board.</td>
</tr>
<tr>
<td>Level 5: Partnership</td>
<td>Service users / carers and teaching staff work systematically and strategically together across all areas of the course. All key decisions made jointly.</td>
</tr>
</tbody>
</table>

Why have service user and carer involvement?

Policy dictates

There are a range of policies that dictate that service users and carers should be involved in all aspects of service delivery, including training (Department of Health, 1998; 1999; 2000). More specifically, in relation to Clinical Psychology, the British Psychological Society (BPS) accreditation criteria (BPS/MQB, 2002) states that one outcome of training is that trainees should be able to work ‘collaboratively and constructively with fellow psychologists and other
colleagues and users of the service, respecting diverse viewpoints' (p.5). User involvement in training would be an essential aid in helping to fulfill these requirements.

The 'real world' benefits

By incorporating user and carer contributions, trainees should gain a richer training experience. Users have expertise that professionals do not, which would provide a personal insight into the reality of living with a mental health problem and the experience of engaging in services.

Involvement will enable people to have a say over the care they receive. Goodwin, Holmes, Newnes and Waltho (1999) suggest that having some ownership of services may lead to people feeling an increased sense of responsibility for their own healthcare. Personally, I've had the experience of feeling pressured to ensure that the therapy I'm engaged in is effective for the client, which is often heightened by a sense of helplessness that clients can experience. The idea of encouraging a greater sense of responsibility within the client is appealing as it focuses on the therapy being much more about collaborative work and responsibility.

Current models of involvement

There is variation across professions and institutions as to how developed people are in user involvement strategies. This section will present some ideas from ongoing work in two different areas; one related to general mental health training and one specific to clinical psychology. This is not an exhaustive overview as there are many schemes underway, instead it is intended that it will provide an introduction to thinking about how Surrey could continue its development.

West Midlands

Tew et al. (2003) undertook a study to ascertain what new developments were occurring in the West Midlands. The main findings that are most relevant to our thinking were:

- it is becoming more common for users to be full members of the teaching team, rather than being invited for one off sessions.
- training institutions have ensured more availability for support and supervision both from peers and individuals independent from the course teams.
- training institutions are providing schemes that enable users to access mainstream educational programmes to gain skills and qualifications relevant to training and adult education.
users are participating as panel members, who help to assess the portfolios presented by students in training.

Exeter
Exeter has a commitment to including community psychology in its curriculum (Curle & Mitchell, 2004), this is important when considering how successful they are in involving users and carers in the programme. Clegg (as cited in Goodbody, 2003) states that central concerns in community work include 'the unequal distribution of power and support resources, and the development of collaborative intervention methods for working with social groups' (p.10). Work with users should help trainees to explore these areas in more depth. My previous work in a Primary Care Community Mental Health team (where a significant proportion of the work involved liaising and setting up partnership work with other voluntary organisations and users of services), has made me aware of both the challenges and benefits this way of working can provide.

Exeter has for many years engaged users and carers in individual teaching slots. They have since developed their strategy and invited users to join the programme team by forming a user advisory group, providing an influence beyond just teaching slots. This way of working shows a rise up the 'ladder of involvement' and infers influence at the course planning level.

Although I've only presented a brief introduction of current schemes, there appears to be a bias towards the most significant progress being made in the area of course planning and delivery. This may be an area that feels more comfortable for courses, however this bias needs to be recognised and strategies for more complete involvement will need to be considered.

What stage is Surrey at and what else could it consider?

Surrey’s progress (as classified by the ladder of involvement) would best be described as 'growing involvement'. We are working from other models, and setting up a system that will allow us to incorporate user and carer perspectives across the breadth of the programme. A strong influence has been the Exeter programme, and their concept of an advisory committee is an idea we are currently some way into piloting. The key to the Surrey approach seems to be the idea of developing relationships to help discover what needs to be implemented to aid collaborative working.
When considering in more depth what Surrey is currently doing to introduce and promote involvement, it is useful to look individually at the core aspects of training as stipulated by Tew et al. (2004).

**Teaching**

With the move into core competency based training, skills such as relationship building, the management of power inequalities and communication through similarities and difference are being emphasised (Goodbody, 2003). I feel that user involvement embraces these ideals and aids this learning process. Surrey has begun to change its teaching practice in order to accommodate these new elements and I think it would be interesting to reflect on my experience of the teaching to help think about what is proving useful. The induction introduced trainees to the ‘therapy skills’ module which was invaluable in helping us to reflect on our own experiences and draw on these in discussions and role-plays. I think for the future it would be beneficial to try and engage trainees, service users and carers together at the stage where they are learning listening, communication and counselling skills, as the role-play situations at times felt quite contrived.

The new problem based learning exercises also offer scope to include valuable input from service users. This could come in the form of ‘problems’ being designed by users, and for them to act as consultants in the sessions.

**Course / Module Planning**

Where courses are already established, it may not be realistic to consider consulting and re-drafting established programmes. Instead it may be more useful to think about involvement when developments or changes are being planned. I am unsure of exactly how involved Surrey are in this process, but service users and carers are already being consulted about the content of various national training programmes, an example being the involvement in decisions regarding the course content of the new Primary Care Graduate Mental Health Workers (Gell, 2003).

**Programme management**

To have representation at the planning level would help to ensure the programme remains user and carer focused. In order to achieve this, Surrey will need to consider its decision-making processes, and consider how service users can be represented. Since involvement in programme management ‘often evolves from engagement in direct teaching’ (Tew et al.,

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*Academic Dossier Essays: Service Development*
2004, p.23), it may be appropriate to prioritise this. It could be a consideration to employ a service user or carer as a joint module / programme co-ordinator.

**Recruitment and selection of students**

Surrey currently doesn't involve service users or carers in the recruitment or selection of trainees. However, this would provide an important message about the value base of the course – one that is actively involving and respecting users' opinions in all aspects of training. There are various ways that involvement could be achieved, ideally it would mean having a say on all aspects of recruitment and selection, in reality it might mean beginning by including users on an interview panel. In the West Midlands, service users and carers are involved in the selection of trainees, and are incorporated not only into the interview setting, but more fully in a selection steering group (Tew *et al.*, 2004).

**Practice learning**

This will have a potential impact on the way that clinical placements might be approached. The main premise is that trainees would gain as much knowledge and exposure to working alongside users and carers in a collaborative manner. Trainees would have the opportunity to work alongside users and carers, perhaps with them in the role of consultant or mentor (Tew *et al.*, 2004). Ideally this would involve finding opportunities within placements where service users are already involved in service delivery in some capacity. During my current placement I am being given the opportunity to undertake group work with both an occupational therapist and a service user. I think this will be a really positive way to learn and will provide me with a great basis for working collaboratively with a range of people.

**Student Assessment**

Although Surrey does use external markers to assess work, these do not yet include service users or carers. This is an area to consider, for as long as marking guidelines were clear and there was training and support in place, this could be a valuable means of gaining a further perspective on trainees' work. There may also be scope for gaining feedback via placement work, instead of the placement supervisors' comments being key, users could feedback on the service they received and how the trainee was perceived. These kinds of changes would need to be carefully thought through, as a host of anxieties might be created on the sides of both user and trainee.
Course Evaluation

If service users and carers are to be involved in programme planning and direct teaching, then it would make sense for them to have an involvement in the evaluation. There is evidence of successful user evaluation of services in general (Simpson & O'House, 2002; Summers & Kehoe, 1996) and so similar principles could be utilised by course teams to think about training evaluation techniques.

Joining courses as participants

New accreditation criteria for clinical psychology courses state that 'selection procedures must not discriminate between candidates on the grounds of gender, age, sexual orientation, ethnic origin, religion, creed or disability' (as cited in Harper et al., 2003, p.14). This context is relevant when ensuring that courses are also not discriminating against people with a past history of mental health problems. I feel Surrey is already making positive progress; our literature and information encourages applications from service users and carers, and the links we have already made, establish a grounding for involvement which should hopefully have a knock on effect for promoting the course, and making people aware that discrimination will not occur. This last point is extremely important, as I feel there may be a degree of mistrust and uneasiness about 'coming out' to courses. When I applied, I queried whether to disclose the fact that I have Gilles de la Tourettes Syndrome. Having worked in the NHS, directly with clients for three years, I felt I had already proved that this condition didn’t adversely affect my work, however I still chose not to mention it in my application and interview. I wasn’t convinced that it wouldn’t hinder my chances of being accepted onto the programme. In retrospect, I don’t feel this is a factor that would have been taken into account in decision making. However I do think that this is a pertinent example of the anxieties that people with mental or physical health problems may experience.

Involving Users and Carers in the Programme: Issues and Dilemmas

This essay has highlighted a changing value base emerging within the current culture of mental health provision. We have discussed the ideal model of practitioners working with service users and carers within a partnership framework, specifically in relation to training. This involvement reflects a fundamental shift in thinking, and so comes with it a range of issues and dilemmas in implementing these changes. It is not within the scope of the essay to
discuss all possible difficulties that may arise, however I will attempt to discuss key issues, looking at various perspectives and current debates.

How realistic is it to work in partnership?

There still remains in mental health services, a tendency to create a divide between those who 'deliver' healthcare and those who 'receive' it. It is often assumed that practitioners, educators and students are somehow different from people with direct personal experience of mental distress, and so there remains a strong 'them and us' divide. Professional education has historically been founded on the basis of 'practitioners as experts'. Tew et al. (2004) states that;

Practitioners would impose their frames of understanding and intervention methods on service users, who in response would be seen as lacking insight or capacity to help themselves (p.10).

I think it is crucial to highlight this viewpoint as I feel we are only beginning to take significant steps to move away from this type of thinking, and so this will have a profound effect on the concept of working in partnership. It is also important to remember that this attitude is not just prevalent among some health care professionals, but among some users aswell. It is therefore not surprising that the involvement of service users and carers has received a mixed reception.

Do service users want to be involved?

I feel this may be an area that often goes unconsidered when thinking about best practice in relation to involvement. It may be assumed that as long as appropriate methods are found to involve users then the challenge is complete. However it shouldn't be assumed that service users and carers naturally want to be involved. The literature highlights two sides to this argument. Firstly, there is writing on service user enthusiasm for involvement in training (Stacy & Spencer, 1999; Wykurz & Kelly, 2002) the reasons why being quite diverse;

- to give something back in recognition of what they feel they have received from services.
- to tell their story to a wider audience (as a result of both a positive or negative experience within services).
- a desire to bring about change in professional practice, so as to improve services.
However we also need to consider the voices that aren’t so readily captured, those expressing doubt and reluctance to be involved. The literature is sparser in this area, however there are examples of people assessing to what extent service users want to become involved in service planning, which highlight more negative attitudes (Jordan et al., 1998). Interesting questions to think about are;
- why might this difference exist?
- are we missing valuable perspectives?
- what can be done to ensure that a more representative voice is heard?

- How do professionals feel about user / carer involvement?

Again, there needs to be an acknowledgement of the spilt that can occur when considering professionals’ attitudes. Campbell (2001) states that;

*On the one hand professional organisations publicly encourage the greater involvement of service users and carers and acknowledge the legitimacy of direct experience, however on the other there is resistance to non-expert views (p.88).*

There seems to be three main areas that emerge in the literature when considering why professionals may react more negatively to non-professional involvement;

Not wishing to relinquish the role of ‘expert’
Perkins & Goddard (in press) state, that in order to engage service users and carers in all aspects of the training programme there needs to be;

*A move away from a perspective in which the professional is the sole expert who determines what patients need, to one where the expertise of experience is acknowledged, respected and heeded (p.2).*

This may be quite a difficult barrier to cross, as it is not confined to training institutions, but is widespread across the profession. Soffe (2004) interviewed clinical psychologists and found that a general view was that as psychology was still a relatively young profession, psychologists may feel insecure about their own identities and therefore keen to maintain the role of expert;
It's about scientific practice, it's about professional knowledge; that's why we are who we are, we're paid what we're paid and to suggest that you could plan services on a more.... by asking people who aren't experts would maybe undermine that (p.16).

The 'expert model of therapy' (the idea that assessment leads to formulation, which leads to an appropriate intervention based on the clinical psychologists' expertise) may not be particularly appropriate when considering the involvement of service users and carers. Should we be considering moving towards a more user centered approach? If so, what might this look like? I certainly feel that Surrey is attempting to convey this ethos in at least some of the teaching, however I do feel there still remains room for thinking about more open discussion with users about the best type of interventions, hearing about experiences of different types of intervention, and gaining information on what was useful and what wasn't. My experience on placement has led me at times to feel quite uneasy as to my decisions regarding interventions. I have felt quite prescriptive, as if I am at times dictating a Cognitive Behavioural Approach (CBT), as this is an area that I need initial experience in. I don't feel particularly eclectic and aspire to be able to be more collaborative. It would be really beneficial to hear how this type of encounter may have been experienced by service users.

Clinical psychologists perceiving service users as being fundamentally different to themselves
It can be difficult to work 'hand in hand' with users, as it would require an acknowledgement that the 'them and us' culture is not appropriate. Literature (Perkins, 1996; 2002) suggests that professionals see themselves as fundamentally different to service users, they are the ones 'to be helped' and we are 'the ones helping'. To shift the teaching to include more experienced based work, would involve professionals considering to a greater extent their own experiences and mental health difficulties. Professionals who have experienced mental health crisis and have 'come out' have been found to be inspiring to trainees and other professionals and this has gone some way to addressing the divide (May, 2004; Perkins, 2002).

Work Load / Course Content
A perhaps more fundamental reason why the idea of user involvement can be met with a negative stance, is the extra workload this may enforce on professionals. My experience of the NHS so far has been that disillusionment is common when policies are dictated down to people, with limited resources or ideas for implementation.

There are also constraints as to what degree the course syllabus and teaching styles can alter. Training courses have to receive accreditation by the BPS, and so must adhere to certain
criteria. These contexts generate a number of dilemmas for trainers wanting to introduce new ideas;
- how to introduce such ideas within a busy teaching and clinical experience timetable?
- how to balance more theoretical teaching alongside more reflective, user-centred teaching?
- how to manage the tension between encouraging different ways of thinking and teaching, with the need to pass course requirements?

- **Tensions between users and carers**

We need to recognizes that the perspectives of both users and carers, need to be acknowledged individually. Just as practitioners and users' perspectives can differ, so can those of users and carers. Shepard, Murray and Muijen (as cited in Perkins *et al.*, in press) state that;

'while a service user and their relatives / friends may share some common interests and concerns, the priorities and preferences of the two groups are often different' (p.2).

This difference needs to be acknowledged and reflected in the educational process. It is interesting to note that there is 'currently more examples of good practice relating to service user than to carer involvement' (Tew *et al.*, 2004, p.8). Does this suggest that one perspective is considered more valuable than another?

**Other Key Issues**

- **Tokenism**

I think there is a distinction to be made between creating an equal working partnership between people, and 'consulting' them about their views. 'Consultation' is quite prevalent in the NHS, it involves gaining peoples' feedback on an area and using this to inform work. Although this provides useful information, it doesn't set up an environment for an ongoing mutual working relationship, instead it reflects a one off consultation and often leads to limited real involvement and influence.

This is an area I am particularly interested in, having had some experience of 'involving' users in helping to develop services. The service I worked in had increased funds for expansion and
so was interested in asking users what their opinions on the service were, the idea being to gain feedback and ideas on potential changes before 'rolling out' the extended version. However, the impression I gained over the six month period was that it was very much a governmental 'tick box' exercise. Policies had been written stating that users had to be involved in the planning of services (Department of Health, 1998; 1999; 2000), an assistant was employed to undertake this task, however the exercise became more problematic when it came to feeding back user opinion. There was a degree of defensiveness among professionals regarding the feedback, and it felt as if an attitude of 'them and us' became quite apparent. Some of the suggestions were felt to be unreasonable and based on inadequate knowledge of service provision. Therefore instead of thinking about the feedback, it was dismissed as unworkable. I think this highlights an important issue raised by Jordan et al.;

_The purpose of involving service users and their carers is precisely to add the 'expertise of experience' to decision making at all levels, and so it is important that such expertise is not automatically overridden when it diverges from that of professionals (p.3)._  

- **Representativeness**

Crepaz-Keay (as cited in Perkins & Goddard, in press) states that the accusation that individual service user and carer perspectives are not representative of users or carers as a whole has been a valuable tool for discounting alternative viewpoints. Although this is an important point to consider (since ideally we would like to make user/carer input as representative as possible), it is perhaps more useful to consider ways of accommodating this. The challenge of effective user involvement is perhaps therefore to ensure that individual representatives have the opportunity to consult with committees, which represent a range of perspectives (Perkins & Goddard, in press).

There is scope for further work around the involvement of those who may find it particularly challenging to get their voice heard, for example; people from minority ethnic groups, older people and children. Currently there are no published studies specifically relating to the involvement in mental health training of users and carers of ethnic minority groups (Livingstone & Cooper, 2004). This suggests that courses need to consider how to reach these individuals, to ensure that recruitment and selection of users is representative.
Conclusions

This essay has demonstrated that within the wider sphere of mental health services, a culture shift is taking place in which users and carers are starting to be seen as experts in their own experience and active in bringing about their own recovery in partnership with professionals. Although we can see that progressive steps are being taken, both from Surrey University and peer institutions, it is probable that the good practice outlined in this essay will not be reflected universally until user and carer involvement can be imbedded into the routine processes of commissioning, contracting and management of mental health education and training.

I hope I have managed to generate some ideas that may take Surrey forward in this process, but I feel that it is perhaps more likely that the main benefit of this essay will be in my personal growth. I think that the process of writing my first essay and focusing on this specific topic has highlighted for me how easy it could be to go through the training experience and lose the human aspect of it in academia and ‘expert knowledge’. Having written this piece, my resolution is to always remember that I came to clinical psychology (although clichéd!) to work with people, and introducing new and exciting methods for doing this can only be a positive step forward.

References


Supervision is seen as an important part of a psychologist's personal and professional development, yet mental health professions are somewhat ambivalent. Critically discuss your own supervision experiences against two theoretical supervision frameworks of your choice, focusing on supervision and learning, and ethical issues including working with difference.
Introduction

I was drawn to writing this essay because my experiences of supervision over the last five years have been so diverse that they have at times profoundly influenced my feelings towards myself and my abilities, so much so that I have found myself questioning whether I should even carry on in my chosen profession. I have swung wildly between enthusiasm and enjoyment of my work to dread over the prospect of facing another day. For something to have the capacity to produce such an emotional response suggests that any ambivalence towards the process needs to be considered carefully. I also hoped that taking a step back from my experiences and considering them in light of structured frameworks, would enable to me to learn more effectively from both the negative and positive aspects, and take that forward into my own professional development.

Within this essay I intend to provide a short introduction by establishing some clarity on the definition, aims and functions of supervision. I will briefly discuss the concept of ambivalence towards supervision and review some of the research evidence around different professions. Although ambivalence is an important concept, it is not something I will be spending a lot of time thinking about because I feel that the scope of the essay requires me to acknowledge this as a difficulty, but ultimately focus on why supervision is important to the profession of clinical psychology.

In order to do this, I will move on to consider two theoretical supervision frameworks. I have specifically chosen models that address two different areas or ways of thinking about supervision. The first follows on from the brief introduction and looks more at the purpose of supervision or more succinctly ‘what’s the point of doing it’? The second takes a more developmental standpoint and considers how supervision can most effectively assist individuals in developing through, from novice to experienced clinician. Rather than separate out my personal experiences I am attempting to weave them into the framework of the models, with the aim of illustrating the practicalities, successes and potential pitfalls of supervision.

As a central component of supervision is the development of the supervisee’s knowledge, understanding and skills, it was important to frame this account in terms of how learning and knowledge can be generated via the process of supervision. Also the significance of maintaining a principled and ethical stance in relation to our work, not only with clients, but also in all of the professional roles and tasks undertaken is an important objective addressed in
the supervisory relationship. I have aimed to incorporate into this account, ideas and reflections on ethical dilemmas, specifically focusing on the issue of ‘working with difference’.

As I found this piece of work particularly challenging, I felt it was useful within the concluding section to consider the limitations of the account and the difficulties I experienced in trying to cover effectively, such a vastly researched and theorised area. I used this space to add some reflections on what I was taking away from this piece of work and how it may influence my future practice.

**What is supervision?**

There are many definitions of supervision but all essentially agree that it is a formal process of support and learning, involving discussion and reflection with a colleague in a safe environment. The purpose of which is to develop competence, take responsibility for one’s own practice and ensure quality patient services.

Definitions of supervision mainly embody understandings about its purposes and functions. Proctor (1987) proposed an influential formulation regarding the functions of supervision, and outlined three main areas – normative (administrative), formative (educational) and restorative (supportive). The idea of the three functions or roles of supervision – management, education and support is reflected across professions; for example medicine (Coles & Peyton, 1998), nursing (Johns, 1993), social work (Kadushin, 1992) and educational psychology (Crispi & Fischetti, 1997). The importance of supervision is highlighted in all of these careers, however a literature review on individuals’ feelings regarding supervision demonstrates that there is varying degrees of ambivalence towards the process, with psychiatry portrayed as more ambivalent than other disciplines (Clarke, 1999; Whitman, 2001). I thought it was important to remark on this as the title of the essay flags ambivalence up as an issue to consider, however I feel it is beyond the scope of this essay to reflect and discuss exactly why the difference in attitude may occur. Instead I feel it is relevant to be aware that ambivalence exists and consequently it is important to consider this when discussing supervisory models.

The main focus of this essay will be on supervision’s relevance to clinical psychology, where it is seen as an integral aspect of training, and recommended by the British Psychological Society (BPS) as an essential part of good clinical practice. However, this is not to suggest
that ambivalence does not also exist in our profession, although the research evidence is less, it would be naïve to think that supervision is consistently embraced.

Within this introduction it would be extremely easy to spend the word limit describing the common features, different types, aims and functions of supervision. However, I feel instead that it will be of more value to briefly highlight the benefits of supervision - therefore continuing on with the idea of why it is important - and then move on to discussing the models, which will inevitably give the reader a flavour of the finer details of what supervision realistically involves.

The benefits of supervision for the supervisee are vast, but to provide just a flavour, it offers; an opportunity or forum to reflect upon aspects of client work that may be difficult; it helps in developing new knowledge, through the critical evaluation of practice against available research; it provides an opportunity for guided reflection with a skilled practitioner to help supervisee's validate their clinical decision making and ideally it leads to a more confident practitioner, who feels more empowered, self assured, and able to be innovative and creative within their practice (Scaife, 2001).

The benefits for the Trust are also numerous, but can involve; enhancing the quality of patient care through ongoing development of practice; helping to meet clinical governance guidelines; providing a forum for practitioners to demonstrate accountability; it has the potential to reduce sickness through the active management of stressors and it can create a significant contribution to risk management (Johns, 1993).

**Theoretical Frameworks for Supervision**

Literature from supervision in the helping professions reveals that there are a number of models or frameworks within which to conceptualise both the purposes and processes of supervision. Although these models vary considerably in their approach towards clinical supervision, common themes like supervisor-supervisee-client interaction, support, educational development, equality, shared responsibility, and a good interpersonal relationship all emerge. Within this essay I will be looking at two different models, and have chosen ones that look at differing aspects of the supervision process. The first considers the purpose or

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1 There are numerous elements and stages to the models described, all of which I could discuss in relation to my experiences. However this essay needs to be presented within a word limit, therefore I have chosen to reflect only on the areas I most identify with and provide description to aid understanding of the rest.

*Academic Dossier Essays: Professional Issues*
‘why is it we have supervision’, while the second looks more at process issues or ‘what actually happens during supervision’.

So how are these frameworks useful to us? Whilst a framework is only a map, it can serve as a useful way for supervisees to organise their ideas about what is happening so they can get on and be involved in the process. Scaife (2001) says that frameworks can also provide a common language for exploring the events of supervision and feelings evoked through the process.

1) **A model addressing the purpose of supervision**

Inskipp and Proctor (1993)

One of the most widely used and best-known models is Inskipp and Proctor’s (1993) model which talks about three categories of purpose in supervision. This framework suggests that supervision will focus on different aspects of these ‘purposes’ at different times according to both the needs of the supervisee and the responsibilities of the supervisor;

*Normative* – this derives from supervisors managerial and ethical responsibilities. Supervisors have an ethical responsibility to ensure client welfare, therefore one of their roles is to monitor the supervisee’s case load and ensure that they comply with the rules and norms of the organisation within which the supervisee is working.

*Formative* – this specifically focuses on the supervisee’s learning and development. There is no one approach to learning that can be discussed here, instead a range of methods and techniques to further the supervisee’s knowledge and skills are adopted, depending on the orientation and experience of both the supervisor and supervisee.

In my experience the ‘declarative’ knowledge (where I am taught theory via a curriculum at University) is presented in a completely different format to the type of knowledge I gain from supervision. The difference being that instead of being presented with theory and thinking about it within a much broader framework, in supervision, the emphasis is on how this theory can be applied and how it specifically relates to a particular client. Binder and Strupp (1997) state that in therapy, what is needed is a particular set of procedural knowledge that allows for on the spot appraisals of problem situations while simultaneously acting upon them. They refer to this as ‘reflection in action’ and they argue that true therapeutic competence and effectiveness involves becoming proficient in this. This type of knowledge is also described
by Schon (1987) as ‘knowledge in action’, and I think it is important to recognise this
distinction as it clearly highlights an important role and function of supervision.

*Restorative* – this focuses on the potential emotional effects the supervisee may be
experiencing at any one time. It recognises that potential sources of emotional arousal lie not
just from the therapeutic work, but can also stem from organisational issues, relationships
with colleagues and relationships and life events outside of work.

When I first began training, I believed that my supervision experiences would be biased
towards the more formative aspects – I imagined that my weekly slot would be an opportunity
to glean as much practical knowledge and information from my supervisor as was possible
within the hour’s timeframe. Little did I imagine that half way into my first year, a significant
proportion of the time I spent with my supervisor was used in discussing my own ‘mental
healthiness’. I had gone through a difficult year and juggling placement, university and a
rapidly disintegrating personal life sometimes felt quite overwhelming. I found supervision an
invaluable opportunity to gain reassurance and advice over how appropriate working in close
therapeutic relationships was at this particular stage. Also, more simply it was an opportunity
for me to express that now was a difficult time and that I needed certain colleagues to be
aware of this. I find it very hard to consider this particular function of supervision in a critical
light. I’m sure that for some less experienced supervisors, issues of boundaries and what was
or wasn’t appropriate to discuss in this setting could come up, and therefore the value of the
restorative function could be questioned. However I can’t emphasise enough how glad I was
that I overcame my worries about using supervision in this way, and therefore felt more able
to appear emotionally vulnerable, and not always thinking the façade of confidence, assurance
and ‘let’s press on with the job’ should be firmly established. I have definitely taken this over
into my next placement, and although life has settled down, I’m not reticent in expressing
when I’m finding things difficult both of a personal nature (obviously there are limits to this!) and
professionally.

Also in relation to the restorative function, Mollen (cited in Scaife, 2001) discusses negative
emotional experiences that can occur between client and therapist, and describes them as
‘narcissistic insults’. These are feelings that are considered unacceptable to the supervisee
such as resentment, dislike or sexual feelings towards a client. Often the natural response to
these feelings is one of shame and a desire to conceal them from an ‘authority’ figure. The
restorative function of supervision believes that it is useful to be able to ‘bring’ these feelings
and feel supported in discussing them and using them in a useful way to inform the work.

*Academic Dossier Essays: Professional Issues*
Even though this is considered the ideal, research shows (Ladany, Hill, Corbett & Nutt, 1996) that hiding these feelings or experiences from supervisors is a common occurrence due to worries about being evaluated negatively. It is important therefore to be able to discuss the purpose of supervision beforehand so that the supervisee can appreciate the importance of addressing these issues. I feel that this is also an important ethical consideration, these types of experiences can consist of very relevant ethical dilemmas. Again, when faced with such a dilemma the supervisee can either choose to handle it themselves, or bring it to supervision. The probability of disclosure is likely to be directly related to the supervisory relationship. If non-disclosure tends to occur in this relationship - due to any number of factors - then unsafe practice will be more likely to result.

Even though I have worked clinically with clients for only three years, in my experience it is impossible to have worked with such a diverse range of people and not to experience negative emotions towards some. I would challenge anyone that states otherwise. During my days as an assistant I worried a lot more about not wanting to admit these feelings. Somehow it didn’t ‘feel right’ to discuss the fact that you found someone quite difficult and unpleasant at times to be with. I think my perception of how I should be as a therapist, was an image of someone very caring, understanding and non-judgmental. Myself as a human who disliked and didn’t look forward to sessions with someone, did not fit this stereotype. I therefore remained silent and continued to find the work difficult and continued to find the client unpleasant. As a trainee, I’m finding it easier to discuss these issues and I think this has been influenced by an increased level of exposure to the psychodynamic way of thinking. I now actively reflect on the concepts of transference and counter transference and consider how useful these feelings can actually be in therapy and in aiding formulation. Reading this back, I realise I have again sung the virtues of the restorative aspect of supervision and so my critical eye will instead be trained on other areas, as I have found it nothing but invaluable.

Reflective criticism of the model in relation to my own experiences

This way of representing the functions of supervision does leave me with some questions. Smith (1996) discussed the fact that the way these functions are depicted can make it seem as if the supervisee is being framed within a ‘deficit’ role, with the idea that they are lacking in certain ways – and it is the job of the supervisor to help them put things right. With this dynamic occurring, it would be quite easy for supervisors to slip into acting on, or upon behalf of supervisees. If a supervisor has a responsibility to an organisation for the actions of their supervisee, such a ‘deficit orientation’ is in a way understandable. Ideally a supervisor would try to create an environment in which supervisees could endeavour to take responsibility for
their own actions, with the support of the supervisor. I felt that I could relate to Smith’s (1996) concerns, as one of my supervisory experiences was with a ‘new supervisor’. I did feel that her own anxieties about her new role and the responsibilities she had taken on, in some ways hindered our relationship and my confidence in undertaking work in any kind of independent manner. I don’t think that this criticism undermines the shape of the model, i.e. splitting it into administrative, educative and supportive functions, but it does remind us to take care when approaching it.

Another query I had was how much this model neglects to consider the more relational aspects of supervision? Through my own experiences, I am a firm believer in the idea that the relationship between the two participants is probably the key to whether supervision is effective and useful. I wonder if this area has taken a bit of a ‘back seat’ in a model that looks more at the mechanics of why supervision occurs. I felt that the relationship issues were addressed slightly within the restorative ideas, in that in order to be able to acknowledge and discuss more intimate feelings, a somewhat positive relationship needs to be in place – however this was not directly emphasised.

The idea that the relationship between supervisor and supervise is key, also relates to some of the more ethical dilemmas that can be raised in supervision. I think it is really important from an ethical stance to consider some of the potential differences between yourself and your supervisor and how these may impact upon the supervisory relationship and potential ethical practice. While writing this account, I have been interested in the research that looks at how the supervisory relationship is subject to influence by the personal characteristics of the participants. It is this area that I wanted to highlight in this account, as I have been asked to consider ethical issues around working with difference. Instead of focusing on the idea of difference when working with clients, I thought it was highly relevant to consider the issue in relation to difference in the supervisory relationship. Major sources of influence, have been identified and discussed in reviews of the supervision literature. Factors receiving prominent attention were gender and sex role attitudes, supervisor's style, age, race and ethnicity, and personality characteristics (Borders & Leddick, 1987; Leddick & Dye, 1987). To highlight a couple of useful examples, Nelson and Holloway (1990) found that it was often the case that female counsellors were less encouraged and supported to assume power in supervision by both male and female supervisors. They also identified that female supervisors generally were found to defer power to the supervisee more readily than their male counterparts. To summarise, the salient information to bear in mind is that individual differences can affect the
manner in which supervision is both conducted and received and both parties need to be able to recognise this and potentially incorporate it into their work.

2) Developmental Models

In the past two decades, numerous developmental models have been emphasised in an attempt to further advance the application of supervision (Loganbill, Hardy & Delworth, 1982; Rodenhauser, 1994; Stoltenberg & Delworth, 1987; Watkins, 1995). Developmental models have in common a focus on supervisee change from novice to experienced clinician through a stage process with challenges facing supervisees at each level. Developmental models are particularly useful when considering the needs of individual supervisees and how these might differ from one individual to another. They help supervisors to expect different presentations from supervisees who are at different stages of professional development, and propose that supervisors adapt their approach according to these different presentations.


Stoltenberg, McNeil & Delworth (1998) take a stage approach to the description of these differences. They describe four main stages and within these consider how the supervisee is progressing within the domains of;

1. Self and other awareness – this reflects the level of the supervisee’s self preoccupation, self awareness and awareness of the client’s world.
2. Motivation – describes the supervisee’s interest, investment and effort expended.
3. Autonomy – recognises changes in the level and appropriateness of independence demonstrated by the supervisee over time (Scaife, 2001, p.93).

Stage One - Dependency Stage during this stage the supervisee is likely to be highly motivated but anxious and insecure about their ability. The supervisee will tend to be quite focused on themselves, and use supervision as a ‘survival tool’ for therapy. As supervisees at this stage tend to feel quite unconfident in their knowledge base, they need to have the time to consider theory, skills and rules, therefore this stage is viewed as being a time where reflecting on the self or others is seen as being less of a priority by the supervisee. The supervisor will often be viewed as a ‘safety net’ and it’s important that the supervisee can feel contained. Loganbill, Hardy & Delworth (1982) propose that more direct, instructional interventions by the supervisor are going to be the most effective at this stage. At this point, if the work or level of supervision is pitched at a level that exceeds the ability of the supervisee,
this will only serve to increase the anxiety and emphasis on the self and lessen the opportunities for the supervisee to develop and build up their skills. In relation to this, Egan’s (1990) work looked at the fact that peoples fears of being exposed as less knowledgeable than peers can impede learning, in that individuals are less keen to embrace more challenging situations. I feel this research is very relevant to this stage, as if this anxiety is high, then a more instructional, contained forum may be most useful for the supervisee at this time. I remember (and part of me is defiantly still there), that comparison with fellow trainees was a concern of mine, both in respect to my year group peers, but also the previous trainee’s shoes that I was now filling.

I feel that this is a crucial stage and one that ideally needs to be acknowledged at the start of the supervisory relationship. It is difficult to admit to feeling worried and insecure. As an assistant my experience was one of needing to look confident and capable as I needed to get on the course. As a trainee, I’m on the course, however now I need to justify my being on it. By using this type of model in a proactive way, I believe my supervisors could have made the beginning experiences of supervision less intimidating. Having moved to my new placement, even though I have gained in experience, this rationale was laid down for me, which I feel is allowing me to move towards a more reflective stage at a faster rate.

Stage Two – Dependency / Autonomy Conflicts during this stage the supervisee can fluctuate between being over-confident and being overwhelmed. This can lead to individuals feeling insecure and uncertain about both their abilities and career choice, (if I recall, I reflected on this exact issue when I introduced my reasoning behind choosing this essay). The focus of the work is likely to have moved from being centred around the supervisee’s needs and become more focused on client issues. At this stage, supervisees are unlikely to have developed an ability to be able to reflect on a session as it is occurring, and will need to have the supervisor to draw these issues to their attention. They will tend to work with whatever the client brings and be unable to really consider their counter transference reactions to the client. The role of the supervisor at this stage would be to provide a ‘secure base’ to which the supervisee may return when feeling overwhelmed.

Stage Three – Conditional Dependency at this stage, the supervisee is continuing to develop increased self confidence, greater insight and more consistency in their sessions with clients. They are able to focus more on the processes occurring during a session. At this stage, this type of reflection would still generally be conducted within supervision and less often within
the actual session. There is greater opportunity to focus on the thoughts and feelings that are influencing the work and less emphasis is now placed on techniques and survival strategies.

Stage Four – Master Professional the supervisee at this stage would now have personal autonomy, insightful awareness and would able to confront and discuss both personal and professional issues. The supervisory relationship becomes increasingly more equal and the responsibility for the structure and process of supervision is largely taken by the supervisee or shared with the supervisor.

Developmental models can also be applied when considering the supervisor's particular developmental stage. Stoltenberg, McNeil and Delworth (1998) believe that the effectiveness of the supervisory relationship is influenced by the stage of development of both participants. Someone at an earlier stage of 'supervisor development' is more likely to be highly anxious and very keen to 'do the right thing' (this can be likened to the early stages of the supervisee's progress). If this individual is paired with a level two supervisee in a state of 'conflict and confusion', then this matching can result in a highly anxious, difficult relationship. I find this particular aspect of the developmental model interesting, having now experienced supervisors at varying levels of their own development. I was placed with a 'new supervisor' when I first came into training and I'm not sure our experiences complemented each other. Our relationship at times was highly anxious and I think I felt less able to move forward and begin to think more from the perspective of the client, and consider process issues. When we did address this, it was in a quite rigid and structured manner which did not complement the nature of the work. I am now with someone who has been supervising for many years and I feel more able to jump between stages and initiate conversations. It is therefore interesting to reflect on whether I have moved 'stage' and this new confidence is a result of that, or whether my supervisor is within a different stage and this in turn frees me up to advance within the model.

Reflective criticism of the model in relation to my own experiences
Worthington (1987) reviewed studies based on developmental models and concluded that there was some support for conceptualising supervision in this way. My own experiences and having heard about experiences of others also offers a degree of face validity as we tend to think of ourselves as improving with experience (although on a bad day, I may tell you the opposite!). I have also been able to witness a noticeable change of focus in my supervision as I progress and gain more experience. When I started out, I definitely tended to focus much more on myself and what I needed to know to 'survive'. Now as I progress through training, I
like to believe and have been told that my focus is much more client orientated. It is only when I feel more uncertain (e.g. when beginning a placement) that I tend to initially revert back to my more egocentric ways. Reflecting on this point though, made me consider whether these types of models are too ‘clear cut’ in their presentation. Is it the case that you smoothly progress through each stage as you gain in experience, or is it more realistic to think of the stages as rough guides, that you ultimately progress through but can move backwards and forwards between? This reminded me very much of work I was involved in with a client whereby I conceptualised within Worden’s (1991) grief model, and struggled with the concept of her displaying traits from various stages of the model and often progressing forward and then moving back. Perhaps these models are useful when looking at overall development, and gaining a clearer idea of where someone lies within a framework, yet specifics should not necessarily be the focus.

Conclusions

I feel at this stage that it’s important to think about some of the limitations and difficulties I had with tackling this essay, as it has certainly been one of the more challenging pieces of work I’ve completed. The concept of supervision within the mental health professions is a topic that has received a huge amount of research interest. Consequently it has so many different aspects and related areas to it that I seemed to be left constantly feeling as if I had excluded particularly pertinent details, or that I was skimming over the majority of the material. After my initial excitement about a more reflective style of essay, I feel the title was actually quite anxiety provoking for me. It seemed to include so many different facets, all of which could have been written on at length, that I found myself getting quite confused if I spent too long considering whether I had sufficiently covered a particular topic within the text. Reflecting back, I feel the challenge - and I would guess why the title was posed in this way - was to be able to sift through the large volumes of information and draw on ideas and research that were specifically more relevant to my experiences. Once I’d learnt to relax and started to write more within this style I found the work flowed a lot more easily.

Consequently, I remain unconvinced as to whether I have successfully completed the set task, however I did really enjoy the process of digging around in my memories and unearthing the good, the bad and the ugly in terms of my supervision experiences. So, rather than completely unpick my account and reflect on all the things I could have incorporated into this writing, I’m going to leave it as an enjoyable amble through my recollections, punctuated by more theoretical aspects. One thing I do need to pick myself up on though is the fact that when
reading back through the work, I became very aware that I had written from a narrow perspective, that purely being my own! The account is very biased towards thinking about trainees using and experiencing supervision. Ideally it would have also been useful to further reflect on supervision within the context of the NHS in general, especially in terms of thinking about how supervision will change as I progress beyond training (this point will come!). I would like to think that my theory of mind is developed enough to acknowledge that supervision is a valuable resource used by clinicians outside of training, and so it will be important to consider how I can extrapolate the knowledge I’ve gained from the models and apply it to my future within the NHS.

References


PROBLEM BASED LEARNING
REFLECTIVE ACCOUNTS
Problem Based Learning Reflective Account 1

March 2005

Year 1

'Relationship to Change'
As we begin to embrace the core competency training approach, new ways of learning and developing as a course continue to emerge. The concept of Problem Based Learning (PLB) was introduced for the first time this year, with the aim of providing an innovative way of gaining certain key professional skills, such as co-operative working and reflective practice. The first PBL task involved trainees working within a group situation in order to prepare a presentation based on an ambiguous title.

As a founder member of the PBL experience, I aim to use this account as a means of reflecting upon the process and content of the work undertaken, and consider this in light of the knowledge and experience I have gained through placement. I hope this will result in a learning tool for both myself, and the course to consider in the future.

The Topic

My first reaction to the title 'the relationship to change' was a mixed one. Initial thoughts ranged from 'where's the nice concrete topic that is going to help us become the competent clinicians we aim to be' to 'what on earth does that mean?'. As the first piece of work for the course, I feel I can speak for the group when I say we craved and expected more clarification, direction and structure. Although we were provided with 'discussion prompts', the task still felt very undefined and vague and resulted in my first flutterings of anxiety. I felt the need to convey the image of 'the ultimate trainee', to confirm in the mind of the course tutors that they hadn't make a fatal mistake in choosing me, and I wasn't about to be 'found out'. However, in order to do this I needed familiarity and I needed to work in a way I was used to. Surely there was plenty of time to be more creative once I'd found my feet?

It's interesting to consider whether my need for structure and familiarity has carried over into my placement, as this was quite an intimidating 'new beginning'. I'd love to conclude that the experience of PBL rid me of my 'structured shackles' and enabled me to fearlessly embrace all new challenges that came my way. However, although not so dynamic, it is more realistic to report that I have taken with me into placement a more balanced view of working. In one sense, I can recognise the importance of maintaining structure and routine, but can also appreciate the benefits that working in a more exploratory manner can bring. This is highlighted particularly well in relation to my current client work. There is a need for structure and routine in terms of session times, lengths and boundary issues, but equally as important, there is a need to be open to explore and work with what the client brings to therapy,
especially when issues of difference occur. The ability to strike the right balance between structure and flexibility is an ongoing learning curve for me, but I'd like to think that the PBL set me on my way.

Ironically my 'relationship to change' involved a degree of resistance at the beginning. I was unsure about adapting my style and more importantly this didn't seem to be fitting in with my expectations of what I would be learning. I wanted to learn, but wasn't sure if I wanted to learn this way. My issues around resistance were by no means original, Psychodynamic theorists have been wise to the concept of resistance in the face of anxiety for many years (Lemma, 2003). What may be useful to consider in relation to this, is how my own experience of feeling resistant towards the task may be replicated by clients with whom I work. I talked about my expectations not being met and the resulting anxiety this caused me. It seems likely that this could be a common experience for clients entering therapy. Leahy (2003) talks about the link between clients' expectations and the resulting resistance that can occur if they are not met. During my placement experience I'm discovering the need to ensure that I am guided by both my own ideas about what may be useful as well as the client's expectations. I do feel that reflecting on my experience of feeling resistant has potentially made me more perceptive in 'spotting it' in others, and for that I'm glad I dragged my heels at the beginning of the PBL exercise.

The Group's Approach

The group consisted of five apprehensive (but extremely keen) trainees and one slightly nervous facilitator. In a way it was like being involved with one of those 'challenging' interviews, whereby they like to see how you interact in a group situation. No one wants to be seen to be overly dominant or even worse, overly lazy; and so we began with a tentative start. Thinking back on our decisions, I felt that they were predominately guided by the need to be 'fair', both in the amount of work people did and the amount of time they had to present. We spent an obscene amount of time ensuring that each person had exactly four minutes, bizarrely this at times felt more important than the material itself. Do I feel that this desire for 'fairness' is replicated in my multi-disciplinary team (MDT)? My experience so far indicates that often 'fairness' is not top of the priority list or particularly realistic in the 'real world' and the implications this brings with it can be difficult to manage. I will discuss this more in the next section as 'relations within teams' seems to be a recurring theme that has come up for me within my work and there are useful links to be made in relation to the PBL experience. I felt
that the benefit of working within the structure of a group, was that you naturally begin to think about peoples’ strengths and weaknesses, what they can bring and where they may need more support. This can only be an invaluable asset to MDT working, and it begins to make clear the valuable role of consultation, which I’m aware is something I have yet to feel confident in.

The Direction We Chose

After much wading through more ego-centric ideas, we eventually struck upon the concept of how the client may be viewed as an agent of change. I specifically chose to consider how we as therapists might change as a result of our interactions with clients, and discussed the idea of the ‘inspirational’ client. Being quite early on in my placement, I don’t feel I can honestly identify feeling significantly ‘changed’ by a client, but I would say I have experienced quite strong emotions towards people, both in a positive and negative sense. Having more of an awareness that this could occur has helped me to reflect upon this in supervision, and not to feel as if this should be something to hide.

I talk dismissively when I say we ‘struck upon’ an idea. In reality, we undertook an emotional rollercoaster before we established where we were going with the PBL. In the space of three weeks, I went from dubious through to excited, while experiencing frustration, annoyance, despondency and interest along the way. It is important to recognise the potential for clients to experience the huge array of emotions I did and more, and it is something that must be very real at the beginning and during the course of the therapeutic experience.

Once a direction had been decided on and the interested / excited stage had been firmly established, the inevitable curiosity over what other groups were doing took over. I found this a difficult hurdle to jump, as my experience of this time was similar to the ‘silent competitiveness’ that had haunted me through my school, college and university days. For me, there seemed to almost be a shroud of secrecy that had enveloped my fellow trainees whenever an enquiry was made as to what they had come up with for the PBL. The reason I mention this particular aspect of the experience is because I have seen this replicated during my time on placement to a certain degree. In my particular MDT, although we work as a team, I find that there still remains a slight sense of hierarchy among the professions, and that this can breed a degree of resentment. As an example, I have found myself having to justify the length of time I spend with clients and the number of sessions I offer, to colleagues who work
within a different role and feel frustrated that they are unable to have this time. I have also
been told that as a psychologist, my methods of intervention will always be secondary to that
of psychiatry! I do not feel that this experience is exclusive to my team, Stark, Stronach and
Warne (2002) discuss in length the difficulties and dilemmas that can result from team
working. I am attempting to cope with this by remaining as open as possible and trying to
engage in as much consultation and team socialising as I can (as well as a degree of tongue
biting!) This is an element of the PBL experience that I would have liked to have seen
changed. People being guarded caused me to be guarded, and so by the same token, if I had
been more open would the response have been to have my openness reciprocated?

Our Presentation

I feel that our style of presentation was significantly different from the manner in which other
groups presented their material. Ours seemed to echo the classic presentation style that had
been firmly established at undergraduate level, where we would stand up front and almost
teach our material to the audience. Others had injected humour, amusement and reflection into
their role-plays (yes role-plays!). At the time, watching my fellow trainees' creativity unfold
before me, filled me with a sense of dread as to what people would think of our 'classic' style.
Would 'classic' be considered boring, too intellectual, someone who was incapable of
'thinking outside the box'? Reflecting back on this experience, it is clear to see that people
were more similar than I originally believed. I think that we were all in a way using a certain
level of 'defensiveness', some of us coped with the anxiety of presenting with a more
intellectualising stance, while some, brought humour into the equation. Having been able to
engage in a small amount of psychodynamic thinking while on placement, the role of
psychological defenses appears not be something that is restricted to therapeutic sessions, but
is abundant in all areas of our life. Since engaging in regular supervision, looking back, I also
wonder to what extent our style of working was reflecting that of our facilitator? This is
interesting, as something I am currently struggling with is not feeling at liberty to develop my
own style of working. In an ideal world I would be carving out my own therapeutic style
while incorporating the advice and reflections of my supervisor. Instead I recognise myself
feeling frustrated as I struggle to maintain my individuality. Writing this, I can see it is
something I will need to address in supervision as I suspect it is the result of issues relating to
both myself and my supervisor.
How did I feel about writing this account? Initially I could feel myself slipping back into my trusted pattern of initial dubiousness. Again, this is a new way of working so would I make the grade? However, once I’d sufficiently procrastinated and then launched into it, I honestly loved the experience. I found it a completely refreshing way to work and the benefits of being able to look at my strengths and weaknesses within placement on the basis of what I took from the PBL was enlightening.

References


Problem Based Learning Reflective Account 2

March 2006

Year 2

'Child / Learning Disabilities'
Introduction

This account very nearly did not get written. I started a plan of what to say on four separate occasions and in all of these instances I procrastinated and struggled to consolidate my thinking and produce anything like a reasonable basis for a reflective account. Did I have as much trouble on my last piece of work? I don’t recall such a struggle and I remember even enjoying this quite unique, more ‘real life’ way of presenting my work. So, I go back and check, and I quote directly from the original manuscript ‘I honestly loved it (the experience)’ and ‘I found it a refreshing way to work’. Was I lying? How could things have so radically altered in the space of six months? Why was this write up such a millstone and where had this ambivalence come from? A reflective writer needs material to work with, so let’s consider this. Gardner (1987) states that aspects of relationships that are simultaneously both positive and negative serve to generate feelings of ambivalence. I have chosen therefore, to construct this account around the good, the bad and the downright ugly aspects of my PBL experience, with the aim of exploring why reflecting on this particular piece of work feels so difficult.

Scene Setting

The challenge for this PBL exercise was to incorporate issues connected to both children and people with learning disabilities, as the groups had spilt and were pursuing different placements. The actual concept was similar to prior tasks in that our finale was to be a presentation to the rest of the year group and staff based on the direction we had chosen to take. To briefly summarise, we were presented with a vignette, which highlighted issues from both camps and provided with a selection of prompt questions to help guide our thinking. We were given three sessions (over a 6 week period), to prepare, and it was all change as a new year also heralded a new facilitator.

The Good

I have chosen to begin on a positive note. Not only because the film title I draw my inspiration from dictates that ‘The Good’ comes first, but because I like to think I can look upon the experience and draw some positives. I am a little concerned that if I start writing from the negative end of the spectrum, I may get a little carried away, and although critical capacity is valued within this profession, so too is the ability to hold a balanced view.
I felt that the vignette presented was a useful one. The subject matter was relevant to clinical practice, and contained a good mix of issues pertaining to both child and learning disability work. Interestingly, our group adopted a seemingly natural division in that those working with children, covered 'child issues' and those working with a learning disabled population, researched aspects relevant to this line of work. It's always interesting to theorise why we do these things and why it was left unchallenged. For me, I feel there was that age-old anxiety about wanting to accumulate as much practical knowledge as possible to take forward onto placement. The question that springs to my mind is that of have we therefore truly embraced the idea of core competency working? Have we fully engaged in thinking about how skills can be effectively extrapolated from one client group to another...I think it may still be early days, as we may be perceiving both 'child work' and 'learning disability work' in an overly individualised way.

Although I was reluctant to leave behind the security of our old facilitator, I must admit it was good to embrace the newness of another. I’m surprised that I reacted in this way however, as I’m a real one for ‘if it ain’t broke then don’t fix it’. I know that certainly at the moment I’m going through all sorts of anxieties about the horrors that could await me in the form of a new supervisor (I’m possibly slightly unhealthily enmeshed with my current one). So what made it better this time? The support of the group? Possibly. A challenging experience always seems more manageable when it’s shared. I think it also helped that our new facilitator was an expert in the field of learning disabilities. Selfless as always, I was aware that my needs were going to be met as a result, in terms of more knowledge and understanding of the work coming in my next placement. I wonder whether I would have experienced this transition in the same light had I been geared up to start a child placement?

One of the most valuable aspects of PBL for me, is being able to create new knowledge and see this translated, utilised or considered in light of clinical practice. This is undoubtedly the case here. It took a bit of thinking about, but once I’d got going, I realised that there are so many areas of my current working life that have been subtly impacted upon;
- Primarily it has prompted me to think further about a client’s level of understanding and how this may or may not be communicated to professionals. I am currently working with a client who presents as being verbally very able, but in reality she understands very little of what is communicated and is reluctant to volunteer this information. The issues around communication (or lack of it) contained in the vignette have been useful in ensuring I
remember that ease of communication is not necessarily a given, and that it may be part of my job to ensure that any difficulties are raised and communicated effectively to the team.

- During the exercise I was made to address my ideas and prejudices about parenting in a learning disabled population. A client I’m seeing has had the experience of having a child taken from her, and this has been overlooked and fundamentally ‘brushed under the carpet’ by her support network. PBL has helped to gather my own reflections and assumptions on this controversial area, which has made me more able to take a step back and contain my emotive feelings, rather than unintentionally imposing them on my client. It has also made me consider ‘both sides of the story’ in terms of child protection and the rights of the parents, and therefore helped me to work in a less emotionally biased manner.

- My role within a group is something the PBL ensured I considered and this has more recently come up for me within placement. It’s a little hard to admit, and it’s always a little uncomfortable when you realise that sometimes your best attributes are not highlighted in a certain context. However, I have reached the conclusion that at times I can be a little lazy (can you admit to this on a clinical psychology training course?). I have been thinking about this since the establishment of a ‘mindfulness’ group I am currently co-running. I seem to have an eternal sense of guilt that I’m not doing enough. Whether this really is because I’m not doing enough, or whether it’s my own anxieties, combined with different ways of working, I don’t know, I suspect it’s a mixture of the two. I think the idea of group dynamics and working within a group is really important to highlight. Psychologists are intrinsically part of a well-oiled (or at times not so well-oiled) multi-disciplinary machine, and these ponderings about my ability to work in this manner need to be considered and addressed as I progress through training. Right, that felt decidedly uncomfortable, let’s bring the criticism away from me and place PBL back in the frame.....

The Bad

Although a fascinating case and one that offered a lot of scope, I wonder whether it was too big? I understand the importance of being exposed to all aspects of a psychologist’s role and the need to bear witness to some particularly complex cases while training. However for me the content of the PBL was relatively intimidating and not something I feel we would be asked to take on as trainee. I question whether something more basic would have served as a better learning tool. Vygotsky’s (1978) ideas around the zone of proximal development considered differences between the level of development when independently solving problems and contrasted this with potential development when problem solving under adult guidance or in collaboration with more capable peers. Having a facilitator more competent than us obviously

PBL Accounts: Child / Learning Disabilities
aided the learning process, however I still wonder whether this level of complexity was placed at the right time in training or just served to intimidate. The jury remains out.

In relation to this, the broadness of the topic had the effect (within our group at least) of smothering any kind of individuality or personal interest. Our group opted to present a general overview on key issues, however this raised a lot of frustration because we didn’t feel we could focus our interests for fear of being penalised, and missing crucial areas. Consequently the discussion of the work felt more in keeping with a ‘tick box’ exercise and smothered any creativity (something which I feel PBL strives to incorporate into the course for us).

**The Ugly**

The time frame was undeniably a huge stumbling block, it wasn’t a ‘challenge’, it was just too short. Three sessions culminating in a presentation dictated that our focus was primarily style over content. The scope was huge, varied and interesting, but none of this could realistically be investigated, as the pressure of a fully completed presentation in three sessions was imminent. Rant over. This did have an amusing connection to the realities of clinical work in terms of time pressures, but this learning aid was not enough to assuage the frustration.

There is no positive way to express this. We were spoilt first time round. We were given cake, coffee and more importantly interested audience members. This time round we got coffee, the cake (as always) was well received, however the absence of course team members was particularly hard to swallow. I do not wish to use this account as a ‘complaints mechanism’ so I will consider this in light of theory. Perhaps our lack of enthusiasm, worries about time limits and generally more listless embracing of the task somehow translated itself into the course team (some kind of strange transference / counter-transference type occurrence?). Perhaps it occurred the other way around? Whatever the explanation, it left us questioning the value placed on PLB by the course team.

**Conclusions**

This does make for interesting re-reading. I assumed from the outset that the bias in my writing would be towards the bad and possibly even the ugly, but there are only mere fleeting comments on these in comparison to all the good I’ve pulled out. Writing this has made me realise that when you actually take the time to reflect on a task, the positive benefits can really
come through, even if they were not so apparent first off. I like the fact that my learning has been done in a very subconscious manner, it gives me hope that I am actually far more accomplished than I realise! I have however come away with a slight feeling of having been 'therapised', that subconscious change that becomes realised only upon reflection. This makes me draw interesting parallels with the potential experience of my clients.

Reading back on my writing, by far the biggest impact for me is how much PBL has influenced my thinking when on placement. This makes the experience a really valuable one, as the drive at University is towards extrapolating knowledge between teaching space and placement, and sometimes this can be questionable as to whether or not this is achieved. So although teething problems do arise and disenchantment at some stage of the process is inevitable, proceeding on with PBL is undeniably an important addition to our learning repertoire....even if it takes some reflecting upon to realise this!

References


Problem Based Learning Reflective Account 3

February 2007

Year 3

'Older People'
Pre-Account Musings

I was interested to read an article in the November issue of Clinical Forum, describing the Problem Based Learning (PBL) experience of a group of trainees on the Exeter PsychD course (Griffith, Love, Newell & Scrase, 2006). Exeter appears to be somewhat of a flagship for the inclusion of PBL work in their curriculum, as it has now been up and running for five years, putting paid to the misguided perception of myself as one of PBL’s initial guinea pigs. The article was helpful in that it was focused around a group’s experience of PBL over a three-year period, and was geared towards understanding the trainees’ experiences on a reflective, phenomenological basis. It was useful to read this style of article since I too, am in the position of having completed all the required PBL tasks (I nearly wrote trials), and now have to pen my final reflective account. Although the specific remit of this account is to reflect on and discuss issues around the last exercise we completed, in order to gain a sense ‘PBL closure’, I’m aiming also to incorporate reflections on the process as a whole.

Since the start of training, I have consistently looked forward to writing these accounts. They are refreshingly different from any of the other pieces of work we are required to complete, and have provided me with a forum that allows more of my personality and creativity to be reflected in my training. My writing has by no means been consistently positive, but it has always been surprisingly honest, which has led me to learn far more about myself as an individual than I ever cynically thought possible when first presented with the task. I think it’s partly for these reasons that I felt a strong sense of disappointment when reading the Forum article and was aggrieved by what I thought to be a relatively contrived piece of reflection. The trainees reported all the benefits they felt PBL had afforded them and had also proffered just enough of the ‘challenges’ to make it a balanced piece of writing. Disappointingly though, I felt I came away without a real sense of the reality of their experiences. Reading this back, I question how appropriate it is to include this critique, since who am I to comment on what another’s experience of something is (surely my training has shown me that this is a position that no-one is equipped to assume?). However, I do not feel this is a simple case of disliking another’s work (on the contrary, it was brilliantly written). The problem, on reflection, lies with me and so I feel justified in including my comments as they serve to successfully establish the backdrop to my final account.

PBL Accounts: Older People
The Final Experience

My problem I think is jealousy. I didn’t enjoy my last PBL task and I don’t feel I gained a significant amount from it, so reading how others have embraced and grown both personally and professionally from the effort they put in, increased both my level of guilt and also annoyance with myself. The last task was a vignette based on a clinical situation that trainees may come across in an older adult setting. To summarise, its’ emphasis was on the recognition and consideration of diversity (specifically cultural diversity) issues within a clinical setting.

This caused controversy within our group from the offset, however I need to set the scene a little more, as I don’t think the task itself can really be held accountable for our reactions. It was a standard clinical vignette that encouraged us to take a very culturally orientated approach. Pretty harmless stuff really. However, at the start of the third year, instead of being geared up and ready to take the final year by storm, our group was in what can only be described as a very negative place. A series of events that are pretty much inevitable within the political climate of any workplace, had culminated to cause a significant amount of resentment and defiance within the year (which seemed to reach its pinnacle within my PBL group). Ironically the ‘peer support’ and ‘development of a shared group experience and identity’ that was so positively highlighted within the Exeter account, caused us to unite together in a negative stance against the course team. Therefore any ideas (innovative or not) that came our way, were to a certain degree instantly rubbished.

Our main gripe was the over emphasis on cultural issues. As third years, were we really so ignorant as to need an entire task based around this area? Surely there were other issues of equal importance that needed to be considered? We felt patronised and so became very close-minded. Our mission was ‘just to get through it’. The pressures of training obviously meant that our workload was high, and this seemed like ‘a waste of time’. It didn’t take long for us to totally disregard the point of PBL, divide the vignette into sections, allocate topics and then go our separate ways. We planned to all prepare ‘our bit’ then put them into an umbrella presentation at the end. We had done well...minimal work, yet still enough for us to have a viable presentation. One member of our group attempted to rally up enthusiasm for approaching the exercise in a manner that meant we might gain more from it, however that lone voice was shouted down, and the ‘inclusion of others’ perspectives’, a trait understandably valued by the Exeter trainees, was abandoned.

PBL Accounts: Older People
I fear my less than eloquent description paints us in a more childish light than was actually truthful, but I do feel it's important to also be as honest as you can if you're ever going to grow from these experiences (surely the point of the accounts). Writing about our reactions, makes me aware just what a powerful role group dynamics can play upon individual members. This awareness has such relevant implications for future work, both clinically and in terms of multi-disciplinary working. As I write I'm imagining the prospect of running a clinical group where members, for whatever reason, feel strongly united (be it a clinical diagnosis or shared experiences), and the challenges and benefits this bond may impart on the group process or myself as the professional. I've also already encountered the discomfort of the divided multi-disciplinary team, and Agenda for Change seems to have in some cases further cemented these divisions, creating almost sub-groups in some contexts. I take away with me now the knowledge that even as adults (and humans) we can all behave in a manner that doesn't seem quite appropriate for the workplace, but that the more able we are to recognise this in ourselves, hopefully the more able we will be to rein it in and maintain professionalism?

And so to the final presentation. Presenting at the best of times is not my idea of fun. Presenting when you know your work is relatively uninspired and not overly connected is hideous. It seemed oddly competitive within the group, we had all researched areas that had sparked an interest for ourselves and it felt as if we had a four minute spotlight to each impart our contribution and ignite people's interest in that area. It was amusingly reminiscent of competing agendas I have at times encountered in multi-disciplinary teams. Certainly I have been in meetings where different professionals are advocating their particular stance with a degree of immobility when considering other options. Within our presentation, each small part was important but went only a small way to addressing the overall issue. There's a definite moral to be drawn from that particular reflection!

The criteria for these accounts asks for you to reflect on the implications the experience of PBL has had on your clinical work, and certainly issues the vignette brought up around culture, family dynamics and dual diagnosis to name but a few, are ever prevalent in older adult working. Personally though, I feel on this occasion my learning curve has been significantly more geared towards the issues I have already discussed around team-working and professional practice, rather than direct clinical work. In hindsight however, there was one issue that appeared to pervade all areas of our final presentation, which has also proven to be extremely relevant to the majority of my older adult cases. This is the issue of isolation. Within the task, discussion around cultural issues inevitably brought up isolation as a potential

PBL Accounts: Older People
consequence, however my clinical work has emphasised just how prevalent this issue is when working in older adult settings, and I am uncomfortably aware that it is not just restricted to certain unique circumstances.

But why have I chosen this particular topic to focus on? As I've described, I feel these accounts benefit me by providing a forum to engage much more of myself in my training and consider issues that are personal and not just limited to the research base. Working with issues around isolation is an area that I have definitely struggled with on placement and have had to address in supervision on more than one occasion. Nearly all of my formulations have needed to consider the client's feelings of isolation and loneliness. On the one hand I have found this work incredibly frustrating, and I've gone from questioning whether it's my role to be involved, to feeling at times that if the individual could just improve their social circle or if the family would visit more, then their difficulties wouldn't exist. Reflecting on this though, I think that if you wanted to simplify any mental health difficulty down to its basic components then anything would appear simplistic. Why then was I consistently reaching this sticking point with this client group?

I think the reason is more intrinsic to me and writing this has made me consider why this frustration and to a small degree anger is apparent in myself. There are numerous psychodynamic theories I could draw on to help think through this (I attempt in each account to include a tentative interpretation, as even at the end of training psychodynamic approaches remain my biggest nemesis!). The one I feel most able to relate to in respect to this is attachment theory ideas around how anger can be viewed as a secondary emotion, preceding primary emotions, one of which may be fear (Bowlby, 1973). I know that certainly at the moment the transition I'm going through with respect to myself and my parents is unsettling and potentially fear-provoking. The closeness we shared is being challenged by me moving further away, having less intimate contact and generally feeling a pressure to maintain a relationship that is inevitably going to change and develop as I grow older. I think working with a client group who essentially provide a glimpse into a potential future is at times unnerving and evokes emotions that need to be recognised and considered in the context of how personal issues do inevitably impact upon your working life.
Endings

So as PBL draws to a close it appears that it has once again, despite stubborn resistance, managed to advance me as a reflective practitioner. It's an odd experience embracing the belief that something has been of limited benefit only to discover upon reflection that you have moved on and developed from it. Interesting parallels to some ending stages of therapy spring to mind....

In some respects I'll be pleased to be say goodbye to aspects of PBL, however I also question whether I will ever be granted the luxury of having such a designated space to reflect on myself and my work again. Perhaps an ambition for my future is to ensure I strive to continue to carve out such an opportunity.

As training draws to a close the most important lesson I can take away from my PBL experiences is that 'reflective practitioner' is not just a buzz word you write on your form to get into training, it's actually a reality and a very useful one at that.

References


PBL Accounts: Older People
Summary 1

September 2005

Year 1
Case discussion groups were introduced onto the PsychD programme with the aim of facilitating an environment that allowed open discussion and reflective learning on issues relevant to clinical practice. They aimed to minimise the divide between 'placement' and 'university' learning and attempted to create a more integrated experience for trainees.

I used this account as an opportunity to reflect on both mine and what I believed to be others' experiences of our group, both personally and professionally. I wanted to consider the challenges, successes and difficulties generated and lastly to contemplate what this held for the future of the group as we headed into our second year together.

My account based was based around Tuckman's 1965 model of group development, which involved four stages; forming, whereby individual behaviour is driven by a desire to be accepted by others, and avoid controversy and conflict; storming, whereby conflict, competition or struggles may arise within the group; norming, whereby consensus develops about the tasks, behaviours and responsibilities of the group and performing, a stage characterised by a state of interdependence and flexibility.

During this account I described the year long group journey based around ideas derived from this model. Finally, I reflected on the stability that the group had achieved and the implications this would have for the following year. In conclusion I considered Tuchman's final stage of adjourning, whereby people complete and disengage both from tasks and group members, and used this to consider issues around endings.
Summary 2

July 2006

Year 2
The second account followed on from the first and considered the progress and growth of the group through its second year of training. I began by thinking through my expectations of the group and its process in the second year, and based on these ideas, reflected on the reality of the experience.

I provided a brief insight into the appearance and function of our second year case discussion group, and then considered the implications of the changes that had occurred. Not only had the experience of being part of this group influenced myself both personally and within clinical practice, but individual members had also developed and the group as a whole had altered and grown. I used the account to consider both the positive and negative attributes of this.

To conclude, I reflected on the fact that writing the account had helped me put into perspective what it was I hoped to gain from the third year as a group together. Importantly, that I needed to stop hiding behind a process account and start to initiate these types of discussions, as they provide me with valuable experience for my future working life!
Clinical Dossier

The clinical dossier contains summaries of all the clinical placements completed during training and abstracts of each of the clinical case reports presented in Volume II.
### Client Demographics
- Direct work with 9 clients (1 male, 8 female) ranging in age from 21 to 56.
  - Group work with 15 clients (4 male, 11 female) ranging in age from 19 to 52.
  - Psychometrics with 4 clients (2 male, 2 female) ranging in age from 38 to 66.

### Presenting Problems
- Depression
- Anxiety
- Memory problems
- Issues around loss of physical health
- Obsessive Compulsive Disorder
- Assertiveness
- Emetophobia
- Compulsive overeating
- Adult ADHD

### Settings
- CMHT and Day Centre

### Assessment Procedures
- Clinical interviews, questionnaires (BDI, BAI, Browns AADD Scale), psychometric assessment (WAIS-III, WMS-III, WAIS-R, WMS-R).

### Interventions
- Cognitive behaviour therapy; behavioural therapy; assertiveness skills group, CBT for depression group.

### Other Experiences
- Conducted research to gather service user feedback on day hospital service (SRRP).
- Attended MDT meetings, team supervision and locality psychology meetings.
- Presentation to multidisciplinary team on SRRP.
- Presentation on the Behavioural approach to phobias (specifically Emetophobia), using client based material.
- Observation of assessments by CPNs and social workers within MDT.
- Attended day service groups as part of induction.
- Attended team meetings as part of the continuing needs team.
- Observed ‘mindfulness’ group on acute inpatient ward.
- Attended training on: CBT skills, manual handling, working with personality disorder and Asperger’s Syndrome.
### Learning Disabilities Placement

**Community Learning Disabilities Team**

#### Client Demographics

- Direct work with 1 client (female) aged 50.
- Indirect work with 6 clients (2 male, 4 female) ranging in age from 22 to 75.
- Group work with 7 clients (5 male, 2 female) ranging in age from 25 to 64.

#### Presenting Problems

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<tr>
<td>Dementia</td>
<td>Challenging behaviour</td>
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<td>Depression</td>
<td>Appropriate level of support queries</td>
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<td>Preparation for bereavement</td>
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#### Settings

- CLDT, residential homes, family homes.

#### Assessment Procedures

- Clinical interviews (HALO, Life Events checklist), interviews with care staff; observations; functional analysis of challenging behaviour, psychometric assessment (WAIS-III, Leiter-R, Baseline dementia assessment).

#### Interventions

- Cognitive analytic therapy; mindfulness group.

#### Other Experiences

- Participated in MDT meetings and group supervision.
- Co-facilitated day-long dementia training for support workers.
- Meetings and visits, including: day services, counselling service, residential home, hydrotherapy and music therapy.
- Attended ‘Health for All’ conference.
- Observation of supervisor in various client review meetings.
Child and Family Placement
Child and Adolescent Mental Health Service

Client Demographics
- Direct work with 7 clients (3 male, 4 female) ranging in age from 5 to 15.
- Indirect work with 1 client (male) aged 9.
- Psychometrics with 3 clients (2 male, 1 female) ranging in age from 6 to 12.

Presenting Problems
- Social anxiety
- OCD
- Attentional difficulties
- Anxiety
- Self harm
- Anger
- Low self esteem around body image
- Asperger's Syndrome
- Feeding difficulties
- Behavioural difficulties

Settings
- CAMHS, school.

Assessment Procedures
- Clinical interviews, questionnaires (Beck/Clark OCD Inventory, BAI, Conners ADHD rating scales, Spence Children’s Anxiety Scale), psychometric assessment (WPPSI-R, WISC-IV).

Interventions
- Cognitive behaviour therapy, narrative therapy, behaviour therapy.

Other Experiences
- Participated in MDT meetings and case discussion groups.
- Presentation to psychology team on application of new Beck Youth Inventories.
- Attended team CPD half days.
- Attended systemic training seminars.
- Attended training sessions on: Service History; CAMHS policies; Role of Educational Psychologist; Looked after children; Deliberate Self Harm.
- Attended open day for the Day Treatment Service (Tier 3 multi-agency service).
- Spent two afternoons with the Primary Mental Health team (PMHT).
- Attended open day for the Day Treatment Service (Tier 3 multi-agency service).
- Observed ‘B Clinic’ – multi-disciplinary assessment service for urgent referrals.
- Observed family therapy team.
## Client Demographics
- Direct work with 6 clients (2 male, 4 female) ranging in age from 66 to 87.
- Psychometrics with 2 clients (1 male, 1 female) ranging in age from 73 to 79.

## Presenting Problems
- Dementia
- Depression
- Generalised Anxiety

## Hyperventilation
- Memory difficulties
- Agoraphobia

## Settings
- CMHT (OP), clients' homes.

## Assessment Procedures
- Clinical interviews, questionnaires (HADS, BAI, BDI), psychometric assessment (NART, WAIS-III, FAS, AMIPB, Wisconsin, Dellis-Kaplan).

## Interventions
- Cognitive behaviour therapy, interpersonal therapy.

## Other Experiences
- Provided consultation to staff on continuing care ward.
- Attended MDT teaching sessions on topics such as dance movement therapy, telecare services, music therapy and memory clinic.
- Presentation on Mindfulness Therapy for older people to MDT.
- Participated in psychology meetings.
- Meetings and visits, including: CPN, wards (continuing care, functional, organic).
- Attended day workshop on Dementia Assessment Tools.
**Specialist Placement**  
*Child Eating Disorders Service, CAMHS*

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<th>Client Demographics</th>
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<tr>
<td>Direct individual work with 3 clients (all female) ranging in age from 15 to 17.</td>
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<td>Family intervention work with 14 clients (1 male, 13 female) ranging in age from 11 to 17.</td>
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<th>Presenting Problems</th>
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<td>Anorexia Nervosa</td>
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<th>Assessment Procedures</th>
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<td>Clinical interviews, questionnaires (Eating Disorders Examination (EDE), Beck Youth Inventories).</td>
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<th>Interventions</th>
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<td>Transdiagnostic CBT for Eating Disorders, systemic family intervention work.</td>
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<th>Other Experiences</th>
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<tr>
<td>Presentation on Major Research Project to Surrey CAMHS, Eating Disorder Teams.</td>
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<td>Participated in service development and service planning meetings.</td>
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<td>Conducted audit on service around NICE guidelines (2004) for eating disorders.</td>
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<td>Attended ‘Obesity Awareness in Young People’ training day.</td>
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<td>Observation of dietetic assessments</td>
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<td>Liaison with inpatient service around client discharge.</td>
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CLINICAL CASE REPORT
ABSTRACTS
Adult Mental Health Case Report Abstract 1

A Cognitive Behavioural Assessment and Intervention with a 45 Year Old Woman Presenting with Obsessive Compulsive Disorder

Referral/Presenting Problem
Jane, a 45 year old woman of Caucasian origin was referred by her GP to the Community Mental Health Team. Jane presented with symptoms of Obsessive Compulsive Disorder (OCD). She described experiencing obsessive thoughts around dying of bowel cancer and compulsive behaviours which took the form of repeatedly checking her bowel motions for evidence of blood. She reported that the onset of her OCD symptoms stemmed back to when she was 16 years old but had worsened since the death of her father, 18 months ago.

Formulation
Jane’s difficulties were formulated within a cognitive behavioural framework. Salkovskis, Forrester and Richards’s (1998) cognitive model of OCD proved useful when considering Jane’s difficulties. It appeared that Jane’s father’s early overprotective and controlling behaviour may have made Jane more sensitive to responsibilities (especially parenting). She discussed her beliefs around parenting; how she felt that parents should be ‘completely responsible’ for their children otherwise they risked ‘going off the rails’ or being ‘unable to cope’. Key beliefs Jane held around responsibility e.g. ‘failing to prevent harm as being as bad as causing harm in the first instance’ were also identified. Jane described her father’s death as being a ‘key reason’ for the worsening of her OCD symptoms. This incident seemed to have prompted Jane to experience distressing, intrusive thoughts around rectal bleeding and dying from bowel cancer (we discussed why her OCD may have taken this form and thought about the experience of her father dying as a result of a blood clot, the worsening of her IBS symptoms and her history of bowel difficulties). When we explored these thoughts, it appeared that her concern around dying was specifically linked to her worry about leaving her son. She felt he would be unable to cope without her. She described feeling an ‘overwhelming need’ to perform her checks as she felt it would be her fault if she ‘missed the blood’ and ‘didn’t catch the cancer in time’.

Intervention
At the time of writing the report, Jane’s intervention was ongoing and she had currently been seen for 10 sessions. Her goals were to reduce her checking behaviours, gain an increased sense of control and develop skills and strategies she could refer back to and use in the future.
Socialisation
Jane was initially socialised to the cognitive behavioural model of OCD, and her symptoms explored in terms of Salkovskis, Forrester and Richards’s (1998) model. The rationale for both cognitive and behavioural interventions were discussed; by modifying assumptions and schemas of danger and responsibility, cognitive restructuring would help Jane learn that her obsessive thoughts did not pose a threat and need not lead to action; secondly, by exposing Jane to her thoughts without her performing the rituals would lead to a decrease in her anxiety, in the frequency of the thoughts and in the urge to ritualise.

Cognitive Restructuring
Examples of this work included identifying Jane’s tendency to catastrophize events and predict ‘worst scenario’ outcomes. One method used to challenge this was to adopt Oppen and Arntz (1994) suggestion of having a client list the probability of each step leading to a feared outcome, and then calculate the cumulative probability of this outcome occurring. Also key beliefs Jane held around responsibility were challenged by using Whittal, Rachman and McLean’s (2002) suggestion of constructing a responsibility pie chart, which aimed to demonstrate that responsibility does not lie solely with one individual.

Building Motivation
Although keen to engage in therapy, Jane understandably expressed anxiety over the prospect of starting exposure work. We used the time between consolidating the cognitive work and beginning the behavioural intervention to think about the advantages and disadvantages of undergoing treatment.

Exposure and Response Prevention
Franklin and Foa (1998) stated that it is important to include both imagined and real life exposure techniques. As it is common for exposure work to be ‘therapist aided’ at the beginning, I felt it was important that we started with ‘imagined exposure’ (the nature of her difficulties made it difficult to engage in any direct behavioural experiments). We constructed a series of scenarios of increasing levels of unpleasantness and imagined them in order of difficulty and for increasing periods of time. This begun the process of exposing Jane to her anxiety, and showed her that it was something she was able to manage.

Contrary to standard exposure / response prevention work we did not base our intervention on the total exclusion of a ritual (Salkovskis, 1989), as Jane did not report many varied rituals and tasks but experienced distress by one extended ritual. I discussed this difference in
supervision and we considered that it would be excessively challenging for Jane to extinguish her entire ritual at once, instead we considered how to adapt the behavioural techniques to Jane's specific case. We used the principles of graded exposure (Butler, 1989) and begun by discussing the ritual in detail and breaking it down into smaller parts. From this we explored which elements would be more and less anxiety provoking to 'give up', and created a hierarchy based on this information. Each time Jane experienced anxious thoughts around bleeding and needing to check for blood, she would disrupt her compulsion and minimise it according to the hierarchy.

**Outcome**

As therapy was still ongoing, standardised outcome measures had not been completed with Jane at the time of the report. During our sessions Jane reported feeling increasingly more positive about the control she had over her OCD symptoms. She reported that the cognitive work had provided her with strategies for questioning her thinking which had allowed her more space to 'make a conscious decision' over her compulsions. She was still in the early stages of her exposure work but she reported being hopeful of the outcome as she already felt more able to cope with her anxiety.
Adult Mental Health Case Report Abstract 2

Behavioural Therapy with a 21-year-old Woman Presenting with Symptoms of Emetophobia and Injection Phobia

Referral / Presenting Problem
Jane, a 21 year old woman of Caucasian origin was referred by her GP to the Community Mental Health Team. Jane presented with symptoms of Emetophobia (fear of vomit) and a specific fear of injections. She talked about her fear of people vomiting close to her, and specifically identified the sound of people vomiting as being particularly distressing. Although she was concerned about vomiting herself, her main anxieties were around witnessing other people vomit. She discussed wanting to get help because her anxiety currently prevented her from being able to; use public transport, comfortably watch television programmes and films and ‘be there’ for people when they were unwell. She also described a feeling of ‘constantly being on edge’ whenever she was out and feeling frustrated that she was unable to ever feel relaxed. Jane was unable to remember exactly when these difficulties started, however she did recall ‘growing up with them’. Jane also reported a fear of receiving injections. She felt able to handle a needle as well as watch someone else receive an injection, but completely anxious about receiving one herself. Again she was unable to remember exactly when these concerns started, but thought they may have been around for ‘about ten years’.

Formulation
Jane’s difficulties were formulated within a behavioural framework.

Development of phobic response
Although the exact cause of phobias is unknown, they are generally believed to be learned (or conditioned) fears. Although Jane is unsure exactly when her phobias began, it seems likely they formed as a result of aversive experiences she had while growing up. Conditioning theory states that Jane’s fears would have developed out of a learned association between these negative experiences and her feared objects. She described how, when she was 6 or 7, she remembered visiting her father and him being ‘violently sick’ in front of her. She remembered feeling worried and anxious at this time. It may therefore be that she had learnt to associate being sick (or others being sick) as being something to fear. She also described a negative experience at 10 years of age where she recalled being ‘held down’ while receiving stitches. Again, she may have learned to associate needles as something to be feared.
Maintenance of phobic response
The maintenance of Jane’s phobias were explained in reference to Butler’s (1989) vicious circle model of phobic anxiety, who states that it is peoples’ reactions to symptoms that maintains their phobia. Each time Jane faced a situation that could potentially expose her to vomit, she would experience physical anxiety symptoms. As a result of these anxious feelings, she was concerned that she wouldn’t be able to ‘deal with’ the situation and that the image of vomit would remain with her. Consequently she would leave the situation or perform an action that minimised or cancelled any risk of her being exposed to vomit. Also, thoughts she had about the anticipated consequences of entering phobic situations, ‘I won’t be able to cope’ served to enhance her anxiety. External factors, such as the actions of people close to Jane also needed to be taken into account. Jane’s boyfriend would agree not to use public transport and would instead take a taxi with Jane, supporting her avoidant behaviour.

It appears that Jane’s injection phobia was based almost entirely around avoidance. She was not as readily exposed to situations where she could experience an injection. It may be that she is reacting to the symptoms of imagining an injection or it may be that simply by avoiding the situation she is unable to learn that her level of fear is misplaced.

Intervention
Jane was seen for 10 sessions. She was keen to prioritise the Emetophobic symptoms, as she felt they currently had the largest impact upon her life. Jane was initially socialised to the behavioural model of phobias. In the early stages, Jane was taught relaxation strategies to help her cope and gain some control over her symptoms of anxiety. Graded exposure techniques were then introduced, whereby a hierarchy of anxiety provoking situations was initially compiled. Davey (1997) states that it is important to include both imagined and real life examples when conducting exposure work. Imagined exposure work also allows a relatively safe starting point for the client which was crucial as Jane’s level of anxiety was particularly high towards the start of therapy. We identified the elements that we would be able to work on during the sessions, and which ones would be more appropriate for Jane to focus on outside of the sessions. Within the sessions we focused more on imagined scenarios and looking at pictures and film clips related to vomit. Jane continued this work at home but also focused her attention on gradually using public transport at different times of the day.

Although this was predominately a behavioural intervention, restructuring unhelpful cognitions is also reported to be useful in the treatment of phobias (Butler, 1989). Jane however, found it extremely difficult to identify and reflect on her thoughts in relation to her
anxiety, and instead appeared to understand and feel more comfortable working within a
behavioural framework.

Outcome
Both the BDI and BAI scores indicated a limited change in Jane’s symptoms, however since
she began with a relatively low score on these scales, it is questionable how useful they were
in relation to Jane’s symptoms. The Fear Questionnaire rating scale indicated that Jane felt
that her phobic anxiety symptoms had reduced from being between ‘markedly and very
disturbing’ to between ‘slightly and definitely disturbing’. However, again this reflects quite a
simplistic way of measuring change. I found the feedback from Jane most beneficial in
establishing how useful she had found the intervention. She reported that her anxiety levels
had improved and that she was now able to look at and listen to visually and orally presented
images of vomit. She had also managed to increase her use of public transport. However,
although she managed to face these situations, her level of anxiety was still relatively high,
and so she continued at times to restrict herself in various activities.
Learning Disabilities Case Report Abstract

Assessment and Intervention with a 50 Year Old Woman Using a Cognitive Analytic Approach

Referral / Presenting Problem
Jean, a 50 year old woman of Caucasian origin with mild learning disabilities was referred by her care worker to the psychology service attached to the community learning disabilities team.

Staff viewpoint: Staff described Jean as a person who regularly became ‘obsessed’ over men, and would become extremely upset if a relationship did not work out. Jean’s boyfriend had moved accommodation eight months previously, and staff were concerned by her reaction to this loss. Staff requested advice on how to help Jean come to terms with what had happened, and help her manage her mood.

Jean’s viewpoint: Jean described feeling sad because her boyfriend had moved away, and she talked about missing him. She described feeling angry because she felt staff were preventing her from seeing him, and talked about not being happy in her accommodation, as she was being ‘told off all the time’.

Formulation
Jean’s difficulties were formulated within a cognitive analytic framework. Two main reciprocal role procedures were hypothesised:

1. Abandoning to Abandoned
Jean had learned the “abandoned” role from an early age. Experiences included the loss of her Dad on a day-to-day basis due to working hours, the lack of attention from her Mum due to a large family, and the feeling of abandonment from not being protected from ‘the man down the road’ who had abused Jean at an early age. All these factors contributed to an expectation and fear in her current life of being left or abandoned. As she expects this role to be played out, when she fears a loved person may no longer be there for her, this makes her feel upset and negative about herself. Consequently she clings onto that loved person and tries to keep them with her, often resulting in them moving further away. This goes to prove to her that she should cling more firmly, and so serves as a trap or self-fulfilling prophecy. These factors, combined with her lack of contact with family members, led to a significant sense of isolation and loneliness for Jean.
2. Critical to Criticized

Jean talked about being unhappy because she was being ‘told off all the time’ and staff were concerned by Jean’s fluctuation in mood between extremely passive and apologetic to verbally aggressive and angry. During supervision, we discussed Jean’s experiences of a critical mother figure. If she is used to being criticized, this helps explain her ‘passive apologetic’ role, however she will also have learnt to be critical. When she feels that people may criticize her she pre-empts this by becoming very passive and apologetic, but is also able to be more assertive and can be quite critical or impatient with others. Both of these means of communicating result in Jean’s needs not being met.

Intervention

A major part of the work involved using the Sequential Diagrammatic Reformulation (SDR) pictures we created (these are based on the RR procedures and describes via a diagram the problematic sequences a client becomes engaged in) to help Jean understand the patterns of behaviour she was enacting that were causing her distress. We used examples to think about times when Jean felt she was being criticized during the week and used the diagram to talk about the position she found herself in and her reactions to this. We identified that it wasn’t always useful for Jean to ‘keep it all in’ or get angry and shout because that made it hard for people to understand her needs. It is also an essential part of CAT to identify times when these roles are being enacted during therapy. It was useful for us to take these instances and apply them to the SDR’s and get Jean to consider what position both her and I were taking.

Jean did find it particularly hard to discuss the reality of her relationship with her boyfriend. A focus of the work was to help Jean to ‘stay with the unbearable’, as her loneliness and sadness needed to be processed emotionally in order to help her move on. Since this was an emotive area, we broached it in a way that would remove direct confrontation and instead engage Jean from a more imaginary viewpoint. I felt this would be more tolerable, and hoped that Jean would be able to start to have discussions around this topic instead of cutting off and becoming upset.

During the course of our therapy sessions, I met with the staff team on two separate occasions. The original meeting involved feeding back to staff about the patterns that Jean exhibits and how staff may be inadvertently reinforcing these behaviours by their collusion with her RR procedures. We focused a lot on Jean’s volatile moods and difficulties in communication, and thought through ideas of how it might be easier for Jean to have space to discuss difficulties.
Jean does feel lonely and cut off from her family and so having easier access to communicating with staff would help her to feel less isolated.

We also discussed the difficult patterns Jean gets into with boyfriends. This included work around considering realistic expectations of psychological input. I needed to reflect with staff on their hopes that therapy would offer a 'cure' and that change would come directly from Jean. Instead we talked about the reality of therapy 'opening doors' and providing both Jean and the staff team with an increased awareness.

Outcome
The main way of assessing outcome was through client and staff feedback. At the end of our work, Jean reported having 'enjoyed talking to someone' and she felt that she could now 'stop herself getting angry more easily', however she was still unhappy living were she was and the issues around her relationships had not changed. I also used the Assimilation of Problematic Experiences Scale (Stiles et al. 1990) as a qualitative tool to help consider changes Jean may have made in her understanding of her 'problematic experiences'.

Staff fed back that there had been limited change, however, by the end of therapy, it had become clear that the onus of intervention would lay with them.
Referral / Presenting Problem

Jamie, a 10 year old white British boy, was referred to the Child and Adolescent Mental Health Service by his GP due to concerns Jamie’s family had around various facial tics he was displaying.

Examples the family gave were Jamie’s repetitive eye rolling and sucking of his bottom lip. They said that these had started within the last two years and tended to be ‘up and down’ in severity. Although the family were concerned by these behaviours, they did not feel they particularly impacted upon Jamie's life. Instead, Mum’s concern was that they might be indicative of a more serious underlying disorder, as both of his older brothers had received a neuro-developmental diagnosis.

Other concerns the family raised were related to comments received from the school. They discussed how Jamie’s teachers were worried about his inability to sit still, follow instructions and general lack of attention in the classroom. Jamie said that he did find it difficult to stay still because he 'jiggled' a lot and found it hard to pay attention sometimes in class. His parents commented that this was also apparent in Jamie's home life but they were used to his behaviour and so the impact was less noticeable.

After discussion, it became clear that the main worries were not around Jamie’s facial tics but more around his difficulties at school, coupled with Mum’s anxiety about a potentially undiagnosed disorder.

Formulation

Various explanations around why Jamie might be experiencing these difficulties were considered. Firstly, the concerns around Jamie’s ability to focus at school suggested a possible attentional problem. The symptoms the family described around lack of concentration and inability to sit still and follow instructions, combined with elevated scores on the Conner’s forms suggested the possibility of a diagnosis of ADHD.

At this stage, the possibility of Jamie being on the Autistic Spectrum was also kept in mind, due to the increased genetic risk that Jamie had in terms of a diagnosis. This was not a key
hypothesis however as there wasn’t strong evidence in terms of how Jamie presented and the specific concerns the family had, that suggested an Autistic Spectrum Disorder was likely.

We also kept in the mind the unusual environment that Jamie appeared to have grown up in. He seemed to have had a very structured childhood with less opportunity to socialise outside of his immediate family than would normally be expected. He spent a lot of time playing and socialising with both of his brothers, and this interaction would inevitably have had an effect on the manner in which Jamie interacted and behaved.

**Extended Assessment**

It’s advised that an extended assessment should incorporate information from as many informants as possible, including interviews, assessment scales, cognitive assessment and direct observations. The assessment for Jamie involved:

**Interviews and Observations**
- Interview with class teacher
- School Observation
- Interview with Mum – Developmental History

**Structured Questionnaires**
- Conners Teacher Rating Form – Revised (long version) (CTRF-R:L)

**Cognitive Assessment**
- Wechsler Intelligence Scale for Children – fourth version (WISC-IV)

**Outcome**

The assessment highlighted that Jamie was experiencing difficulties with attention and concentration, which were becoming a particular issue within his school environment. At the start of the assessment we hypothesised about a potential neuro-developmental disorder being the underlying cause of Jamie’s difficulties and thought primarily about ADHD, based on the initial information provided by the family. Although the assessment highlighted that Jamie did have traits similar to those experienced by individuals with a diagnosis of ADHD, my supervisor and I felt, that the picture gained from the assessment was not one consistent with a diagnosable ADHD profile as Jamie did not appear to consistently meet DSM criteria. The Conners forms highlighted some issues around attention, concentration and restlessness but they had not been rated with sufficient severity to suggest a diagnosis. Although the WISC-IV
results cannot be used to diagnose, they also did not suggest that Jamie displayed common traits associated with children with ADHD. Lastly, during the times when I had observed Jamie, I did not witness difficulties which made me think a diagnosis was appropriate.

Although we did not feel the evidence was strong enough to confirm an ADHD profile, the results did appear to suggest that there was a cognitive element to Jamie’s difficulties. He displayed some difficulties around impulsiveness, poor attention and problems in following instructions and completing tasks. Kutscher (2005) wrote about defining ADHD in a more ‘user friendly’ way, and discussed one component of this as ‘problems with executive functioning’. From the assessment, it seemed that the areas Jamie was having most difficulty with were ones most commonly associated with executive functioning problems. If difficulties in this area are apparent in a child then they may exhibit some or all of the following; poor self control, impulsivity, erratic, careless responses, poor attention, inflexibility and failure to carry out tasks that require them to use executive abilities.

Based on the assessment results, neither myself nor my supervisor felt comfortable placing a diagnostic label on Jamie and we discussed how this cognitive explanation of Jamie’s difficulties would offer a more practical, functional description and understanding of why Jamie may exhibit certain behaviours. Based on this we were able to offer suggestions to both Jamie’s school and parents to help them find ways to aid Jamie.

We also thought the more systemic hypothesis around Jamie’s family life would also have had an impact upon his behaviour. The very structured, routine nature of family life (to accommodate the needs of both older sons) together with limited opportunities for wider social interaction outside school would likely have contributed to some of the behaviour displayed by Jamie. Lastly, the mild facial and body tics he experienced may also in part explain why maintaining a focus and remaining still would be more problematic for him.
Older People Case Report Abstract

Cognitive behavioural therapy with a 66 year-old woman presenting with problems relating to anxiety and low self-esteem

Referral/Presenting Problem
Margaret, a 66 year old woman of Caucasian origin was referred to the Older Adult CMHT by her GP, due to a range of difficulties, including 'problems coping with life', hoarding, guilt around relationships and anxiety around cognitive functioning. Margaret described how she no longer felt she was 'coping with life' and this was causing significant anxiety for her. One example of this was that she felt her flat was in 'a complete state' and was anxious because the mess and 'backlog of work' had become 'uncontrollable'. She said this fed into anxiety she felt about having a social life, as she was consumed by guilt at the amount of work around the house she needed to complete. She also expressed anxiety about her general levels of ability, describing herself as someone who 'functioned very slowly'. She felt she was to blame as she had never really 'stretched' herself academically. She described how this fed into difficulties she was experiencing with friendships, as she had problems meeting people and forming attachments since she could not communicate 'on the same level'. A recent disagreement with a close friend had resulted in the friend ceasing contact with her, and she was anxious about the role she had played in this.

Formulation
A cognitive approach was used to help formulate Margaret's difficulties; I chose to draw on ideas from Melanie Fennell's (1999) work as an approach that focused specifically on self-esteem issues seemed relevant. Although this model is not specific to older adult work, cognitive behavioural therapy in general is well established as an effective treatment choice, however important adaptations to the therapy need to be considered.

Fennell (1999) proposes that early experiences have a significant impact upon a person's self-esteem, with our experiences creating a foundation for the general conclusions and judgments we make about ourselves. Margaret experienced a particularly critical relationship with her mother, and perceived herself as failing to meet parental standards. Based on these experiences Margaret appeared to draw conclusions about and judge herself as stupid, worthless and as somebody who 'gets things wrong'. Based on these conclusions, rules for living are composed, which are guidelines, policies or strategies for getting by in life. For Margaret, these were based around never expressing an opinion, always putting others before
herself, and needing to achieve very high standards in order not to fail. If a trigger situation occurs, in which these rules are broken, then the judgments a person attributes to themselves are activated, leading to negative predictions about themselves and situations they find themselves in. Margaret’s recent trigger situation was the rejection by her friend, leading to a significant increase in negative judgments and conclusions about herself.

**Intervention**

**Socialisation**

Margaret was initially socialised to the cognitive model of low self-esteem and subsequent treatment approach. The primary focus involved discussing the role self-critical thinking played in maintaining low self-esteem.

**Cognitive Interventions**

*Raising awareness of self-critical thoughts*

At first Margaret found it difficult to identify any critical thoughts she expressed in relation to herself. Fennell (1999) talked about the problems in identifying these thought processes if an individual’s self-esteem has been low for a significant period of time. Instead, looking for changes in your emotional state can help in cueing people into spotting self-critical thinking. Margaret found that outside of sessions, she was able to notice times when certain emotional states were apparent and so found it easier to identify times when she was thinking critically.

*Questioning self-critical thoughts*

I encouraged Margaret to consider alternative perspectives to her self-persecutory thinking. Margaret was able to come up with alternatives, however would quickly follow these with ‘but I’m not sure that applies to me’. At this stage it was useful to think about the realities of therapy and how change would not be instantaneous, and doubt would still remain at first. The onus instead was on practising these techniques, eventually leading into a change in thinking.

*Enhancing self-acceptance*

Fennell (1999) also emphasised the importance of helping an individual to enhance their self-acceptance. One suggestion is making a list of your qualities, talents, skills and strengths to help build a more positive view of yourself and also to help you become aware of how you
might be screening out and discounting positives. Again, this was a task that took some time to complete as often Margaret’s self-critical thinking would counteract any positives. We used this as an opportunity to continue to practice and consolidate the work we had begun on challenging thoughts.

**Behavioural Interventions**

As well as undertaking the cognitive aspects of the work, Fennell (1999) advocated that behavioural experiments can also be a useful tool to combat low self-esteem. An example we took, encompassed Margaret’s frequent need to apologise for what she was saying. We agreed she would try and pre-empt this and try to stop herself. This was something she commented on being most helpful about the therapy, as it provided evidence that people were not offended by things she said and didn’t appear to think she was stupid, lessening her anxiety around these issues.

I also wanted to address Margaret’s second goal of feeling more in control of household tasks. We had worked together to address her critical attitude to the home and spent time normalising her lifestyle, however we also thought about ways to help her organise better. This was not based upon psychological constructs or theory, but it was something that Margaret identified as important to her.

**Adaptations**

I was aware of the importance of drawing on Margaret’s life experiences in the work (Zeiss & Lewisohn, 1986) and being respectful of these. Although there were many experiences that she related to as being very negative, there was also a lot of past coping techniques that she had found useful. Morris and Morris (1991) also talk about needing to keep in mind the age contrast between yourself and the client, and the realities of truly emphasising with someone who is significantly older.

**Outcome**

Although Margaret’s scores on the BAI and BDI at the start of therapy did not indicate significant difficulties, it was still useful to repeat these measures as they showed a small improvement. Margaret reported finding this reassuring as she felt it showed tangible evidence of progress. Although Margaret remained at times quite critical towards herself and somewhat anxious, she felt she was making progress in tackling this, and said she now had ‘a way forward’ and felt able to build upon the work.
Research Dossier

This section comprises a research log, detailing research activity over the three year course, the Service Related Research Project, an abstract of the Group Qualitative Research project and the Major Research Project.
Logbook of Research Experience
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<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
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<td>7</td>
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<td>Setting up a data file</td>
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<td>21</td>
<td>Summarising results in figures and tables</td>
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</tr>
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<td>22</td>
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<td>Transcribing and analysing interview data using qualitative</td>
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<td>27</td>
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Research Dossier: Research Logbook
Service Related Research Project

July 2005
Year 1

'Assessing Client Satisfaction with a Day Service Group Programme'
Abstract

Recent government initiatives have emphasised the importance of user involvement in the planning and provision of services. The aim of this research was to explore service users' experience of attending a day service group programme, to consider how satisfied they were with the programme and to hear their views about possible improvements that could be implemented. The design was a non-experimental cross sectional survey using a self-designed questionnaire; the sample size was 41. The results indicated that overall, people were positive in their feedback about the group programme, with 92.8% of people rating themselves as either mostly or very satisfied. Areas that highlighted a greater degree of discrepancy were; the amount of choice within the programme and whether it had fully met individuals' needs. The most positive feedback was given in respect to staff members' attitudes and approachability. The results also produced qualitative feedback on potential changes for the programme. Design and methodological limitations are discussed.

Acknowledgements

I would like to thank all members of staff at the day service who helped with both the design and distribution of the questionnaire, in particular the senior occupational therapist whose advice and support was greatly received. I would also like to thank my university research supervisor for her time and advice. Finally I would like to thank the participants of this study.
Introduction

The National Service Framework for Mental Health (DoH, 1999) states that service users should be involved in the planning and delivery of care that they receive. This is supported by the Patient and Public Involvement Policy (DoH, 2001) which established the Government’s intention that service users should be at the heart of the NHS, and have a right to be involved in decisions that affect their healthcare. It is thought that people who use services are arguably the best judges of their strengths and weaknesses, and will be the people who are most affected by the quality of the service offered.

Satisfaction surveys are an important means of evaluating quality and outcomes in mental health care services, and emphasize the essential role of service users in the assessment and development of services. Service users’ views are vital as they may influence treatment outcomes, for example whether the client attends regularly or drops out, or the extent to which they engage with or participate in treatment. Lebow (1982) has proposed that minimum satisfaction or acceptability is a necessary condition for treatment success, and should therefore be considered a goal of treatment. Feedback from service users can also be a valuable source of information in the development of effective services. Recognition of service users’ preferences and views can offer guidance in the planning and provision of healthcare (Fitzpatrick, 1991a).

The day service is established as part of the Community Mental Health Team (CMHT) and offers a comprehensive group programme aimed at helping people cope with and rehabilitate from mental health problems. It runs activities and group sessions throughout the week, ranging from social / recreational activities through to more therapeutic and psycho-educational groups. As the day service is run by an occupational therapist and a community support worker, it is also able to offer vocational assessments and advice (a complete programme is cited in Appendix 1).

The day service presently gains evaluative feedback via brief questionnaires at the end of individually run groups (however this is completed on an ad hoc basis, and does not incorporate feedback about the entire programme). Therefore the service was keen for an overall evaluation of the group programme to take place, targeting a greater number of clients. They felt that gaining insight into the views of clients could help in offering guidance and suggestions for ways of improving the content or process of the programme. It was also felt
that involvement in a survey that could directly influence the service could empower clients and encourage open feedback about groups on a more informal and regular basis.

The relevant literature discussed above, combined with dialogue with staff at the day service, contributed to the formation of the research questions:

- What are service users’ views and perceptions about different aspects of the day service group programme?
- Overall, to what extent are they satisfied with the service they received?
- What are their suggestions for improvements to the service?

Method

Design
The design was a non-experimental cross-sectional survey of service user satisfaction, through the use of a self-designed questionnaire.

Setting
The setting was a day service that currently runs 13 different groups, alongside centre meetings, coffee times, computer provision and an internet café (see Appendix 1). It is run by three core members of staff: a senior occupational therapist, a mental health worker and a community support worker, and has further involvement from two extra occupational therapists and two social workers. Service users can be referred via their GP or any member of the attached CMHT. They receive an initial assessment from a member of the day service staff and decisions on an appropriate group programme develop from the assessment. Clients are allocated a certain number of sessions within a group, which is then reviewed by a member of the day service on a set date. Groups such as assertiveness and anxiety management run on an eight week programme. Groups range in length from 60 to 120 minutes.

Participants
Participants were all individuals who were either currently attending the day service or who had attended and had subsequently been discharged within the last six months. A total of 104 participants were identified. Overall, 41 questionnaires were returned, establishing a response rate of 39%. The demographic data are presented in tables 1 to 3 below.
Table 1: Sex

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>Male</td>
<td>56.1%</td>
<td>23</td>
</tr>
<tr>
<td>Female</td>
<td>39.0%</td>
<td>16</td>
</tr>
<tr>
<td>Missing data</td>
<td>4.9%</td>
<td>2</td>
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</table>

Table 2: Age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percent</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>19 or under</td>
<td>2.4%</td>
<td>1</td>
</tr>
<tr>
<td>20 – 29</td>
<td>19.5%</td>
<td>8</td>
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<tr>
<td>30 – 39</td>
<td>17.1%</td>
<td>7</td>
</tr>
<tr>
<td>40 – 49</td>
<td>12.2%</td>
<td>5</td>
</tr>
<tr>
<td>50 – 59</td>
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<tr>
<td>Over 60</td>
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<td>6</td>
</tr>
<tr>
<td>Missing data</td>
<td>4.9%</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 3: Ethnicity (categories from Commission from Racial Equality website)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>92.7%</td>
<td>38</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>2.4%</td>
<td>1</td>
</tr>
<tr>
<td>Missing</td>
<td>4.9%</td>
<td>2</td>
</tr>
</tbody>
</table>
Outcome Measure

I designed a questionnaire investigating service users' experience of and satisfaction with the day service group programme. The literature suggests that this method is the most straightforward and direct means of assessing views amongst this population whilst maintaining anonymity and reducing 'interviewer bias' (Lebow, 1982; Fitzpatrick, 1991b).

In order to design the questionnaire, it was necessary to consult:

- with the day service team as to what aspects of the group programme could be assessed for satisfaction.
- relevant literature discussing the dimensions of satisfaction (Lebow, 1982; Fitzpatrick, 1991a).
- established satisfaction questionnaires with proven reliability and validity measures and construct my questionnaire around this format (Attkisson & Greenfield, 1996).
- relevant literature discussing areas service users consider important to incorporate into a satisfaction survey (Lelliott, et al. 2001).

From this I designed a short questionnaire to distribute to all staff at the day service, asking for their ideas and comments about the questions, the response format and any other suggestions for further items (see Appendix 2). Four questionnaires were completed during this expert sampling process, so there were multiple judges of content validity.

The questionnaire was amended accordingly, with staff making suggestions around both the language used and the type of questions asked. In addition we decided to include three open-ended questions at the end (as well as comments sections next to each question) to encourage participants to indicate further comments or suggestions. Although Oppenheim (1992) highlighted the risk of contextual effects, it was felt that it would be most helpful to start with easier questions as this would encourage responses. Demographic questions were asked at the end.

As some people define satisfaction as a 'minimum level of acceptability' and others as 'near perfection' (Lebow, 1982, p.247) we agreed that it might be more useful to ask questions about the features of the group programme and limit specific satisfaction questions to two of the nine items. Lebow (1982) has suggested that it is useful to include items that do not explicitly focus on satisfaction in a consumer satisfaction survey, as long as such items are kept contextually separate from satisfaction items in the analysis.
The questionnaire for service users is in Appendix 3.

**Procedure**

Questionnaires were distributed by post to the 104 identified service users. Edwards, *et al.* (2002) suggests that to increase the response rate it was necessary to;

- keep the questionnaire to a short format
- include a covering letter
- send out the questionnaire by first class post
- include a stamped addressed envelope for returns
- inform participants before they receive the questionnaire

All of these criteria were adhered to (the only exception was clients who no longer attended the service were not informed prior to receiving the questionnaire).

**Ethical Considerations**

Prior to data collection, I completed a Trust Clinical Audit proposal form for the Clinical Audit and Effectiveness Department with a draft of the questionnaire. I was informed that my research had been approved and that my project proposal did not require scrutiny from the Ethics Committee.

All participants were given information about the purpose of the research and informed that their participation was voluntary. The information at the top of the questionnaire highlighted that the procedure of data collection ensured anonymity and that responses would remain confidential. Staff did not have access to the completed questionnaires as they were returned directly to me. At the end of the questionnaire, there were details of how to contact me should participants want further information.

I will be attending a team meeting on 26th August 2005 to feedback the results of the study (see Appendix 4).
Results

Out of the 104 questionnaires that were distributed, 41 were completed and returned.

Figures 1 to 9 illustrate frequencies of responses to the nine closed questions.

Descriptive statistics were used rather than further analysis because there was a limited sample and the possible variance in responses was limited (only four response options).

Quantitative Data: Questions 1-9

Figure 1: How satisfied are you with the amount of help you received?

1- Quite dissatisfied
2- Indifferent or mildly dissatisfied
3- Mostly satisfied
4- Very satisfied
5- Missing data

Figure 2: How supportive did you find the group programme to be?

1- Not at all supportive
2- Somewhat supportive
3- Fairly supportive
4- Very supportive
5- Missing data
Figure 3: To what extent has the group programme met your individual needs?

- 1- None of my needs have been met
- 2- A few of my needs have been met
- 3- Most of my needs have been met
- 4- Almost all of my needs have been met
- 5- Missing data

Figure 4: Has the support you received helped you to deal more effectively with your problems?

- 1- No, it seemed to make things worse
- 2- No, it did not help
- 3- Yes it helped somewhat
- 4- Yes, it helped a great deal
- 5- Missing data

Figure 5: Do you feel that your experience of the group programme will help you cope more effectively in the future?

- 1- No, definitely not
- 2- No, not really
- 3- Yes, generally
- 4- Yes, definitely
- 5- Missing data
Figure 6: If you needed and were offered help again, would you come back to the group programme?

1- No, definitely not
2- No, not really
3- Yes, generally
4- Yes, definitely
5- Missing data

Figure 7: Did you feel that the group programme offered enough choice?

1- No choice at all
2- Not enough choice
3- An adequate amount of choice
4- A lot of choice
5- Missing data

Figure 8: How approachable did you find the staff?

1- Not at all approachable
2- Somewhat approachable
3- Fairly approachable
4- Very approachable
5- Missing data

Research Dossier: Service Related Research Project
As the results indicate, service users were generally positive about the group programme, with 92.8% of people stating that they were either mostly or very satisfied. A greater degree of discrepancy was apparent when people were asked about 'choice' within the programme and whether it had 'met peoples' individual needs'. This was also reflected in the brief qualitative comments generated from questions 1-9. When asked whether the group programme offered enough choice, 12.2% of people felt that 'not enough choice' was offered. Qualitative remarks (7% of people) included the fact that 'there was not enough choice and spaces were limited' and 'the variety could have been wider'. When asked whether their 'individual needs had been met', 26.8% of people felt that only a 'few of their needs had been met'. Qualitative comments (5% of people) included 'more explanation of my disorder would have been helpful' and 'I wanted to do more classes'. Although the greatest discrepancies lay within these areas, it is important to recognise that the majority of people did feel that there was adequate choice and that their needs had been sufficiently met. The most positive response was given in relation to how approachable people found the staff. 80.5% of people found the staff very approachable and 24% of people wrote complementary comments about how they had interacted with the staff.
Qualitative Data: Questions 10-12

Overall 26 (63%) of the 41 respondents wrote comments.

* I have reported the suggestions that had been made by more than one individual. All other suggestions can be viewed in Appendix 5.

**Question 10: Do you have any suggestions of how the group programme could be improved?**

Forty-one and a half percent (17 responses) suggested ways to improve the group programme.

- 6 suggested that groups should be increased in length (both session length and number of sessions).
- 5 suggested that there should be more variety in the choice of groups.

It is difficult to gain a consensus on what changes people feel would benefit the group programme as the majority of responses were offered by one person. The suggestions that were highlighted on more than one occasion were the desire to have more choice and to increase the number and length of sessions. It is important to highlight this as it mirrors the emphasis on choice that was found in the quantitative results.

**Question 11: Is there anything else you would have liked included in the group programme?**

Sixty-three percent (26 responses) suggested potential inclusions for the group programme.

- 4 suggested a poetry/creative writing group.
- 3 suggested a drama group.
- 3 suggested a yoga group.
- 2 suggested a relaxation group.
- 2 suggested that the gardening group run last summer would be beneficial this summer.

The comments were again varied, however the most popular suggestions were groups for creative writing, drama, yoga, relaxation and gardening. One of the suggestions was already included in the group programme, this will be addressed in the discussion.
Question 12: Any other comments?

Twenty-nine percent (12 responses) of people commented further.

- 8 commented positively about the day service staff.

These comments again reflect the quantitative results by highlighting the highly positive views people hold towards staff members at the day service.

Discussion

The results suggest that overall people were satisfied with their experience of the day service group programme, with 98.2% of participants stating that they were either mostly or very satisfied. Although all aspects of the programme received positive feedback, there was more discrepancy around whether enough choice was offered and whether the programme was specifically meeting individual needs. These are areas that will need to be considered by the day service team when they review the programme in September. The area that received the most positive feedback was the approachability of the staff, and as the programme is conducted in a therapeutic context, this will be useful and reassuring feedback.

The qualitative data demonstrated the responses to the open ended questions. It is important to highlight that the sample size is small and so it is hard to generalize beyond anything other than individual opinions. There were suggestions that were repeated by more than one individual, and again it will be important to consider these when the programme is reviewed.

The qualitative feedback did raise the issue of how aware people were of the options open to them within the programme. Two people suggested a gardening group should be established, however, at the time this activity was already running. Perhaps it will be important to review how decisions about programme planning are made and how options are communicated to service users.

The above conclusions should be considered in light of a number of design and methodological limitations.
Future design considerations

On reflection, one of the main limitations was the lack of service user involvement in the design of the questionnaire. Although I consulted literature to establish what factors service users might consider important to address (Lelliott, et al. 2001), I did not consult directly with clients currently based at the service. A criticism around the use of satisfaction surveys has been, how valid are they if they are devised by clinicians and therefore reflect only their concerns? It will be important in future studies to consider how best to incorporate users’ advice in all stages of the research.

The questionnaire was designed with closed questions first, followed by open questions. The service preferred this order as they felt that starting with the simpler closed questions would encourage responses. Oppenheim (1992) has warned of contextual effects so participants were asked explicitly to list any suggestions for improvements (as suggested by Barker, Pistrang & Elliot, 2002). A future study could distribute half the questionnaires with open questions first and half with closed first to enable an investigation of any contextual effects.

There are also issues concerning the notion of satisfaction, and what constitutes a ‘satisfaction survey’. The service agreed that they were most interested in general views and perceptions about many aspects of the programme, so I designed the questionnaire asking direct questions about features that may not strictly be components of ‘satisfaction’. Lebow (1982) has argued that it is valid to include ‘nonsatisfaction items’ in the questionnaire as long as they are relevant to consumer concerns and kept conceptually separate from the satisfaction items in the analysis, as was done.

I am aware that the questionnaire was designed to obtain an overall picture of the day service and did not focus on satisfaction with specific groups and activities. Therefore, the conclusions are quite broad and more difficult to identify specific areas within the programme that could be improved. This approach was taken as it was the first time an overall analysis of the service had been completed. It would be useful in the future to look more specifically at individual groups.

Future methodological considerations

One inherent difficulty with satisfaction surveys is how representative they are of the population you are targeting? Peoples’ motivation for responding to questionnaires must be considered and Oppenheim (1992) talks about the potential differences in responders and non-responders and the influence this can have on results.
In retrospect it would also have been useful to have gathered the cultural demographics of all participants who received a questionnaire, as only one respondent classed themselves as 'non white British', and it is unclear how representative this is of the client base.

Another possible response bias is that of acquiescence. This was addressed to some extent by emphasising anonymity and asking explicitly about any suggestions for improvements.

Questionnaires are likely to have less 'interviewer bias' than interviews (Fitzpatrick, 1991a). However, demand characteristics are still possible. The 'halo effect' has been noted by many (e.g. Hurst and Ball, 1990), whereby single striking impressions of a member of staff or group shape all other views about them (as cited in Fitzpatrick, 1991a). This was addressed to some extent by asking specific questions about many aspects of the group programme and staff.

In conclusion it seems that this study of service user satisfaction has offered a number of interesting insights and tentative conclusions about service user views and their suggestions for improvements to the service. As noted above, it is important to consider the results in light of the discussed limitations. However, the study remains a valuable contribution to the service as it indicates that overall, service users have had predominately positive experiences and have some useful suggestions for service delivery.

References


Appendices

Appendix 1: Timetable for Day Service Group Programme
<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:30 Coffee</td>
<td>10:30 Local</td>
<td>9:45 Coping with</td>
<td>10:30 Photography</td>
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<tr>
<td>12:15 Time</td>
<td>12:30 Healthy Walks</td>
<td>11:15 Motherhood</td>
<td>12:00</td>
<td></td>
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<tr>
<td>Hall/Dining Room</td>
<td></td>
<td>11:15 Healthy Walks</td>
<td></td>
<td>12:00 Cafè</td>
</tr>
<tr>
<td>11:30 Centre Meeting</td>
<td>Joining with</td>
<td>10:30 Gardening Volunteer</td>
<td>10:45 Therapeutic Art &amp;</td>
<td>12:00 Catering</td>
</tr>
<tr>
<td>12:30 Hall</td>
<td>Embirch Healthy Walks</td>
<td>12:00 Work Force</td>
<td>12:15 Craft Workshop</td>
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<tr>
<td>Monday 25th October 2004</td>
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<tr>
<td>Monday 22nd November 2004</td>
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<tr>
<td>Monday 20th December 2004</td>
<td></td>
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<tr>
<td>LUNCH BREAK Access to computer use</td>
<td>LUNCH BREAK Access to computer use</td>
<td>LUNCH BREAK Access to computer use</td>
<td>LUNCH BREAK Access to computer use</td>
<td></td>
</tr>
<tr>
<td>12:20 Main Meal Cooking</td>
<td>12:30 at 2:30</td>
<td>1:30 Music Therapy</td>
<td>1:30 Badminton &amp;</td>
<td>12:20 Internet Café</td>
</tr>
<tr>
<td>4th October - 6th December</td>
<td>(Vocalisation Advice)</td>
<td>(By Referral)</td>
<td>3:30 Swimming Group</td>
<td>3:00</td>
</tr>
<tr>
<td>1:30 Anxiety Management</td>
<td>1:30 Health Management</td>
<td>1:45 Therapeutic ***</td>
<td>7th Oct - 9th Dec Fee £15.00</td>
<td></td>
</tr>
<tr>
<td>3:00 Usual Members Hall</td>
<td>2:45 Health Management</td>
<td>3:15 Clay Work</td>
<td>Workshop for Beginners</td>
<td>Lunch served 12:30 - 1:30</td>
</tr>
<tr>
<td>Assertiveness Group (TBA)</td>
<td>2:45 Hall &amp; Dining Room</td>
<td>3:30 - 5:00</td>
<td>Continuing Computers</td>
<td></td>
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</table>

Use of Computers at the Centre can be booked via your link worker

Please Note: due to training in the hall some groups may have to be relocated on certain days.

*** marked by groups means that provisional places only will be allocated, confirmation of a place will be given at a later date.

Committments to Groups: Due to groups running waiting lists if you are on 2 consecutive groups without leaving a message you may lose your place in that group.
Appendix 2: Questionnaire for Staff
As part of my PhD in Clinical Psychology, I am required to conduct a small-scale service related piece of research or audit.

I am going to be investigating service-user satisfaction with the group programme ran by the day service. I will be designing a questionnaire to distribute to all clients who have used the service in the last six months, and would like to know your ideas and comments regarding the content of the questionnaire.

The questions on the questionnaire will probably use a tick box format, with space for additional comments.

Example: *Overall, how satisfied were you with the group programme?*

<p>| | | | |</p>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>not at all satisfied</td>
<td>fairly satisfied</td>
<td>very satisfied</td>
</tr>
</tbody>
</table>

Please tick whether you agree or disagree that this should be asked in relation to the day centre group programme. Please feel free to write any comments next to the question, and further ideas or possible questions in the space provided.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Disagree</th>
<th>Comments</th>
</tr>
</thead>
</table>

How satisfied
How helpful
How interesting
How challenging
How supportive
How approachable were the staff
How relevant
Met individual needs
Helped you cope
Enough choice

(open ended questions)

Any suggestions for improvements?
Anything else that should be included?

Thank you for your time and suggestions.
Please return these forms to
Appendix 3: Client Satisfaction Questionnaire
Client Satisfaction Questionnaire

We are asking for your views and opinions on the Programme in order to help us improve the service we offer here. The questions will ask you about your opinion on a range of areas, and will take about 10 minutes to complete. We are interested in your honest opinion whether it be positive or negative, we also welcome your comments and suggestions. All information you provide will remain strictly private and confidential. Please note that the completion of this questionnaire is voluntary.

When you have completed the questionnaire, please post it back in the stamped addressed envelope provided.

Many thanks, we appreciate your help.

For the following questions, please circle the number that best reflects your view. Feel free to write any further comments in the space provided. Please answer all questions:

1. How satisfied are you with the amount of help you have received?
   1  2  3  4
   - Quite dissatisfied  - Indifferent or mildly dissatisfied  - Mostly satisfied  - Very satisfied
   Comments (optional):

2. How supportive did you find the group programme to be?
   1  2  3  4
   - Not at all supportive  - Somewhat supportive  - Fairly supportive  - Very supportive
   Comments (optional):

3. To what extent has the group programme met your individual needs?
   1  2  3  4
   - None of my needs have been met  - A few of my needs have been met  - Most of my needs have been met  - Almost all of my needs have been met
   Comments (optional):
4. Has the support you received helped you to deal more effectively with your problems?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>Yes, it seemed to make things worse</td>
<td>No, it did not help</td>
<td>Yes, it helped somewhat</td>
<td>Yes, it helped a great deal</td>
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</table>

Comments (optional)

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5. Do you feel that your experience of the group programme will help you cope more effectively in the future?

<table>
<thead>
<tr>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>No, definitely not</td>
<td>No, not really</td>
<td>Yes, generally</td>
<td>Yes, definitely</td>
<td></td>
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</table>

Comments (optional)

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6. If you needed and were offered help again, would you come back to the group programme?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>No, definitely not</td>
<td>No, not really</td>
<td>Yes, generally</td>
<td>Yes, definitely</td>
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</table>

Comments (optional)

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7. Did you feel that the group programme offered enough choice?

<table>
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<th>1</th>
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<th>3</th>
<th>4</th>
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<tbody>
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<td>No choice at all</td>
<td>Not enough choice was offered</td>
<td>An adequate amount of choice was offered</td>
<td>A lot of choice was offered</td>
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</tr>
</tbody>
</table>

Comments (optional)
8. How approachable did you find the staff?

1 2 3 4
Not at all approachable Somewhat approachable Fairly approachable Very approachable

Comments (optional):

9. Overall, how satisfied are you with the group programme?

1 2 3 4
Quite dissatisfied Indifferent or mildly dissatisfied Mostly satisfied Very satisfied

Comments (optional):

10. Do you have any suggestions of how the group programme could be improved?

11. Is there anything else you would have liked included in the group programme?

12. Any other comments?
It is helpful if you provide a little information about yourself, so that we can classify your answers. Again, this information is strictly confidential.

1. Sex:  
   - Male
   - Female

2. Your age:  
   - Under 20-29
   - 30-39
   - 40-49
   - 50-59
   - 60 or over

3. Which of these groups best describes you? Please tick one box only:

<table>
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<th>Irish</th>
<th>Any other White background (please specify)</th>
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4. Please name the groups you attended (are attending) as part of the Group Programme:

Thank you very much for completing this questionnaire, your views are very important to us.

If you would like any further information about this project, please contact (Trainee Clinical Psychologist): I am available on Wednesday, Thursday and Friday at

Research Dossier: Service Related Research Project
Appendix 4: Evidence of Presentation and Exemption from Ethical Scrutiny
To:  PsychD Clinical Psychology, Department of Psychology, University of Surrey

This is to confirm that Elly Evans, Trainee Clinical Psychologist, at
presented the results of her Audit of the Day Service group programme to the
Team at
on 20th July 2005.

Yours sincerely,

Clinical Psychologist
The nature of the proposed project is such that I am satisfied that it will not require scrutiny by the trust's ethical committee.

Name of Field Placement Supervisor: ________________________________

Signature of Field Placement Supervisor: ____________________________

Name of Trainee: ________________________________

Title of SRPP: Assessing Client Satisfaction with a Day Service Group Programme

Date: ________________________________
Appendix 5: Additional Qualitative Results
Question 10: Do you have any suggestions of how the group programme could be improved?

- 1 suggested that there should be less structure and greater spontaneity.
- 1 suggested that there should be an ‘in house’ psychologist to offer support.
- 1 suggested that there should be more spaces available, so waiting time would be less.
- 1 suggested that there should be more contact from ‘leaders’ during the holidays.
- 1 suggested that there should be better media for presentations e.g. power point instead flip-chart and pen.
- 1 suggested that there should be more ‘activity days’ outside of the centre.
- 1 suggested that it would be better to not feel pressured to speak in front of people in groups.
- 1 suggested that the time it takes to get an initial appointment should be shorter.
- 1 suggested that the sessions should be shorter.

Question 11: Is there anything else you would have liked included in the group programme?

- 1 suggested an art group.
- 1 suggested an alternative therapy group e.g. reflexology and reiki.
- 1 suggested music therapy (it was acknowledged that there was a music therapy group currently running but the suggestion was specifically related to singing).
- 1 suggested a book club
- 1 suggested a cycling club
- 1 suggested that the health management sessions should be reinstated.
- 1 suggested having computer use and internet facilities.
- 1 suggested a first aid course.
- 1 suggested a self-esteem group.
- 1 suggested a weekend support group.
- 1 suggested cookery sessions.
- 1 requested a decent coffee machine.
- 1 suggested that the presence of a celebrity or famous footballer would be welcome!
Question 12: Any other comments?

- I commented that it would be better if the day service could be used as a 'drop in centre' throughout the weekend.
- I commented that having a subsidised hot meal would encourage people to attend.
- I commented that the option of doing more charity work should be available. They felt that the craft work and photography that was completed could be put up for sale and the proceeds given to charity. They felt this would give added purpose to the groups and increase motivation.
- I commented that there was not enough staff.
Group Qualitative Research Project Abstract

May 2006

Year 2
Abstract

With the increasing involvement of psychologists in a host of 'reality TV' programmes that have pervaded our culture in recent years, ethical dilemmas and other issues have been highlighted by qualified clinical psychologists. However, less is known about the opinions of trainee clinical psychologists who are developing as professionals within this climate. Six trainee clinical psychologists participated in a focus group to explore their perspectives. Interpretative phenomenological analysis (IPA) was used to analyse the data. Five main themes emerged, these were: public views; credibility; accessibility; professional identity and ethics/responsibility. The emerging themes reflected some of the concerns of qualified practitioners which have implications for individual practice and for the profession as a whole.
Major Research Project

July 2007

Year 3

‘Impulsive and Compulsive Relationships to Food in Disordered Eating’
Abstract

Objective: A unified sense of what constitutes a compulsive and an impulsive relationship to food and eating is currently unclear. The research aimed to create a clearer conceptualisation around these relationships; to explore any differences in disordered eating behaviour between individuals who demonstrated impulsive and compulsive relationships to food; and to consider any co-morbidity between the relationships. Method: Data were collected from a general population and eating disordered sample, who answered two self-report instruments related to food and eating (the EDE-Q and a researcher designed questionnaire aimed at conceptualising impulsive and compulsive relationships to food). Principal components analysis of the researcher questionnaire items was conducted and differences on the factors between binge and restrictive eaters, and potential co-morbidity between the factors was explored. Results: Four factors were produced which highlighted different ways of relating to and interacting with food, suggesting that the concepts of impulsivity and compulsivity in respect to food cannot be conceptualised in terms of two distinct processes. The research found that Emotional and Spontaneous Eating and Food Obsession were relevant to binge-eating and restrictive eating behaviours, but that Food Obsession was more pertinent for restrictive eaters. The factor Pleasure from Food was seen as representing a healthy relationship to food. The research contributed to the evidence base that conceptualises impulsivity and compulsivity as non-mutually exclusive, identifying this dynamic in respect to food. Discussion: Further research is required to substantiate the initial findings, clarify the nature of the underlying processes and develop treatments to help individuals with disordered relationships to food tolerate and manage distress, and engage in regular eating patterns.

Acknowledgements

Thank you to all the participants who took part in the study. Thank you to the Research and Development, Local Research and University Ethics Committees for allowing me to undertake the study. Thank you to the staff at the Eating Disorders Service, and to the Eating Disorders Association for allowing me to approach participants. A particular thank you to Dr Martin Carroll and Dr Tushna Vandrevala, my field and research supervisors for their continued help, advice and encouragement.
Introduction

The field of eating disorders is a rapidly expanding area of clinical concern in the NHS, therefore research into psychological approaches to the assessment, formulation and management of eating related difficulties is an important area. As the expansion of eating related concerns has grown, not only in clinical settings but also in the general population at large, a lack of clarity has emerged around how to describe and conceptualise certain eating and food related issues. Specifically the concepts of impulsivity and compulsivity in respect to food and eating are referred to in both clinical and general contexts, however a unified sense of what constitutes a compulsive relationship to food and an impulsive relationship to food and eating remains elusive. Establishing a clearer sense of what is involved in terms of these two ways of relating to food, would provide greater clarity around the use of these terms within the eating disorder field. Clinically, this information could be valuable in assessing and formulating around disordered eating behaviours, as it would enable a clearer understanding of the specific function and meaning that food and eating provides for an individual. These ideas in turn could help in the planning and implementation of intervention techniques for individuals with disordered relationships to food.

Compulsive and Impulsive Eating in the General Domain

The prevalence of the term ‘disordered eating’ has increased rapidly in the last decade, with the magnitude and volume of interest around difficult and unhealthy relationships to food and eating expanding significantly within both the media and internet domains. Disordered eating, at one point was most commonly associated with a subgroup of individuals who were clinically diagnosed with an eating related disorder, most frequently anorexia or bulimia nervosa (Ogden, 2002). Although this clinical group is rapidly expanding (cited in http://www.b-eat.co.uk), the term disordered eating no longer appears to be restricted to clinical groups, instead the explosion of media information around diet and weight related issues, combined with society’s increasing obsession and drive to be thin, appears to have given rise to the labelling of new forms of unhelpful eating behaviour (Ogden, 2002). Possibly the most common of these, based on search engine results is the notion of ‘compulsive eating’ or ‘compulsive overeating’ depending on the source. Although this term appears to have become commonplace, what is evident, is that there is little consensus around the definition of this term. For the lay person interested in researching compulsive eating on the internet, the descriptions include compulsive eating as a clinical disorder in its own right (although this is not validated by any current diagnostic manual); a descriptive term for binge-eating disorder
(see Appendix A for DSM-IV-TR suggested criteria); basic overeating that is generally associated with obese individuals; binge-eating (consuming an excessive amount of food over a limited time period) but not specific to binge-eating disorder and lastly, an addiction to food.

The type of descriptions used to conceptualise compulsive eating, are also used in reference to impulsive eating. It appears that within the current media domain, the terms ‘compulsive and impulsive’ are being applied relatively indiscriminately to describe a range of disordered eating behaviours, with no real sense of the criteria for each one, or the difference between them. The difference in name suggests that impulsive eating would be quantifiably different from its compulsive counterpart; however this is difficult to substantiate as, similar to compulsive eating, the internet does not provide a coherent story on what impulsive eating entails. The information available does not provide a distinction between compulsive and impulsive eating, instead similarities are readily apparent in that impulsive eating essentially involves excessive, non-restrained eating, frequently associated with binging behaviour, and is again, at times classified as a disorder in its own right.

Compulsive and Impulsive Eating in the Scientific Literature

As the general literature provides little clarity in helping understanding the terms impulsive and compulsive eating and the mechanisms behind them, it is useful to look towards the eating disorder literature to help understand the conceptualisation and distinction between these terms.

Compulsive Eating

Problems with Conceptualisation and Measurement

Within the eating disorder research literature, the term compulsive eating is also used extremely frequently, being cited in thousands of articles which cover a massive spectrum of research ideas. Although the term is used abundantly, again there appears to be little consensus as to the specific criteria for compulsive eating. As in the media domain, the term is being quantified to a certain extent, but not consistently, as descriptions differ significantly between sources. Two main avenues of thought around the clarification of compulsive eating have emerged from the literature.

Firstly, that compulsive eating can be conceptualised in terms of uncontrolled binge-eating behaviour. Dunn and Ondercin (1981) have defined compulsive eating as relating to ‘periodic
episodes of uncontrolled eating of excessive amounts of food, often to the point of illness, which is generally accompanied by feelings of loss of self-control, self-degradation and consequent guilt’ (p.43). In this respect, compulsive eating is associated with a loss of control over eating and focuses on the actual quantity of food consumed, possibly binge related. Similarly, compulsive eating has been defined as ‘the presence of binges (without purges) during which people eat in response to emotions’ (Lyon, 1998, pp1158). Ghiz and Christer (1995) also concur with the idea that binge-eating is central to compulsive eating and view the newly recognised binge-eating disorder as a modern day conceptualisation of compulsive eating. Dunn and Ondercin (1981) have established a compulsive eating scale (CES) based around these ideas. This is a 32-item self-report questionnaire which aims to establish high or low compulsive eating based on two main areas; specific binge-eating behaviours, but also eating patterns in response to emotional states. Although these authors have used the label ‘compulsive eating’ to describe a certain set of behaviors, it seems as if the concept hasn’t been fully explored or justification provided as to what makes these behaviours particularly compulsive in nature, i.e. why is binge-eating or eating in response to emotion specifically compulsive? As in the media domain, it could be argued that compulsive eating has been adopted in the research literature simply as a ‘descriptor’ term for various dysfunctional eating patterns.

Secondly, the term compulsive eating has been linked to traits more commonly associated with Obsessive Compulsive Disorder (OCD) (see Appendix A for DSM-IV-TR criteria). Salzman (1982) in his book Treatment of the Obsessive Personality describes the compulsive eater as one who is obsessive and who eats in a particularly ritualistic fashion. The second measure used in the assessment of compulsive eating is related to these ideas. The Eating Obsessive-Compulsive Questionnaire (EOC: Mount et al. 1990) is a 20-item self-report measure, developed to assess the level of obsessive-compulsive eating tendencies in individuals. The questionnaire was modeled after the Leyton Obsessional Inventory (Cooper, 1970) and the Lynfield Obsessional/Compulsive Questionnaire (Allen & Tune, 1975). It probes for obsessive food ruminations, rituals around food, anxiety or guilt when confronted with food, amount of resistance needed to eat within set limits and the degree to which food interferes with daily functioning. A third measure which is similar to the EOC is the Yale-Brown-Cornell Eating Disorder Scale (YBC-EDS; Mazure et al. 1994) which assesses obsessions and rituals relating to food, eating, weight and shape issues. As these measures consider eating behaviour in respect to specific OCD type symptomatology, there does appear to be a justifiable reason for applying the term ‘compulsive eaters’ to those who score highly. However the questionnaires were derived purely from OCD assessment scales and so
potentially capture a very specific conceptualisation of compulsive eating, without considering all potential compulsive elements. The validity of this statement will shortly be tested when the current definitions and understandings around compulsivity in general are explored.

Compulsivity and Restrictive Eating Behaviour

Although the notion of compulsive eating was visible in the eating disorder literature, most of the research around compulsivity and disordered eating was not focused on this specific concept, instead the majority of studies undertaken were around the relationship between compulsivity (conceptualised in terms of obsessive compulsive traits) and various disordered eating behaviours, predominantly restrictive eating.

Restrictive eating is most commonly associated with the eating disorder Anorexia Nervosa (AN). The essential features of anorexia are that the individual refuses to maintain a minimally normal body weight, is intensely afraid of gaining weight and exhibits a significant disturbance in the perception of the shape and size of their body. Usually weight loss is accomplished primarily through restrictive eating behaviours, i.e. the strict, controlled reduction of food intake being the main feature (see Appendix A for full DSM-IV-TR criteria). Although severe restrictive eating is generally thought of in relation to this clinical disorder, less severe yet still disordered restrictive eating behaviours are becoming increasingly significantly in the general population (Ogden, 2002; Polivy & Herman, 1987).

The current research literature supports a well established relationship between restrictive eating behaviour and obsessive compulsive tendencies. A review article by Vitousek and Manke (1994) highlighted the variety of studies that demonstrated a link between restricting anorexics as ‘constricted, conforming, and obsessional individuals, who repeatedly scored highly on obsessive-compulsive, perfectionism and rigidity measures’ in comparison to the general population. Studies that have reported this link include Kaye et al. (1992) who found that after excluding core anorexic symptoms (disturbances of body image, feeding and exercise), individuals with anorexia nervosa had significantly elevated scores on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) compared to matched healthy volunteer women. Similarly high levels of obsessive traits in individuals with anorexia were found in a study by Solyom et al. (1982) who looked at 15 female anorexics and compared them with 14 age-matched females with obsessive compulsive traits, on a variety of psychometric tests, psychiatrist's ratings and self-rating scales. Obsessives and anorexics obtained similarly high obsessive symptom and trait scores on the Leyton Obsessional Inventory (LOI). Both groups
were rated by the psychiatrist as similarly obsessive, and there were no significant group differences in self-ratings of obsessive symptoms.

As there are an abundance of studies that replicate this obsessive compulsive /restrictive eating link and it is currently a well established phenomenon within the eating disorders field, considering the validity and reliability of each study would not be particularly valuable. What is important to highlight in respect to this research, is that the studies in this field are not focusing specifically on the definition and clarification of a compulsive relationship to food, but are instead identifying a link between restrictive eaters and obsessive compulsive related tendencies.

**Impulsive Eating**

Problems with Conceptualisation and Measurement

In comparison to compulsive eating, the term impulsive eating was far less prevalent in the eating disorder research literature. When it has been conceptualised, it has tended to be considered in terms of spontaneous decision-making around eating and an inability to resist tempting food items (Sengupta & Zhou, 2007). The notion of impulsive eating being less established in the literature is reflected in the fact that there are currently no specific impulsive eating measures available. The Dutch Eating Behaviour Questionnaire (DEBQ: Van Strien et al. 1986) appeared to be the most commonly used measure to help classify an impulsive eater. Ten of the scale items measure lack of dietary restraint, while the other ten measure the tendency to succumb to tempting food-related stimuli. Higher scores on the overall index are said to reflect greater impulsive eating (Sengupta & Zhou, 2007). Other studies (Lyke & Spinella, 2004; Stice et al. 2001) that have attempted to capture similar data have used The Three Factor Eating Questionnaire (TFEQ; Stunkard & Messick, 1985). This has three subscales that measure cognitive (dietary) restraint, perceived hunger, and emotionally based disinhibition of eating. The potential drawbacks to these scales are similar to those highlighted when considering compulsive eating, in that they appear to tap into very specific areas, mainly disinhibited eating; consequently it could be questioned whether this presents a global representation of impulsive eating. The validity of this statement will be tested when the current definitions and understandings around impulsivity in general are explored.

**Impulsivity and Binge-Eating Behaviour**

As with the compulsivity literature, the majority of the research around impulsivity and disordered eating focused not on establishing an understanding of an impulsive relationship to
food, but looked instead at the relationship between impulsive personality traits and disordered eating, specifically binge-eating behaviour.

Binge-eating is defined as the consumption of an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances (Beglin & Fairburn, 1992). An episode may or may not be planned in advance and is usually characterised by rapid consumption and accompanied by a sense of lack of control. The two main clinical disorders associated with binge-eating are Bulimia Nervosa (see Appendix A for full DSM-TR-IV criteria), whose essential features are binge-eating and inappropriate compensatory methods to prevent weight gain and Binge Eating Disorder (see Appendix A for DSM-IV-TR suggested criteria), not a disorder recognised in its own right but located within the Eating Disorders Not Otherwise Specified (EDNOS) category of the DSM-IV-TR (APA, 2000). Also Anorexia Nervosa, although more commonly associated with severe food restriction, has a binge-eating/purging subtype where the individual regularly engages in binge-eating behaviours. As well as binge-eating behaviours occurring in these clinical groups, the rise of binge-eating in the general population is well documented (Kinzl et al. 1999; Striegel-Moore & Franko, 2003).

There is a significant evidence base which suggests a connection between binge-eating behaviour and impulsive personality traits. One avenue supporting this is the consistent findings of heightened impulsivity (typically measured by impulsive personality scales) in binge-eating women from both clinical and non-clinical settings (Claes et al. 2002; Vervaet et al. 2003). Using a self-report measure of binge-eating symptoms, Penas-Lledo and Waller (2001) found that bulimic symptoms correlated significantly with a range of ‘impulsive’ behaviours, including suicidal thoughts, self-harm, unsafe sex, as well as alcohol and other drug use in a non-clinical sample of women. Correlation research has further supported this relationship in clinical samples, with scores on specific self-report measures of bulimic symptomatology correlating with impulsivity scale scores and with greater numbers of co-occurring impulsive behaviours (Lacey, 1993; Pidcock et al. 2000; Vervaet et al. 2003). Such findings have led to the proposal that some bulimic women may be categorised within a ‘multi-impulsive’ subgroup (Lacey, 1993; Lacey & Evans, 1986). Women in this subgroup of bulimia are characterised by engaging in a range of impulsive behaviours including suicide attempts, self-injury and shoplifting (Fichter et al. 1994).
The Co-morbidity of Impulsivity and Compulsivity

As discussed, much has been written regarding the association between symptoms of obsessive-compulsive disorder and restrictive eating behaviours, and the impulsive traits present in binge-eating individuals. However, the literature is not as simplistic as this bias suggests. Several authors have also recognised impulsive traits in individuals who restrict their eating and OCD symptoms in people who binge-eat. A study by Butler and Montgomery (2005) investigated subjective and behavioural impulsivity in women with anorexia and found that although self-reported impulsiveness was low and self reported control was high, there was actually a significant elevation in behavioural impulsivity scores in anorexic individuals. Various comparison studies performed across eating-disordered subjects also indicated that, although a wide variety of impulsive behaviours were more common among individuals who binge-eat than those who restrict their eating, nonetheless, pathological impulsivity was not negligible among restricting eaters: Herzog et al. (1992) report that 10% of surveyed sufferers of anorexia have a history of suicide attempts; Vandereycken and van Houdenhove (1996) report that 35.3% have a history of stealing; Fava et al. (1995) found that 28% have experienced uncontrollable anger attacks; Thompson et al. (1999) report that 49% have engaged in violence and Yaryura-Tobias et al. (1995) describe a number of cases of self-harming behaviour. Similarly, Askenazy et al. (1998) found high rates of impulsive behaviour (non-premeditated suicide attempts, self-harm, kleptomania and alcohol use) among a mixed sample of anorexics with and without binging behaviour. It appears paradoxically therefore, that highly self-controlled restrictive eaters sometimes display a wide variety of impulsive behaviours.

The overlap between impulsivity and compulsivity is not only found within restrictive eating behaviour, studies of psychiatric co-morbidity in bulimic subjects have also suggested that psychopathology reflecting compulsive behaviour, such as obsessive-compulsive disorder and anxious-fearful personality disorder, is relatively common in bulimia nervosa (Umberto et al. 2001). A study by Von Ranson et al. (1999) supports the suggestion that bulimic individuals have a significant correlation with OCD symptomatology and that OCD symptoms targeted in treatment are improved in patients who have recovered from bulimia.

McElroy et al. (1994) have also considered the ‘blurring’ of impulsivity and compulsivity in relation to eating disorders. They suggest that Anorexia Nervosa of the restrictive type (AN-R), Anorexia Nervosa of the binge-eating/purging type (AN-P) and Bulimia Nervosa might be considered to belong to a spectrum of disorders with varying degrees of obsessive-compulsive
and impulsive traits. This obsessive-compulsive spectrum includes a number of disorders that are drawn from several diagnostic categories that share core obsessive-compulsive features. Although the disorders are clearly distinct from one another, they have similarities in phenomenology, etiology, pathophysiology, patient characteristics and treatment response. It is thought that individuals with these disorders exhibit repetitive behaviours because they are unable to inhibit their behaviour. The disorders vary in the extent to which they are characterised by compulsivity versus impulsivity, with this difference being discussed in terms of a compulsive-impulsive spectrum. Compulsive disorders include OCD, body dysmorphic disorder (BDD), hypochondriasis, and interestingly, anorexia nervosa. Individuals who act compulsively are considered to be avoiding risk and seeking safety; these individuals appear to have an exaggerated sense of harm and are driven to avoid harm or reduce anxiety and distress by performing the compulsive behaviours. Impulsive disorders include, for example, pathological gambling and sexual compulsivity. Those who act impulsively are risk takers, who underestimate the likelihood or severity of possible harm; they are seeking pleasure, arousal, or gratification; their actions may also be aggressive and are often accompanied by feelings of loss of control (Castle & Phillips, 2006). The understanding is that the seemingly opposing drives of compulsivity and impulsivity can exist at the same time in one individual or appear at different times during the course of a disorder.

Developing a Conceptualisation of Compulsive and Impulsive Relationships to Food

Current media perceptions and the scientific literature have indicated that the concepts of impulsivity and compulsivity in respect to an individual’s relationship to food remain relatively undefined. It appears that in order to establish a more comprehensive understanding of a compulsive relationship to food and an impulsive relationship to food, it is necessary to consider the conceptualisation of both impulsivity and compulsivity within a broader sense. Once this is more defined, a fuller understanding of what each might entail in respect to food and eating can be established. There are numerous benefits to obtaining a clearer understanding around a person’s relationship to food, specifically addressing a compulsive and impulsive relationship. Fundamentally, it would provide greater clarity around the use of these terms within the eating disorder field. Also, clinically, this increased insight could be utilised in assessment and formulation around disordered eating behaviour. It would enable a clearer understanding around the specific function that food and eating may provide for an individual, i.e. why they may engage in problematic eating behaviours. It would also provide an increased understanding around the meaning of food for an individual and help to consider
any specific food beliefs they may hold. Lastly, these aspects of the formulation would help in considering appropriate intervention techniques.

**Conceptualising Impulsivity**

The concept of impulsivity pervades contemporary psychology and currently the term is used by researchers and clinicians across a variety of different areas. It has been implicated in fields as varied as offending (Patton *et al.* 1995), personality disorders (Moeller *et al.* 2001), risk-taking (Stanford *et al.* 1996), substance abuse (Lee & Pau, 2002) and aggression (Halperin *et al.* 1995). In the most recent revision of the *DSM-IV-TR* (APA, 2000) in addition to an entire section devoted to impulse-control disorders (a specific group of impulsive behaviours that have been accepted as psychiatric disorders under the *DSM-IV-TR* e.g. kleptomania, pyromania and pathological gambling) impulsivity appears in the diagnostic criteria for psychiatric disorders as diverse as, borderline personality disorder, antisocial personality, attention deficit/hyperactivity disorder (ADHD), mania, dementia, substance use disorders, and the paraphilias.

In essence, all these behaviours fundamentally possess similar 'impulsive' traits, and there are a variety of underlying causes suggested which highlight these particular traits and help to explain the impulsive actions of individuals. Firstly, impulsive behaviour may occur because there is little consideration of consequence (McMurran *et al.* 2002). Prior to acting it is assumed that individuals should utilise an executive cognitive function (forethought) through which the likelihood of expressions of behaviour are influenced by perceived outcomes (reward/punishment). When impulsive behaviour occurs, it’s believed that this forethought process is absent, or at least deficient. In connection to an individual’s lack of forethought, some authors have referred to impulsive behaviour as arising from a general cognitive emphasis on the present and a failure to consider the future (Pattern *et al.* 1995) and a lack of organisation (Kaplan & Sadock, 1998). Connected to this idea, but less common in the literature is the explanation that impulsive behaviour results from an individual ‘making up their mind’ too quickly, possibly as a result of quick reactions to internal or external stimuli (Serfontein, 1994). A decision to act is reached swiftly, and the individual is thought too rigid to be able to deviate from their plan of action, possibly as a result of the failure to consider other alternatives or the assimilation of other information. In contrast to the suggestion that impulsivity results from a failure to plan or consider the consequences of action, it has been proposed that impulsivity is characterised by an inability to delay gratification (Cherek *et al.* 1997; Newman *et al.* 1992). This occurs when an individual must choose between the receipt of an immediate, small reward or a delayed, larger reward, with an impulsive individual...
unable delay the reward, instead opting for the allure of the immediate, here and now condition. Based on this, the idea of impulsivity being strongly associated with pleasure seeking behaviour is prominent in the literature.

Whiteside and Lynam (2001) brought some of these ideas together and proposed impulsivity as a multi-faceted concept, by identifying four separate components associated with impulsive behaviours, which are the basis for the creation of a scale called the UPPS Impulsive Behavior Scale. The four personality traits measured by the UPPS are: (1) Urgency, defined as the tendency to experience strong impulses, frequently under conditions of negative affect' (p.685); (2) Premeditation, defined as 'the tendency to think and reflect on the consequences of an act before engaging in the act' (p.685); (3) Perseverance, defined as 'the ability to remain focused on a task that may be boring or difficult' (p.685); (4) Sensation Seeking, defined as 'a tendency to enjoy and pursue activities that are exciting, and openness for new experiences' (p.685).

Conceptualising Compulsivity

The American Psychiatric Association defines compulsivity as the performance of 'repetitive behaviours' or 'mental acts' with the goal of reducing or preventing anxiety or distress, not to provide pleasure or gratification (APA, 2000). A further trait of compulsivity is that these repetitive behaviours, or acts, tend to be performed according to certain rules or in a very stereotyped fashion. In comparison to impulsivity, the conceptualisation of compulsivity is an area that appears to have received less focus in terms of actually quantifying and defining its characteristic features.

The concept of compulsivity is not one that appears to stand alone. When considering the definition and features of compulsivity the majority of the research inextricably links it with Obsessive Compulsive Disorder (OCD) (similar to the results found in parts of the eating disorder research). The phrase obsessive-compulsive is often used in an offhand manner to describe someone who is meticulous or absorbed in a cause, however this more casual explanation should not be confused with an actual clinical diagnosis. Appendix A presents the DSM-IV-TR criteria for OCD, but to summarise, OCD is generally characterised by both obsessions and compulsions (however a diagnosis does not necessarily require both of these components to be present). Obsessions are defined as recurrent and persistent thoughts, images or impulses that are experienced as intrusive and cause marked anxiety and distress for the individual. A compulsion is defined as a repetitive behaviour or mental act that the person feels driven to perform in response to an obsession. These behaviours or mental acts are aimed
at preventing or reducing distress, but are generally not connected in a realistic way to the obsession. Compulsive behaviours have an ability to produce a positive and pleasurable mood change (Hollander, 1998). They remove us from our true feelings, and can provide a form of escape. However, over the long haul, these compulsions can control the individual, becoming unhealthy and destructive. Although OCD may be the most apparent disorder with compulsive features, compulsivity is also often a prominent symptom in a number of psychiatric disorders e.g. substance-use disorders, personality disorders and schizophrenia (Godlstein & Volkow, 2002). Other behaviours that have been included in this broad focus and have been referred to as 'compulsive' are smoking, overworking, overeating, drinking, shopping, taking drugs, dieting, gambling, and unhealthy relationships.

Although the concept of compulsivity has been defined (APA, 2000), the fact that it is most commonly interlinked with various psychiatric or psychological disorders (most prominently OCD) means that any hypotheses around causal factors are based on individual disorders rather than considering compulsivity as a more personality based trait. The behavioural/learning account of OCD is based on Mowrer’s (1960) ‘two factor’ theory of learning, which supposes that certain environmental stimuli have acquired anxiety producing properties by a means of classical conditioning. The account suggests that compulsions provoked by these feared stimuli are actually escape or avoidance behaviours. The compulsive behaviour reduces or prevents anxiety and is reinforced by a process of instrumental learning. De Silva and Rachman (1981) suggest that this model is essentially one of learned anxiety reduction. Rachman and Hodgson (1980) recognised that the 1960 model extended further than just anxiety and discussed its application to mood disturbances in general, which they labelled as ‘discomfort’. The maintenance of compulsions may therefore be attributable to learned discomfort reduction (De Silva & Rachman, 1981). The cognitive account of OCD focuses more prominently on the actual obsession and believes that compulsive behaviour can best be understood as a response to obsessions. The core assumption of the cognitive theory (Rachman, 1993, 1997, 1998; Salkovskis, 1985) is that the interpretation a person gives to an intrusive thought determines the obsessive qualities of that intrusion. Therefore, individuals who feel extremely responsible for their thoughts will experience greater discomfort when they experience intrusive thinking, leading to an exacerbation of the obsessions.

Tables 1 and 2 present a summary of the main ideas that have emerged from the general literature around the cognitive, behavioural and phenomenological aspects of impulsivity and compulsivity, and initial ideas on how these may be conceptualised in respect to an impulsive and a compulsive relationship to food.
Table 1: The Main Impulsive Characteristics Identified from the General Literature and Initial Ideas on their Relevance to Food and Eating

<table>
<thead>
<tr>
<th>Impulsive Traits Identified in the General Literature</th>
<th>An Impulsive Relationship to Food: Initial Ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>little consideration of consequence</td>
<td>Not thinking about the consequences of (over)eating at the present time.</td>
</tr>
<tr>
<td>cognitive emphasis on the present and a failure to consider the future</td>
<td>Eating as soon as possible when hungry.</td>
</tr>
<tr>
<td>(Pattern et al. 1995)</td>
<td>Eating food for pleasure, trying new types of food.</td>
</tr>
<tr>
<td>a lack of organisation / planning</td>
<td>Eating food based on appealing smell, visual appearance</td>
</tr>
<tr>
<td>(Kaplan &amp; Sadock, 1998)</td>
<td>When hungry, eating very quickly, grabbing the first thing.</td>
</tr>
<tr>
<td>lack of premeditation, no forethought</td>
<td></td>
</tr>
<tr>
<td>(Whiteside and Lynam, 2001)</td>
<td></td>
</tr>
<tr>
<td>making up your mind too quickly</td>
<td></td>
</tr>
<tr>
<td>(Serfontein, 1994)</td>
<td></td>
</tr>
<tr>
<td>an inability to delay gratification</td>
<td></td>
</tr>
<tr>
<td>(Cherek et al. 1997; Newman et al. 1992)</td>
<td></td>
</tr>
<tr>
<td>the driving mechanism is pleasure/sensation seeking</td>
<td></td>
</tr>
<tr>
<td>(Hollander, 1998)</td>
<td></td>
</tr>
<tr>
<td>a rapid reaction to external stimuli</td>
<td></td>
</tr>
<tr>
<td>(Serfontein, 1994)</td>
<td></td>
</tr>
<tr>
<td>a rapid reaction to internal stimuli</td>
<td></td>
</tr>
<tr>
<td>(Serfontein, 1994)</td>
<td></td>
</tr>
</tbody>
</table>
Table 2: The Main Compulsive Characteristics Identified from the General Literature and Initial Ideas on their Relevance to Food and Eating

<table>
<thead>
<tr>
<th>Compulsive Traits Identified in the General Literature</th>
<th>A Compulsive Relationship to Food: Initial Ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>learned discomfort reduction</td>
<td>Eating to get rid of uncomfortable feelings, enhance mood.</td>
</tr>
<tr>
<td>(De Silva &amp; Rachman 1981)</td>
<td>Obsessive thinking around food and eating.</td>
</tr>
<tr>
<td>compulsive behaviours have an ability to produce a positive and pleasurable mood change... provide a form of escape</td>
<td>Particular rules around food and eating to reduce anxiety.</td>
</tr>
<tr>
<td>(Hollander, 1998)</td>
<td>Repetitive, rigid behaviours around food and eating to reduce anxiety.</td>
</tr>
<tr>
<td>intrusive thinking and rumination</td>
<td>Food and eating patterns are planned and rigid.</td>
</tr>
<tr>
<td>(Rachman, 1993, 1997, 199; Salkovskis, 1985)</td>
<td></td>
</tr>
<tr>
<td>repetitive behaviours or mental acts with the goal of reducing or preventing anxiety or distress</td>
<td></td>
</tr>
<tr>
<td>(Swinson et al. 1998)</td>
<td></td>
</tr>
<tr>
<td>repetitive behaviours, or acts, tend to be performed according to certain rules or in a very stereotyped fashion</td>
<td></td>
</tr>
<tr>
<td>(APA, 2000)</td>
<td></td>
</tr>
<tr>
<td>planned and thought through</td>
<td></td>
</tr>
<tr>
<td>(Hollander, 1998)</td>
<td></td>
</tr>
</tbody>
</table>
Overall Summary

Disordered eating behaviours are rapidly expanding in both a clinical capacity and within the general population at large. As the expansion of eating related concerns has grown, a lack of clarity has emerged around how to describe and conceptualise certain eating and food related issues. Specifically the concepts of impulsivity and compulsivity in respect to food and eating are referred to in both clinical and general contexts, however a unified sense of what constitutes a compulsive relationship to food and an impulsive relationship to food remains elusive. This is demonstrated by the use of the terms impulsive and compulsive eating, which are cited frequently in the literature, but are indiscriminately applied to describe various disordered eating behaviours, with no apparent consensus on the definition and meaning of the terms. There are currently few measures that directly address impulsive and compulsive eating, and those that are available, do not appear to sufficiently capture all the facets of impulsivity and compulsivity highlighted within the general literature, nor provide a useful distinction between impulsive and compulsive eating.

The majority of the eating disorder research does not appear to be focused on defining, conceptualising and providing an understanding of an impulsive and compulsive relationship to food; instead the research base is focused on the relationship between impulsive personality traits and disordered eating behaviours and the relationship between obsessive-compulsive symptomatology and disordered eating behaviours. The research in this area currently suggests that; individuals with disordered eating tend to display higher levels of compulsivity and impulsivity in comparison to non-disordered eating individuals; that restrictive eating behaviour is more commonly associated with compulsive individuals and binge-eating behaviour more commonly associated with impulsive individuals; lastly, that although this bias exists, both impulsive and compulsive traits have been shown to be associated with the spectrum of eating disordered behaviours, suggesting that the relationship between impulsivity, compulsivity and disordered eating is complex, and that the concepts of impulsivity and compulsivity are not necessarily mutually exclusive of each other.

It appears that having a clearer understanding of the specific differences between an impulsive and a compulsive relationship to food and subsequent eating behaviour would be beneficial for numerous reasons. It would create greater clarity around the use of these terms in respect to disordered eating. It would enable a more accurate assessment and formulation of those clients with problematic eating behaviours, particularly in respect to gaining an increased
understanding around the specific function and meaning of food for particular individuals. In turn, this increased insight could influence any treatment approach undertaken.

Research Aims

1. To create a clearer conceptualisation around what an impulsive relationship to food and a compulsive relationship to food entails.

2. To explore any differences in disordered eating behaviour between individuals who demonstrate an impulsive relationship to food and individuals who demonstrate a compulsive relationship to food, in both a general and clinical sample.

3. To consider any potential co-morbidity between an impulsive and a compulsive relationship to food, across eating disordered behaviours.

Research Hypotheses

1. Impulsivity and compulsivity in respect to an individual's relationship to food are two distinct, measurable constructs.

2. Individuals with higher levels of eating disordered psychopathology will display a relationship to food that is more significantly impulsive and compulsive in nature, as compared to individuals with lower levels of eating disorder psychopathology.

3. Individuals who engage in higher levels of binge-eating behaviour will display a relationship to food that is more significantly impulsive in nature, as compared to individuals who display higher levels of restrictive eating behaviour.

4. Individuals who engage in higher levels of restrictive eating behaviour will display a relationship to food that is more significantly compulsive in nature, as compared to individuals who engage in higher levels of binge-eating behaviour.
Method

Methods of Recruitment and Participants

For the purposes of the study, participants were recruited from both a community sample and a specialist eating disordered population, as research indicates that food related psychopathology is not simply restricted to clinical groups but is also largely prevalent and growing within the general population (Kinzl et al. 1997; Polivy & Herman, 1987; Striegel-Moore & Franko, 2003).

Non-clinical student sample
Participants comprised of 134 undergraduate and postgraduate students at the University of Surrey. The researcher approached students at the end of lectures, where brief information about the study was given verbally. Questionnaire packs were given out to individuals who expressed an interest in participating, and individuals were asked to return completed forms to the psychology office. A total of 338 questionnaire packs were provided, therefore a response rate of 40% was achieved. Within this sample, there were no participants that indicated on the demographics form that they had either received an eating disorder diagnosis or felt they currently had or were recovering from an eating disorder.

Clinical eating disorder sample
The clinical sample was collected from two separate sources:

1. Outpatient Eating Disorder Service
The clinical sample consisted of 23 individuals recruited from a specialist eating disorders service. Clients that attended an appointment at this service between October 2006 and May 2007 were provided with a questionnaire pack by their clinician. They were asked to return the forms to the service in the stamped addressed envelope provided. A total of 48 questionnaire packs were provided, therefore a response rate of 48% was achieved.

2. The Central Eating Disorders Association (EDA)
The EDA office was contacted and sent questionnaire packs, containing a stamped addressed envelope. Members of the EDA are required to complete a questionnaire when they join the organisation, and they are able to opt in if they would consider taking part in student or medical research. The EDA office distributed the questionnaire packs to individuals on the database who endorsed on the questionnaire that they currently had or were recovering from...
an eating disorder. A total of 50 questionnaire packs were provided, however no questionnaire packs were received back from the EDA.

Measures

All participants completed the same questionnaire pack, which took approximately 40 minutes. The questionnaire pack (see Appendix B) included an invitation form, an information form, two copies of a consent form, a demographics form and the following two measures:

The Eating Disorders Examination-Questionnaire (Fairburn & Beglin, 1994)
The EDE-Q is a self-report version of the Eating Disorders Examination investigator-based interview developed by Fairburn & Cooper (1993). The EDE-Q is a 41 item measure which generates two types of data; firstly it provides frequency data on key behavioural features of eating disorders in terms of number of episodes of the behaviour and in some instances number of days in which the behaviour has occurred. Secondly, it provides subscale scores reflecting the severity of aspects of the psychopathology of eating disorders. The subscales are Restraint, Eating Concern, Shape Concern and Weight Concern. To obtain a particular subscale score, the rating for the relevant items are added together and the sum divided by the total number of items forming the subscale. To obtain an overall or global score, the four subscales are summed and the resulting total divided by the number of subscales. The scale also measures methods of weight control including laxative and diuretic misuse, vomiting and excessive exercise.

The EDE-Q is currently widely used as a screening tool in the clinical assessment of eating disorders and has been demonstrated to have good reliability and validity in both community and clinical populations. It has been shown to have excellent internal consistency and test-retest reliabilities for the subscales (Luce & Crowther, 1999). The EDE-Q co-efficient alpha values ranged from .72 (Eating Concerns) to .83 (Shape Concerns) for the subscales.

The EDE-Q was selected as a measure of eating disorder symptomatology in this study as it provided both information on the global severity of eating disorder symptoms and psychopathology, and provided scores for specific disordered eating behaviours, i.e. binge and restrictive eating behaviours.
The Impulsive / Compulsive Relationships to Food Measure

As described in the introductory section, one of the main aims of the research was to construct a measure that helped to operationalise a clearer distinction between, and understanding of an impulsive and compulsive relationship to food. An in depth review of the literature around the definitions and differences between impulsivity and compulsivity was conducted, to help develop clear, conceptual definitions of the cognitive, behavioural and phenomenological experience of an impulsive and a compulsive relationship to food. An initial questionnaire was constructed based on these definitions and given to two clinicians within an eating disorders service and twenty individuals from a community sample to gain consultation on the structure and content. Small revisions were made based around the readability and clarity of questions. A 25-item inventory was produced, which asks participants to rate statements on a Likert scale from 1 to 5 (does not describe me at all, describes me a little, describes me moderately, describes me a lot, completely describes me). The final version contained 11 items the researcher had hypothesised as relating to an impulsive relationship to food and 14 items hypothesised as relating to a compulsive relationship to food.

Table 3 provides a summary of the definitions and differences identified between an impulsive and compulsive relationship to food, and their relation to questions selected for the final measure.
Table 3: Main Characteristics of an Impulsive and Compulsive Relationship to Food

<table>
<thead>
<tr>
<th>Relationship to Food Characteristics</th>
<th>Impulsive Items in Measure *</th>
<th>Compulsive Items in Measure *</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cognitive</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of forethought around food and eating.</td>
<td>I find myself eating for no reason (25) I eat impulsively with no thought to what I'm doing (14)</td>
<td>I think about food a lot (2) I find myself preoccupied by food (13)</td>
</tr>
<tr>
<td>Lack of planning around food and eating.</td>
<td>I find myself eating on impulse when I hadn’t planned to (7) My decision to eat is frequently spontaneous (21) My eating patterns are chaotic (22)</td>
<td>I spend time dwelling on what I’m going to eat (10) I feel reassured when I plan what I’m going to eat (12) I feel more comfortable if I think carefully before choosing what to eat (17)</td>
</tr>
<tr>
<td>No thought in the present around the consequences of eating behaviour.</td>
<td>When overeating I do not think about the consequences, but later regret my actions (8)</td>
<td>When I'm sad I eat to make me feel better (4) I eat to manage everyday tensions (16) I use food to help avoid facing difficult issues in my life (18)</td>
</tr>
<tr>
<td>Obsessive ruminations around food and eating.</td>
<td>Thought and planning occurring before eating.</td>
<td>Driving mechanism behind eating is avoidance of negative affect (i.e. thoughts of food as calming / reassuring).</td>
</tr>
<tr>
<td>Behavioural</td>
<td>Phenomenological</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>---------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A rapid reaction to external stimuli associated with food and eating.</td>
<td>The driving mechanism behind eating is pleasure/sensation seeking.</td>
<td>I try new types of food because I feel I will gain a lot of pleasure from them (23)</td>
</tr>
<tr>
<td>A rapid action, spur of the moment eating. A rapid reaction to internal stimuli e.g. hunger.</td>
<td>Desire for immediate physical gratification</td>
<td>I jump at the chance to try new types of food (1)</td>
</tr>
<tr>
<td>Repetitive, ritualistic behaviours occur around food and eating to avoid or reduce negative affect.</td>
<td>Subjective feelings of reassurance through food and eating.</td>
<td>I urgently need to eat when I start to feel hungry (11)</td>
</tr>
<tr>
<td>I feel compelled to eat food if it smells or looks really good (9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I feel the urge to eat I often grab the nearest thing there is to eat (15)</td>
<td></td>
<td>I feel uncomfortable when my plans to eat change unexpectedly (3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I feel anxious if I am unable to eat at set times of the day (5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I have set routines around when I eat and feel uncomfortable when they're broken (19)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I like to know when I'm going to eat next (24)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Food provides me with a sense of security (6)</td>
<td>I turn to food for comfort (20)</td>
</tr>
</tbody>
</table>

* Number in brackets refers to the question number in the Impulsive/ Compulsive Relationship to Food Measure
Procedure

Ethical Approval
Ethical approval was initially sought through the COREC process, and was approved by the LREC committee in August 2006. Approval was also obtained from the local NHS Trust Ethics Committee in September 2006 and the School of Human Sciences (SHS) Ethics Committee in October 2006, for use of participants from the Eating Disorders Service and The University of Surrey. Ethical approval letters are presented in Appendix C.

Procedure
All participants were given an invitation form and information sheet, and written consent was obtained. Participants also completed a demographics form. Invitation forms and information sheets emphasised the voluntary and confidential nature of participation. The information sheet also provided details for seeking support if distress arose, encouraging participants to access their usual support networks, as well as providing contact details for the Eating Disorder Association website and helpline. In addition, participants were provided with contact details of the researcher and her supervisor to discuss any queries or concerns. Individuals in the clinical sample were informed that taking part would not affect any treatment they would receive.

Participants were asked to provide a contact E-Mail address, so the researcher could re-contact them for test-retest purposes if necessary. This procedure and the rationale behind it was explained as part of the information provided to participants. The first 50 individuals who returned their questionnaire pack were E-Mailed three weeks later, requesting that they complete the relationship to food measure for a second time. The researcher received 18 repeated questionnaires. Participants were also given the option of receiving feedback about the study, a summary sheet outlining results and implications will be sent to individuals requesting feedback in October 2007. A copy of the project will be provided to each service that participated.

Statistical Analysis

Statistical analysis of the data was completed in two parts. Part one considered hypothesis 1 and focused on identifying the underlying factor structure of the researcher’s questionnaire and establishing its validity and reliability. Differences in the level of eating disorder

Research Dossier: Major Research Project
psychopathology and different types of disordered eating behaviour, in respect to an individual’s relationship to food was then considered in part 2 of the analysis. The data were analysed using the Statistics Package for Social Sciences (SPSS) version 13.0

Data Analysis for Part 1

Hypothesis 1:
To investigate the hypothesis that an impulsive and a compulsive relationship to food are two distinct, measurable constructs, relationships between items on the impulsive/compulsive relationship to food questionnaire were explored by conducting a Principal Components Analysis. A principal components analysis is a dimension-reducing tool, which aims to reduce a large set of variables to a small set, whilst retaining as much information as possible. The analysis produces new composite variables that are linear combinations of the original variables (Tabachnick & Fidell, 1996). In the current analysis, it was expected that some correlation between the factors would be evident, and so to offer a more accurate solution, an oblique rotation (direct oblimin) was used.

With regard to sample size, statisticians disagree over whether researchers conducting principal components analysis should aim for a minimum total sample size, or whether they should calculate the minimum number of participants needed by examining the ratio of participants to variables (Osborne & Costello, 2004). Hatcher (1994) recommended a minimum participant to item ratio of 5:1. However, Comrey and Lee (1992) suggest the adequacy of the sample size can be evaluated in terms of the total number of participants. Using their guidelines, the sample size of 157² participants was between poor (100) to fair (200), which I judged to be adequate for the purposes of the study.

Test-retest reliability for the impulsive/compulsive relationship to food measure was estimated using Pearson’s correlation coefficients.

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² Both the general and clinical population samples were combined in the analysis, as research indicates that unhealthy relationships to food exist across both clinical and general population groups.
Data Analysis for Part 2

Data Screening

Missing values
Closer inspection of the data revealed that there was a small amount of missing data. Missing data analysis showed that the majority of questions not answered were related to demographic details, which did not present any significant difficulties as this information was not included as part of the overall analysis. Other missing data included 20 responses from the Eating Disorders Examination-Questionnaire (EDE-Q). Given that these data were randomly distributed and that the maximum amount missing on each variable was less than 5%, the cases were retained in the study and missing data points excluded from the relevant analysis (Tabachnick & Fidell, 1996).

The data were screened to identify whether variables met assumptions for parametric analysis. Preliminary assumption testing was conducted, to check for normality, outliers and homogeneity of variance. The majority of the data violated normality assumptions and so non-parametric tests were used (results of the full data screening and reasons behind the researcher’s decision are discussed fully within the results section).

Hypothesis 2:
The hypothesis that individuals with higher levels of eating disordered psychopathology will display a relationship to food that is more significantly impulsive and compulsive in nature, as compared to individuals with lower levels of eating disorder psychopathology, was investigated by comparing the clinical and general population samples (once a significant difference in levels of eating disorder psychopathology had been established) on the factors identified from the principal components analysis. This was investigated via a Mann-Whitney U test.

Hypotheses 3 and 4:
The hypotheses that individuals with higher levels of binge-eating behaviour will display a more impulsive relationship to food than restrictive eaters and individuals with higher levels of restrictive eating will display a more compulsive relationship to food than individuals who binge-eat, were jointly investigated. The potential co-morbidity around an impulsive and compulsive relationship to food was also explored in this analysis.
From the combined sample populations\(^3\), four mutually exclusive subgroups were identified based on eating patterns around restrictive eating and binge-eating behaviours. Restrictive eaters were identified via median splits on the restraint subscale of the EDE-Q. Those participants whose scores exceeded the median were classed as 'high restrictors' and those whose scores were equal to or below the median score were classed as 'low restrictors'. Binge-eaters were classified as either 'high or low binge' according to their response to question 8 of the EDE-Q, which asks for a subjective opinion on an individual's binge-eating history in the last four weeks. The four groups identified were:

- **BR** (high on both binge-eating and restrictive eating behaviours)
- **Br** (high on binge-eating and low on restrictive eating behaviour)
- **Rb** (high on restrictive eating and low on binge-eating behaviour)
- **br** (low on both binge-eating and restrictive eating behaviours)

A Kruskall Wallis test was performed to see if there were any significant differences between the four binge-eating/restrictive subgroups in terms of their means on the impulsive/compulsive relationship to food factors. Post-hoc tests were performed to firstly explore where these differences lay and secondly to consider any interaction effects between the binge-eating/restrictive subgroups on the relationship to food factors. By exploring these potential interaction effects, research aim 3, to consider any co-morbidity between impulsive and compulsive relationships to food across eating disordered behaviours, will be investigated.

**Power, Practical Significance and Effect Sizes**

Requirements for statistical power were initially considered as were levels of practical significance. A power of .80 (allowing for the detection of a true effect 80% of the time) and a maximum significance level of .05 has been suggested as appropriate in the behavioural sciences (Cohen, 1988). These conventions were accepted in the current study. As non-parametric tests were undertaken, the researcher followed the advice of Lehmann (1988) who suggests for non-parametric analysis, to compute the sample size required for the parametric equivalent and add 15% to this figure. For the Mann-Whitney \(U\) test in hypothesis 2, for the level of power set to be achieved, a minimum group size for each of the two groups split on the basis of general population and clinical sample was estimated to be 24. This allowed for the detection of a large effect size \((d=.80)\) (Cohen, 1988). For the Kruskall Wallis test for

\(^3\) Justification for combining the samples can be found in the results section.
hypotheses 3 and 4, for the level of power set to be achieved, this meant a minimum group size for each of the 4 groups split on the basis of binge-eating/restrictive eating scores was estimated to be 22. This allowed for the detection of a large effect size ($f=.40$). For the post hoc Mann-Whitney $U$ tests for hypotheses 3 and 4, for the level of power set to be achieved, a minimum group size for each of the four groups was estimated to be 12. This allowed for the detection of a large effect size ($d=.80$). Sufficient numbers of participants were recruited for all the analyses except the clinical sample was missing one participant for the Mann-Whitney $U$ test comparison in hypothesis 2, and the Br group was smaller than required for the Kruskall Wallis test for hypotheses 3 and 4. The results will therefore need to be interpreted with caution.

**Results**

**Characteristics of the Sample**

**The General Population Sample:**
Demographic characteristics for the general population sample of 134 participants are summarised in Table 4. Age range was from 18 to 49 years with a mean age of 31.04 years. 67.2% of the responses were from female participants ($n = 90$) with 32.8% from male participants ($n = 44$). Body mass index (BMI) scores indicated that 0.7% ($n = 1$) of participants were underweight, 70.1% ($n = 94$) were of a normal weight, 23.1% ($n = 31$) were overweight and 6% ($n = 8$) were classified as obese. All but one participant provided self-reported information on eating disorder characteristics, with no participants indicating that they had previously been diagnosed with an eating disorder or viewed themselves as currently having or recovering from one. Information on ethnicity was gathered from all but one of the participants, with 87.3% ($n = 117$) of participants categorising themselves as ‘White British’.

**The Clinical Sample:**
Demographic characteristics for the clinical sample of 23 participants are summarised in Table 4. Age range was from 18 to 55 years with a mean of 29.17 years. 100 % ($n = 23$) of the sample were female. Body mass index (BMI) scores indicated that 39.1% ($n = 9$) were underweight, 34.8% ($n = 8$) were of a normal weight, 4.3% ($n=1$) were overweight and 13% ($n = 3$) were classified as obese, with 2 participants not providing this information. 20 participants provided information on eating disorder characteristics, with 11 describing themselves as having been diagnosed with anorexia nervosa, 4 with bulimia nervosa, 2 with binge-eating disorder, 1 with both anorexia and bulimia nervosa and 2 with both bulimia and
binge-eating disorder. 11 described themselves as currently having an eating disorder and 9 as currently recovering from an eating disorder. The sample was exclusively ‘White British’.

Difference between the Groups

Comparison analyses between the two sample groups were conducted on demographic variables, to ensure that when investigating differences between the two groups for hypothesis 2, demographic variables would not be viewed as confounding. It was predicted that weight, body mass index and eating disorder related characteristics would be significantly different between the two groups, however the remaining demographic variables ideally would be consistent between samples.

The extent of difference could not be formally assessed for the variables; gender, ethnic group, eating disorder characteristics and body mass index as the clinical group had frequencies in categories of less than five, therefore violating the assumptions of the chi-squared analysis. Although significant differences in body mass index and eating disorder related characteristics were predicted, any results gained from comparing the two groups would still need to consider the possibility of the variables gender and ethnicity as confounding.

With regard to age, the means reported in Table 4 suggest the general population sample and clinical samples had a similar average age. To investigate whether age differences were significant, an independent t-test was conducted. There were no significant differences in age across groups, \( t(155) = .38, p>.05 \). With regard to current weight, an independent t-test showed that there was a significant difference in current weight across groups, \( t(153) = 4.15, p<.001 \). These results were replicated with minimum weight, \( t(153) = 6.18, p<.001 \), but maximum weight showed no significant differences between the groups \( t(22.6) = -3.48, p>.05 \). There was also no significant differences found between the groups on height \( t(40.4) = 3.49, p>.05 \).

As only significant differences were found between the weight variables (as predicted), no further analysis was undertaken to establish if these variables were confounding.
<table>
<thead>
<tr>
<th>Category</th>
<th>General Population (n=134)</th>
<th>Clinical Population (n=23)</th>
<th>Comparison Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Male</td>
<td>44</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>90</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Missing values</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Ethnic Group</strong></td>
<td></td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>White</td>
<td>117</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>British</td>
<td>117</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Irish</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mixed</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>White and Asian</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Black or Black British</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>African</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Missing values</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Eating Disorder Characteristics</strong></td>
<td></td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Previous diagnosis of AN</td>
<td>0</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Previous diagnosis of BN</td>
<td>0</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Previous diagnosis of BED</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Missing values</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>A person with an eating disorder</td>
<td>1</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>A person recovering from an eating disorder</td>
<td>0</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Neither</td>
<td>133</td>
<td>99.3</td>
<td></td>
</tr>
<tr>
<td>Missing values</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Body Mass Index (BMI)</strong></td>
<td></td>
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<td>n/a</td>
</tr>
<tr>
<td>Underweight</td>
<td>1</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Normal weight</td>
<td>94</td>
<td>70.1</td>
<td></td>
</tr>
<tr>
<td>Overweight</td>
<td>31</td>
<td>23.1</td>
<td></td>
</tr>
<tr>
<td>Obese</td>
<td>8</td>
<td>6.0</td>
<td></td>
</tr>
<tr>
<td>Missing values</td>
<td>0</td>
<td>8.7</td>
<td></td>
</tr>
<tr>
<td>Age (yrs)</td>
<td>31.04</td>
<td>10.04</td>
<td>.379 155 &gt;.05</td>
</tr>
<tr>
<td>Current Weight (kgs)</td>
<td>69.75</td>
<td>13.2</td>
<td>4.15 153 &lt;.001</td>
</tr>
<tr>
<td>Maximum Weight (kgs)</td>
<td>74.49</td>
<td>13.82</td>
<td>-3.48 22.6 &gt;.05</td>
</tr>
<tr>
<td>Minimum Weight (kgs)</td>
<td>60.89</td>
<td>10.87</td>
<td>6.18 153 &lt;.001</td>
</tr>
<tr>
<td>Height (cms)</td>
<td>170</td>
<td>.10</td>
<td>3.49 40.4 &gt;.05</td>
</tr>
</tbody>
</table>
Hypothesis Testing

Hypothesis 1:

'Impulsivity and compulsivity in respect to an individual's relationship to food are two distinct, measurable constructs'

Part 1 of the study aimed to create a clearer conceptualisation around what an impulsive and a compulsive relationship to food entailed. A principal components analysis with oblimin (oblique) rotation on the impulsive/compulsive relationship to food measure was performed. Kaiser (1960) recommends retaining all factors with eigenvalues greater than 1, which revealed a four factor solution, accounting for 69.5% of the variance. The researcher used Stevens (1992) recommendation that for a sample size of between 100-200 participants, only the factor loadings that exceed the figure of .512 should be interpreted, to achieve a significance level of .01.

Four factors were apparent from the analysis; the factor loadings for items are presented in Table 5.

Factor 1: contained seven items and accounted for 40.3% of the item variance. It appeared to capture items which related specifically to the consumption of food in response to feelings and emotions. It captured aspects of eating in response to negative feelings such as sadness and tension and incorporated the idea of food as offering security and a means of escape from difficult issues. This factor also included items which referred to a sense of urgency around the need to eat, specifically in response to feelings of hunger. This factor was labelled 'Emotional Eating'.

Factor 2: contained nine items and accounted for 17.7% of the item variance. It appeared to capture items which related to obsessional traits around food and eating, specifically being very preoccupied with food and the planning and organising of meals. The purpose of this obsessional behaviour around food was again related to emotions, but specifically the avoidance of difficult emotions, rather than the consumption of food in response to them. This factor was labelled 'Food Obsession'.
Factor 3: accounted for 7% of the item variance and contained two items, both of which
captured a sense interest in, pleasure and enjoyment from food and eating. The researcher
hypothesised that this factor represented a healthy interest in food, as the items encompassed
an enjoyment of eating, and did not correlate strongly with any of the more pathological
factors. This factor was labelled ‘Pleasure from Food’.

Factor 4: contained five items and accounted for 4.5% of the item variance. It appeared to
capture items that related specifically to a lack of planning and forethought around food and
eating. This factor was labeled ‘Spontaneous Eating’.

Table 5 also includes the two items that did not load onto any of the four factors. This is
likely to be as a result of the stringent factor loading criteria (.512) selected in order to achieve
a significance level of .01 (Stevens, 1992). Item 8 achieved a loading of .510 and item 14 a
loading of .412 on the first factor, Emotional Eating. Even though they were not included as
part of this factor, both of these items, to a certain extent, encompassed the ideas around
urgency when eating.

When considering the factors in terms of the initial hypothesis, they do not lend support to a
two factor solution of an impulsive and a compulsive relationship to food. Although factor 2
is composed of hypothesised compulsive items and factors 3 and 4 are composed of
hypothesised impulsive items, factor 1 contained both impulsive and compulsive items. This
will be further considered within the discussion, but it appears that it may be more helpful to
conceptualise potential relationships to food, based on the factor structure described above,
rather than considering specific impulsive and compulsive relationships. These results are
useful in helping to understand why a lack of clarity around the definitions of impulsivity and
compulsivity in respect to food and eating, and their potential co-morbidity, currently exist
within the literature.
Table 5 – Principal Components Analysis Pattern Matrix (direct oblimin rotation) of the Impulsive/Compulsive Relationship to Food Measure

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Hypothesised Group</th>
<th>Item</th>
<th>Factor 1 Emotional Eating</th>
<th>Factor 2 Food Obsession</th>
<th>Factor 3 Pleasure from food</th>
<th>Factor 4 Spontaneous Eating</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Compulsive</td>
<td>I turn to food for comfort</td>
<td>.919</td>
<td>-.006</td>
<td>-.086</td>
<td>.028</td>
</tr>
<tr>
<td>4</td>
<td>Compulsive</td>
<td>I feel more comfortable if I think carefully before what to eat</td>
<td>.812</td>
<td>.062</td>
<td>.026</td>
<td>.127</td>
</tr>
<tr>
<td>6</td>
<td>Compulsive</td>
<td>Food provides me with a sense of security</td>
<td>.770</td>
<td>-.198</td>
<td>.083</td>
<td>.057</td>
</tr>
<tr>
<td>16</td>
<td>Compulsive</td>
<td>I eat to manage everyday tensions</td>
<td>.754</td>
<td>-.116</td>
<td>.036</td>
<td>.034</td>
</tr>
<tr>
<td>15</td>
<td>Impulsive</td>
<td>When I feel the urge to eat, I often grab the nearest thing there is to eat</td>
<td>.522</td>
<td>-.138</td>
<td>-.10</td>
<td>.370</td>
</tr>
<tr>
<td>18</td>
<td>Compulsive</td>
<td>I have set routines around when I eat and feel uncomfortable when they’re broken</td>
<td>.519</td>
<td>-.463</td>
<td>-.245</td>
<td>.059</td>
</tr>
<tr>
<td>8</td>
<td>Impulsive</td>
<td>When I eat I do not think about the consequences, but later regret my actions</td>
<td>.510</td>
<td>-.108</td>
<td>-.095</td>
<td>.290</td>
</tr>
<tr>
<td>3</td>
<td>Compulsive</td>
<td>I find myself preoccupied by food</td>
<td>-.147</td>
<td>-.882</td>
<td>-.023</td>
<td>.055</td>
</tr>
<tr>
<td>10</td>
<td>Impulsive</td>
<td>I spend more time dwelling on what I’m going to eat</td>
<td>-.076</td>
<td>-.829</td>
<td>-.025</td>
<td>.019</td>
</tr>
<tr>
<td>24</td>
<td>Compulsive</td>
<td>I like to know when I’m going to eat next</td>
<td>.093</td>
<td>-.822</td>
<td>-.051</td>
<td>.211</td>
</tr>
<tr>
<td>12</td>
<td>Compulsive</td>
<td>I feel reassured when I plan what I’m going to eat</td>
<td>.106</td>
<td>-.808</td>
<td>.11</td>
<td>.101</td>
</tr>
<tr>
<td>19</td>
<td>Impulsive</td>
<td>I have set routines around when I eat and feel uncomfortable when they’re broken</td>
<td>.013</td>
<td>-.802</td>
<td>.134</td>
<td>.088</td>
</tr>
<tr>
<td>2</td>
<td>Compulsive</td>
<td>I think about food a lot</td>
<td>.095</td>
<td>-.796</td>
<td>-.005</td>
<td>.013</td>
</tr>
<tr>
<td>5</td>
<td>Impulsive</td>
<td>I feel anxious if I am unable to eat at set times of the day</td>
<td>.123</td>
<td>-.779</td>
<td>-.099</td>
<td>.262</td>
</tr>
<tr>
<td>23</td>
<td>Impulsive</td>
<td>I think about food a lot</td>
<td>-.065</td>
<td>-.759</td>
<td>.167</td>
<td>.329</td>
</tr>
<tr>
<td>22</td>
<td>Impulsive</td>
<td>I eat impulsively with no thought to what I’m doing</td>
<td>-.266</td>
<td>-.640</td>
<td>-.008</td>
<td>.268</td>
</tr>
<tr>
<td>14</td>
<td>Impulsive</td>
<td>I eat impulsively with no thought to what I’m doing</td>
<td>-.023</td>
<td>-.097</td>
<td>.892</td>
<td>.007</td>
</tr>
<tr>
<td>9</td>
<td>Impulsive</td>
<td>I feel compelled to eat food if it smells or looks really good</td>
<td>.013</td>
<td>.073</td>
<td>.887</td>
<td>.097</td>
</tr>
<tr>
<td>21</td>
<td>Impulsive</td>
<td>My eating patterns are chaotic</td>
<td>.378</td>
<td>.009</td>
<td>.445</td>
<td>.268</td>
</tr>
<tr>
<td>7</td>
<td>Impulsive</td>
<td>I eat impulsively with no thought to what I’m doing</td>
<td>-.089</td>
<td>-.113</td>
<td>-.020</td>
<td>.868</td>
</tr>
<tr>
<td>25</td>
<td>Impulsive</td>
<td>I eat impulsively with no thought to what I’m doing</td>
<td>.209</td>
<td>.085</td>
<td>.030</td>
<td>.768</td>
</tr>
<tr>
<td>24</td>
<td>Impulsive</td>
<td>I eat impulsively with no thought to what I’m doing</td>
<td>.232</td>
<td>.012</td>
<td>.042</td>
<td>.721</td>
</tr>
<tr>
<td>25</td>
<td>Impulsive</td>
<td>I eat impulsively with no thought to what I’m doing</td>
<td>.382</td>
<td>-.132</td>
<td>.032</td>
<td>.561</td>
</tr>
<tr>
<td>14</td>
<td>Impulsive</td>
<td>I eat impulsively with no thought to what I’m doing</td>
<td>.421</td>
<td>-.017</td>
<td>-.046</td>
<td>.537</td>
</tr>
</tbody>
</table>

* Factor loadings highlighted in bold.
Correlations between the factors

Table 6 shows the correlation matrix produced by the principal components analysis, which enables the correlations between the factors to be explored. The factors Emotional Eating and Food Obsession were found to be moderately negatively correlated. The factors Emotional Eating and Spontaneous Eating were found to be moderately positively correlated. Small positive correlations were also detected between Emotional Eating and Pleasure from Food and Pleasure from Food and Spontaneous Eating.

Table 6: Component Correlation Matrix between the Factors

<table>
<thead>
<tr>
<th>Component</th>
<th>Emotional Eating</th>
<th>Food Obsession</th>
<th>Pleasure from Food</th>
<th>Spontaneous Eating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Eating</td>
<td>1.000</td>
<td>-.423</td>
<td>.190</td>
<td>.469</td>
</tr>
<tr>
<td>Food Obsession</td>
<td>-</td>
<td>1.000</td>
<td>-.028</td>
<td>-.047</td>
</tr>
<tr>
<td>Pleasure from Food</td>
<td>-</td>
<td>-</td>
<td>1.000</td>
<td>.206</td>
</tr>
<tr>
<td>Spontaneous Eating</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Reliability of the factors

Cronbach alphas were used to assess the internal consistency of the four factors, while Pearson correlations were used to investigate their stability over time (test-retest). The results are summarized in Table 7. The Cronbach alphas all exceeded the level of .7 recommended by Nunnally (1978), while the Pearson correlations were highly significant at a .001 level.

Table 7: Internal Consistency and Test-retest Reliability of the Impulsive/Compulsive Relationship to Food Subscales

<table>
<thead>
<tr>
<th>Relationship to Food Subscales</th>
<th>Cronbach Alpha</th>
<th>Pearson r (p&lt;.001)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Eating</td>
<td>.90</td>
<td>.81</td>
</tr>
<tr>
<td>Food Obsession</td>
<td>.94</td>
<td>.80</td>
</tr>
<tr>
<td>Pleasure from Food</td>
<td>.80</td>
<td>.91</td>
</tr>
<tr>
<td>Spontaneous Eating</td>
<td>.88</td>
<td>.87</td>
</tr>
</tbody>
</table>
Discussion

Part 1

Part 1 of the study aimed to bring further clarity to the concepts of impulsivity and compulsivity in respect to an individual’s relationship to food.

The results did not produce the hypothesised impulsive/compulsive relationship to food distinction based on ideas from the general literature around the definition and differences between these two terms. Instead the results portrayed impulsive and compulsive relationships to food as multi-faceted, involving some overlap between the two concepts. Rather than two distinct factors emerging from the analysis, four factors were produced which appeared to highlight different ways in which individuals might relate to and interact with food:

**Emotional Eating:** appears to represent a relationship to food that revolves around consuming food in response to negative or difficult feelings and emotions. This is consistent with the general compulsivity literature which discusses the primary function of compulsions as being the reduction of negative effect (de Silva, 1988). Food may therefore be seen as a means of coping with and dealing with distress and uncomfortable emotion. This factor also contained items which tapped into the need for urgency around the consumption of food, specifically in response to hunger. This is consistent with the general impulsivity literature around rapid, spur of the moment actions (Serfontein, 1994) and the need for immediate gratification (Cherek et al. 1997), but also with Whiteside and Lynam’s (2001) impulsive concept of urgency, which describes a tendency to experience strong impulses, frequently under conditions of negative affect. Here the consumption of food appears to relate not only to more psychological distress but also uncomfortable physical feelings; it could be hypothesised, that individuals who relate to food in this way, find the actual sensation of hunger less tolerable and experience it as significantly more distressing than other individuals.

The focus of this factor is around the need for the inclusion of food in an individual’s life, as food appears to be used almost as a therapeutic tool. Therefore when considering disordered eating populations, this way of relating to food would fit well with Heatherton and Baumeister’s (1991) model of binge-eating behaviour, which describes how binge-eating ensues from attempts to escape from feelings of distress, by focusing on immediate relief and gratification in favour of long-term goals or consequences.
Food Obsession: appears to represent a relationship to food that is governed by rigid planning, organisation and routine around food and eating behaviours. It also includes items that represent a relationship to food that incorporates a significant amount of rumination and thinking about food. This is consistent with the general literature around the compulsive traits of obsessive ruminations (Salkovskis, 1985) and repetitive, ritualistic behaviour (APA, 2000). These characteristics appear to serve the purpose of avoiding difficult or negative emotions, specifically associated with food and eating. This offers a contrast to Emotional Eating in that the relationship an individual has to food appears to be based around ensuring negative affect is avoided rather than using food as a reaction to negative affect, in an attempt to reduce it. There is also less emphasis on the actual consumption of food and more emphasis around the rigidity and ruminative components of a relationship to food.

When considering eating disordered populations, these compulsive type traits have been shown to be more common in restrictive eaters (Kaye et al. 1992; Solyom et al. 1982). As there is less emphasis on the actual consumption of food and more around the issue of gaining control over food and eating behaviour, this also suggests that this way of relating to food may be more common in restrictive eaters, as research has shown that restrictive eating may partly derive from a desire to gain a greater sense of perceived control (Rezek & Leary, 1991).

Pleasure from Food: contains only two items, which appear to stand alone and show little association with the more pathological relationships to food. This factor is based around the concept of enjoying and gaining pleasure from food and eating. Although these were conceptualised in relation to Whiteside and Lynam’s (2001) ideas around impulsivity as relating to sensation-seeking; as they loaded independently and common sense dictates that these items on their own could represent a healthy enjoyment of food rather than something more pathological, they were conceptualised as representing a healthy relationship to food.

Spontaneous Eating: appears to represent a relationship to food that is based around a lack of planning or forethought before consuming food. This is consistent with the general literature around the impulsive traits of lack of organisation (Kaplan & Sadock, 1998) and lack of premeditation (White & Lynam, 2001). This factor showed a moderate correlation with Emotional Eating, which may be explained by the similarities in both factors in terms of ‘spur of the moment’ eating. In Emotional Eating this appears to relate to a sense of urgency around the need to eat in response to physical or emotional cues whereas in Spontaneous Eating there seems to be more of a sense of immediacy in terms of decision making around food and eating.
When considering eating disordered populations, as this factor incorporates traits that are opposite in nature to the rigid and excessively planned relationship to food, and demonstrates a negative correlation to Food Obsession, it is likely that this type of relationship to food will be less prevalent in restrictive eaters than in individuals who binge-eat.

Summary
The results from part 1 of the analysis suggest that impulsive and compulsive relationships to food are not easily separated into two distinct, measurable constructs. This may help to explain why there appears to be little clarity at present around the definitions and differences between impulsivity and compulsivity in respect to food and eating. Instead, what may be more helpful is to conceptualise potential relationships to food in terms of the four factors produced from the analysis. In terms of eating disordered behaviours, based on the research, it seems likely that binge-eaters will have a relationship to food that is more Spontaneous and Emotional in nature and that restrictive eaters will have a relationship to food that is more Obsessive in nature.

Importantly, the four factors offer an insight into specific behaviour patterns and beliefs around the function and meaning of food for individuals, and so offer scope for assessment, formulation and intervention. These ideas will be considered more fully in the general discussion, after the study has considered whether these differences in individual relationships to food exist across eating disordered behaviours.

Results

Part 2

Part 2 of the study aimed to explore any differences in disordered eating behaviour, specifically binge and restrictive eating, between individuals who demonstrate an impulsive relationship to food and individuals who demonstrate a compulsive relationship to food. As considered in the discussion the concepts of an impulsive and a compulsive relationship to food may not be the most useful way of conceptualising how an individual relates to food, consequently, the factors produced from the initial analysis will be used to consider any differences between binge and restrictive eaters.
The data under consideration was therefore based on:

1. The factors established in part 1 of the analysis. The factor Pleasure from Food was not included in the hypotheses, but was investigated in the analysis to explore any significant results.
2. The Eating Disorders Examination-Questionnaire (EDE-Q) total score, which provided a measure of an individual's level of disordered eating psychopathology.
3. The EDE-Q scores on the restraint subscale and specific data on binge-eating episodes were used to identify binge and restrictive eating behaviours (this procedure is highlighted in the method section).

For part 2 of the study, dependent on the analysis undertaken, the two samples were considered either separately or as a whole. The rationale for these decisions is described for each hypothesis.

Descriptive Statistics and Data Screening

Table 8 presents the descriptive statistics for the three groups (general population sample, clinical sample and combined samples) for each variable used in the analysis.

The data were screened to identify whether variables met assumptions for parametric analysis. Preliminary assumption testing was conducted separately for each group, to check for outliers, normality and homogeneity of variance. Outliers were examined using a z-score cut off 3.29 standard deviations as recommended by Field (2005). No significant outliers were identified in any group.

Table 8 reports the results from an analysis of normality performed on the data. Z-scores for skewness were calculated by dividing the overall skewness value by the standard error, and z-scores for kurtosis by dividing the overall kurtosis value by the standard error. Z-scores with a value greater than 3.29 were assumed to be non-normally distributed, based on achieving a significance level of p<.05 (Field, 2005). Within the general population sample, the variables EDE-Q total, Emotional Eating, Food Obsession and Spontaneous Eating all showed a significant positive skew, with Emotional Eating also showing a significant positive kurtosis value. Consequently, these variables were considered to be non-normally distributed. The variable Pleasure from Food did not show an elevated skew or kurtosis z-score and so was considered to be normally distributed. In the clinical sample, the variable Food Obsession
showed both an elevated negative skew and an elevated positive kurtosis value, therefore the
distribution was considered to be non-normally distributed. All other variables did not show
elevated z-scores and so were assumed to be normally distributed. When the two populations
were combined, the results were similar to the general population in that they showed a
significant positive skew on all variables (except Pleasure from Food), with both Emotional
Eating and Food Obsession also showing an elevated positive kurtosis value. These variables
were therefore seen to be non-normally distributed.

Homogeneity of variance (a test used to determine if the variances of two or more samples are
significantly different) of the four factors was considered across the general and clinical
population groups. The variances of the factors Emotional Eating and Spontaneous Eating
were found to be significantly different ($p>.05$), and so did not meet assumptions for
parametric analysis.

A decision was made by the researcher to adopt non-parametric analyses for three main
reasons. Firstly, all of the variables under analysis (except Pleasure from Food) in two of the
population groups (general and combined) were non-normally distributed to a significant
level, which was not rectified by transforming the data. Secondly, two of the three main
factors under analysis violated the homogeneity of variance rule. Lastly, as scores were based
on Likert scales, the factors were derived from an ordinal measure and although parametric
analyses are used with this type of data, there are arguments against it (Howell, 1997; Tukey,
1986).
Table 8: Descriptive Statistics for the Three Population Samples Based on the Variables under Analysis

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std Deviation</th>
<th>Skew</th>
<th>Std Error of skew</th>
<th>Skew Z-Scores</th>
<th>Kurtosis</th>
<th>Std Error of Kurtosis</th>
<th>Kurtosis Z-scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional Eating</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Population (n=134)</td>
<td>12.9</td>
<td>5.42</td>
<td>1.37</td>
<td>.21</td>
<td>6.56*</td>
<td>1.56</td>
<td>.46</td>
<td>3.38*</td>
</tr>
<tr>
<td>Clinical Population (n=23)</td>
<td>17.8</td>
<td>9.81</td>
<td>1.39</td>
<td>.19</td>
<td>7.16*</td>
<td>1.29</td>
<td>.39</td>
<td>3.35*</td>
</tr>
<tr>
<td>Combined Population (n=157)</td>
<td>13.7</td>
<td>6.45</td>
<td>1.49</td>
<td>.24</td>
<td>-1.46</td>
<td>-1.56</td>
<td>.94</td>
<td>-1.56</td>
</tr>
<tr>
<td><strong>Food Obsession</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Population (n=134)</td>
<td>18.1</td>
<td>7.05</td>
<td>1.01</td>
<td>.21</td>
<td>4.83*</td>
<td>.60</td>
<td>.42</td>
<td>1.44</td>
</tr>
<tr>
<td>Clinical Population (n=23)</td>
<td>34.6</td>
<td>8.56</td>
<td>-1.73</td>
<td>.48</td>
<td>-3.60*</td>
<td>3.17</td>
<td>.94</td>
<td>3.39*</td>
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<tr>
<td>Combined Population (n=157)</td>
<td>20.6</td>
<td>9.31</td>
<td>.855</td>
<td>.19</td>
<td>4.41*</td>
<td>1.29</td>
<td>.39</td>
<td>3.35*</td>
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<tr>
<td><strong>Pleasure from Food</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
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<td>2.15</td>
<td>.078</td>
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<td>-1.75</td>
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<td>1.16</td>
<td>-.63</td>
<td>.94</td>
<td>-0.68</td>
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<td>Combined Population (n=157)</td>
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<td>-.85</td>
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<td>-1.75</td>
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<td></td>
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<td>General Population (n=134)</td>
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<td>4.27*</td>
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<td>-1.41</td>
<td>.94</td>
<td>-1.51</td>
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<td>5.06</td>
<td>.921</td>
<td>.19</td>
<td>4.47*</td>
<td>.07</td>
<td>.39</td>
<td>0.19</td>
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<td><strong>EDE-Q Total Score</strong></td>
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<td>General Population (n=134)</td>
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<td>27.3</td>
<td>.831</td>
<td>.21</td>
<td>3.91*</td>
<td>.31</td>
<td>.42</td>
<td>0.75</td>
</tr>
<tr>
<td>Clinical Population (n=23)</td>
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<td>32.5</td>
<td>-724</td>
<td>.48</td>
<td>-1.51</td>
<td>-1.51</td>
<td>.94</td>
<td>-0.65</td>
</tr>
<tr>
<td>Combined Population (n=157)</td>
<td>42.1</td>
<td>33.8</td>
<td>.777</td>
<td>.20</td>
<td>3.98*</td>
<td>-.24</td>
<td>.39</td>
<td>-0.62</td>
</tr>
</tbody>
</table>

* Non-normally distributed data
Hypotheses Testing

Hypothesis 2:

'Individuals with higher levels of eating disordered psychopathology will display a relationship to food that is higher in emotional eating, spontaneous eating and food obsession, as compared to individuals with lower levels of eating disorder psychopathology.'

Before investigating the hypothesis, the difference between the general population sample and clinical sample, in terms of their level of eating disorder psychopathology was considered. Only the female participants from the general population were selected for two reasons. Firstly, when the difference between the clinical and general population samples were assessed in the initial stages of the research, gender was shown to be a possible confounding variable. Also, a Mann-Whitney $U$ test demonstrated that men and women in the general population differed significantly on two of the four relationship to food factors; Emotional Eating $U = 1082.0, p<.001, r = .37$ and Food Obsession $U = 1444.5, p<.05, r = .22$. As the clinical sample comprised of 100% female participants, it was thought a more accurate comparison could be made by matching the gender variable. Descriptive statistics showed that as expected, the mean score on the EDE-Q total score was higher in the clinical sample ($M = 87.0$) than in the general population sample ($M = 34.2$). A Mann-Whitney $U$ test was performed, which showed this difference to be highly significant $U = 312.5, p<0.001, r = -.48$, indicating that individuals in the clinical sample had significantly higher levels of eating disorder psychopathology.

Due to the significant difference between the clinical and general population samples on eating disorder psychopathology, it was appropriate to compare the two groups to consider whether any differences in means were found between them, based on the factors derived from the original principal components analysis. Again, only the female participants from the general population sample were selected. Table 9 shows the mean rankings for each factor across both population groups and the Mann-Whitney $U$ test statistics.
Table 9: Mann-Whitney U Rankings for Each Factor Across Both Population Samples

<table>
<thead>
<tr>
<th>Factor</th>
<th>Sample</th>
<th>N</th>
<th>Mean Rank</th>
<th>U</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Eating</td>
<td>General Population</td>
<td>90</td>
<td>55.49</td>
<td>899.5</td>
<td>.168</td>
</tr>
<tr>
<td></td>
<td>Clinical Population</td>
<td>23</td>
<td>62.89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Obsession</td>
<td>General Population</td>
<td>90</td>
<td>47.96</td>
<td>221.0</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td>Clinical Population</td>
<td>23</td>
<td>92.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleasure from Food</td>
<td>General Population</td>
<td>90</td>
<td>60.99</td>
<td>676.0</td>
<td>.005</td>
</tr>
<tr>
<td></td>
<td>Clinical Population</td>
<td>23</td>
<td>41.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spontaneous Eating</td>
<td>General Population</td>
<td>90</td>
<td>56.82</td>
<td>1018.5</td>
<td>.454</td>
</tr>
<tr>
<td></td>
<td>Clinical Population</td>
<td>23</td>
<td>57.72</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Three of the factors; Emotional Eating, Food Obsession and Spontaneous Eating were shown to be higher in the clinical than general population sample but only Food Obsession showed a statistically significant difference $U = 221.0, p < .001, r = -.51$. The factor Pleasure from Food was shown to be significantly higher in the general than clinical population sample $U = 676.0, p = .005, r = -.24$. This does not fully support the hypothesis that all three factors would be more significant in the eating disordered sample, as only Food Obsession was shown to be significantly different between the two groups. The results for the factor Pleasure from Food support the idea that this may be indicative of a more healthy relationship to food as it is was seen to be more common in the general population sample, a group that demonstrated a less significant level of eating disorder symptomatology.

Hypothesis 3:

'Individuals who engage in higher levels of binge-eating behaviour will display a relationship to food that is higher in emotional eating and spontaneous eating, in comparison to individuals who display higher levels of restrictive eating.'

Hypothesis 4:

'Individuals who engage in higher levels of restrictive eating behaviour will display a relationship to food that is higher in food obsession, in comparison to individuals who display higher levels of binge-eating behaviour.'
From both the general population sample and clinical sample groups, four mutually exclusive subgroups were identified based on eating patterns around restrictive and binge-eating behaviours (see method section for detailed explanation):

- **BR** = (high binge-eating, high restrictive eating)
- **Br** = (high binge-eating, low restrictive eating)
- **Rb** = (high restrictive eating, low binge-eating)
- **br** = (low binge-eating, low restrictive eating)

Table 10 provides demographic information on the number of participants in each of the four binge-eating/restrictive subgroups, based on sample groups:

**Table 10: Demographic Data on the Binge-eating / Restrictive Subgroups**

<table>
<thead>
<tr>
<th></th>
<th>General Population</th>
<th>Clinical Population</th>
<th>Combined Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (% )</td>
<td>N (% )</td>
<td>N (% )</td>
</tr>
<tr>
<td><strong>BR</strong></td>
<td>33 (24.6)</td>
<td>10 (43.5)</td>
<td>43 (27.4)</td>
</tr>
<tr>
<td><strong>Br</strong></td>
<td>11 (8.2)</td>
<td>2 (8.7)</td>
<td>13 (8.3)</td>
</tr>
<tr>
<td><strong>Rb</strong></td>
<td>23 (17.2)</td>
<td>7 (30.4)</td>
<td>30 (19.1)</td>
</tr>
<tr>
<td><strong>br</strong></td>
<td>65 (48.5)</td>
<td>5 (21.7)</td>
<td>70 (44.9)</td>
</tr>
</tbody>
</table>

As the sample sizes in the clinical population for the binge-eating/restrictive subgroups were small when considering the two sample populations separately, the researcher opted to combine the samples, so as to provide appropriate participant numbers for analysis. The implications this will have for the interpretation of the results will be considered.

Based on the hypotheses, it was predicted that scores on the factors Emotional Eating and Spontaneous Eating would be higher in the Br (high binge/low restrict) subgroup, than the Rb (high restrict/low binge) subgroup, and the factor Food Obsession would be higher in the Rb (high restrict/low binge) subgroup than the Br (high binge/low restrict) subgroup. The BR (high binge/high restrict) subgroup was generated to further consider the third aim of the research, around the potential co-morbidity of impulsive and compulsive relationships in disordered eating behaviours. The factor Pleasure from Food was also included in the analysis to see if the data produced any significant patterns.
A Kruskall Wallis test was performed to see if there were any significant differences between the four binge-eating/restrictive subgroups in terms of their means on the relationship to food factors. The results (see Table 11) indicated that there were significant differences between the binge/restrict subgroups on Emotional Eating \((H(3) = 42.40, p < .001)\), Food Obsession \((H(3) = 40.15, p < .001)\) and Spontaneous Eating \((H(3) = 40.40, p < .001)\). There were no significant differences between the subgroups on the factor Pleasure from Food \((H(3) = 1.18, p = .76)\). However, as the Br subgroup did not meet the power requirements in terms of sample size, these results should be interpreted with caution.

Table 11: Mean Ranks and Test Statistics for the Kruskall Wallis Test

<table>
<thead>
<tr>
<th>Factor</th>
<th>Binge/Restrict Subgroups</th>
<th>N</th>
<th>Mean Rank</th>
<th>H</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Eating</td>
<td>BR</td>
<td>30</td>
<td>117.12</td>
<td>42.40</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td>Br</td>
<td>13</td>
<td>112.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rb</td>
<td>43</td>
<td>71.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>br</td>
<td>70</td>
<td>60.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Obsession</td>
<td>BR</td>
<td>30</td>
<td>113.03</td>
<td>40.15</td>
<td>&lt;.001</td>
</tr>
<tr>
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<td>Br</td>
<td>13</td>
<td>98.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rb</td>
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<td>86.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>br</td>
<td>70</td>
<td>55.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleasure From Food</td>
<td>BR</td>
<td>30</td>
<td>82.40</td>
<td>1.18</td>
<td>.76</td>
</tr>
<tr>
<td></td>
<td>Br</td>
<td>13</td>
<td>80.31</td>
<td></td>
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</tr>
<tr>
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<td>Rb</td>
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<td>82.20</td>
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<tr>
<td></td>
<td>br</td>
<td>70</td>
<td>74.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spontaneous Eating</td>
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<td>30</td>
<td>116.43</td>
<td>40.40</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td>Br</td>
<td>13</td>
<td>105.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rb</td>
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<td>77.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>br</td>
<td>70</td>
<td>58.11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Post hoc* tests were performed to firstly explore where these differences lay and secondly to consider the interaction effects between the binge/restrict subgroups and the factors, i.e. what effect did being both a high binge-eater and high restrictor have on an individual's relationship to food in comparison to being either a binger or a restrictor? Mann-Whitney \(U\) tests were employed to follow up the initial analysis and as multiple comparison tests were employed, a *Bonferroni* correction was used to ensure that Type I errors didn’t exceed .05 (Field, 2005). As six comparison tests were employed, instead of using a critical value of .05, a more stringent critical value of .0083 was adopted. See Table 12 for results of the analysis.
Table 12: Mean Ranks and Test Statistics for the Mann-Whitney U Comparison Tests

<table>
<thead>
<tr>
<th>Factor</th>
<th>Binge/Restrict Comparison Groups</th>
<th>N</th>
<th>Mean Ranks</th>
<th>U</th>
<th>p</th>
</tr>
</thead>
<tbody>
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<td>23.18</td>
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<tr>
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<td>Br</td>
<td>13</td>
<td>19.27</td>
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</tr>
<tr>
<td></td>
<td>BR</td>
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<td>50.07</td>
<td>253.0</td>
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<td>Rb</td>
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<tr>
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<tr>
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<td>br</td>
<td>70</td>
<td>37.99</td>
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<td></td>
<td>Rb</td>
<td>43</td>
<td>66.37</td>
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Emotional Eating
Results showed that for the factor Emotional Eating, the mean for subgroup BR was not significantly different from Br ($U = 159.5, p = .36, r = -.14$) but was significantly higher than the subgroups Rb ($U = 253.0, p < .001, r = -.52$) and br ($U = 319.0, p < .001, r = -.55$). The mean for subgroup Br was significantly higher than the subgroups Rb ($U = 118.5, p = .001, r = -.42$) and br ($U = 134.5, p < .001, r = -.44$). The mean for subgroup Rb was greater than subgroup br, but did not reach statistical significance due to the stringent critical value set by the Bonferroni correction ($U = 127.0, p = .05, r = -.32$).

In summary: $BR = Br > Rb > * br$

* although not statistically significant, a substantial difference in means was apparent.

The results suggest that the factor Emotional Eating is more significant in binge-eating than restrictive eating behaviours, therefore lending support to the original hypothesis. The results also suggest that there is no significant difference on the factor Emotional Eating between individuals who display both binge and restrictive eating behaviours and those individuals who display only binge-eating behaviour. Emotional Eating has also been shown to be higher in eating disordered individuals than controls, however the difference between individuals who restrict (without binging) and controls was not shown to be statistically significant.

Food Obsession
Results showed that for the factor Food Obsession, the mean for subgroup BR was not significantly different from the subgroups Br ($U = 143.0, p = .17, r = -.21$) or Rb ($U = 425.0, p = .01, r = -.29$) (as a result of the stringent nature of the Bonferroni correction) but was significantly higher than the subgroup br ($U = 286.0, p < .001, r = -.56$). The mean for subgroup Br was not significantly different from the subgroup Rb ($U = 244.0, p = .25, r = -.09$) but was significantly higher than the subgroup br ($U = 174.5, p < .001, r = -.37$). The mean for subgroup Rb was also significantly higher than br ($U = 918.0, p < .001, r = -.32$).

In summary: $BR = Br = Rb > br$

The results suggest that for the factor Food Obsession there were no significant differences between binge-eaters and restrictive eaters, suggesting therefore that Food Obsession is prominent in both binge and restrictive eating behaviours. This does not lend confirmation to the original hypothesis, in that Food Obsession has not been shown to be a more significant
feature in restrictive vs. binge-eating behaviour. The results also suggest that there is no significance difference on the factor Food Obsession between individuals who display both binge and restrictive eating behaviours and those individuals who display binge-eating or restrictive behaviours. However, there was a substantial difference in means (although not significant) between individuals who engaged in both binge and restrictive eating behaviours and those who engaged in purely restrictive eating behaviours, suggesting that Food Obsession may be more relevant for restrictors who also demonstrate binge-eating behaviour. Food Obsession has also been shown to be more significant in eating disordered individuals than controls.

Pleasure from Food
Results showed that for the factor Pleasure from Food, the mean for subgroup BR was not significantly different from the subgroups Br ($U = 192.0, p = .94, r = -.01$), Rb ($U = 635.5, p = .92, r = -.01$) or br ($U = 945.5, p = .92, r = -.01$). The mean for subgroup Br was not significantly different than the subgroups Rb ($U = 276.5, p = .96, r = -.12$) or br ($U = 425.5, p = .71, r = -.04$). The mean for subgroup Rb was not significantly different from the subgroup br ($U = 1339.5, p = .14, r = -.09$).

In summary: $BR = Br = Rb = br$

The results suggest that for the factor Pleasure from Food there are no significant differences between participants with disordered eating and non-disordered eating psychopathology, and no significant differences between binge-eaters and restrictors.

Spontaneous Eating
Results showed that for the factor Spontaneous Eating, the mean for subgroup BR was not significantly different from the subgroup Br ($U = 154.0, p = .28, r = -.17$) but was significantly higher than the subgroups Rb ($U = 292.0, p<.001, r = -.46$) and br ($U = 360.0, p<.001, r = -.56$). The mean for subgroup Br was greater than subgroup Rb, but was not statistically significant due to the stringent critical value set by the Bonferroni correction ($U = 168.0, p = .01, r = -.29$). The mean for subgroup Br was significantly higher than the subgroup br ($U = 174.5, p<.001, r = -.39$). The mean for subgroup Rb was greater than subgroup br, but was not statistically significant due to the stringent critical value set by the Bonferroni correction ($U = 1102.0 p = .01, r = -.23$).

In summary: $BR = Br >* Rb >* br$
* although not statistically significant, a substantial difference in means was apparent.

The results suggest that the factor Spontaneous Eating is similar to the factor Emotional Eating in that it is more apparent in individuals who binge-eat than who restrict their eating, which lends support to the original hypothesis. Spontaneous Eating has also been shown to be more apparent in eating disordered individuals than controls, however the difference between restrictive eaters and controls has not been shown to be statistically significant. The results also suggest that there is no significance difference on the factor Spontaneous Eating between individuals who display both binge and restrictive eating behaviours and those individuals who only display only binge-eating behaviour.

Discussion

Findings

A relationship to food that involves obsessive ruminations, significant planning and thought and repetitive, ritualistic behaviours around food and eating in order to avoid negative affect was shown to be significantly higher in the clinical eating disordered sample than in the general population sample. This was predicted as these compulsive type traits have been shown to be significantly higher in eating disordered individuals (Vitousek & Manke, 1994). However, no differences were found between the two sample groups in terms of relationships to food that are characterised by spontaneous, unplanned eating and eating in response to negative or difficult emotions. This was not predicted since both impulsive as well as compulsive traits have been demonstrated to be more significant in eating disordered individuals (Claes et al. 2002; Vervaet et al. 2003). There are various explanations which help formulate why this discrepancy might exist.

Firstly, it is useful to consider why the general population sample might be showing greater than expected levels of both Emotional and Spontaneous Eating. Within the general population, we know that disordered eating behaviour is on the increase (Ogden, 2002), but also that obesity levels are increasing to a significant extent (cited on http://www.esrcsocitytoday.ac.uk). This would suggest that within the general population at large, relationships to food that are increasingly characterised by unrestrained eating
behaviours may be more common. The factors Emotional and Spontaneous Eating are more significantly associated with a less controlled attitude to the consumption of food, in comparison to the factor Food Obsession, whose primary feature appears to be rigid control around food and eating. The demographic information on the general population sample shows that although 70.1% of participants were in the normal weight range, 23.1% were classified as overweight with 6% classified as obese. Another explanation may be that although participants in the general population sample stated that they had never received an eating disorder diagnosis, when the eating disordered subgroups were created for analyses, 17.2% of participants reported significant restrictive eating behaviour, 8.2% reported significant binge-eating behaviour and 24.6% reported significant levels of both binge and restrictive eating. Therefore although the clinical sample had significantly higher levels of eating disorder psychopathology, the general population was a sample that still contained quite high levels of eating disorder symptomatology; which may help to explain why the expected differences between the groups were not as significant as predicted.

Secondly, it is relevant to consider the attributes of the clinical sample that may have impacted upon the results. Again, when the eating disorder subgroups were formed there was shown to be more clinical participants who exclusively restricted their eating (30.4%) than who exclusively binged (8.7%). It is likely that this bias in terms of restrictive eaters would have reduced overall Emotion and Spontaneous Eating scores, therefore the limitations in terms of the size of the clinical sample may have made the comparison unrepresentative in terms of having a sufficient number of clinical participants who displayed binge-eating behaviours. Also of relevance are the five (21.7%) clinical sample participants who emerged as having no significant levels of either binge or restrictive eating psychopathology. As they were included as part of clinical sample in the initial analysis, this may have provided an unrepresentative 'eating disordered' group.

A relationship to food that is based on enjoying and gaining pleasure from food and eating was shown to be significantly higher in the general population, when the two samples were compared. This lends support to the researcher's idea that this represents a healthier relationship to food as it was more common in the general population sample. Although disordered eating patterns were prevalent in the general population sample, healthier relationships to food would also have been evident in numerous participants.
It is important that these results are interpreted with caution however, as the power analysis for the hypothesis, noted that the clinical sample needed a total of 24 participants for the detection of a large effect size, the sample in this study included 23.

In respect to exploring the differences in impulsive and compulsive relationships to food across disordered eating behaviours, the current study found that there was a significant difference between binge and restrictive eaters in terms of experiencing a relationship to food that is based around Emotional Eating. Although not statistically significant - due to the stringent nature of the Bonferroni correction - this difference was also observed in terms of a relationship to food that is based around Spontaneous Eating. As the significance level obtained was still high, clinically it is useful to acknowledge and formulate around this difference. Therefore a lack of planning and forethought around food and eating and the consumption of food as a means of reducing negative affect were seen to be more apparent in binge-eating than restrictive eating behaviours. This lends support to the revised hypothesis, based on the resultant four factor solution from the initial analysis, and is consistent with Heatherton and Baumeister's (1991) model of binge-eating behaviour, which conceptualises binge-eating as resulting from attempts to escape from feelings of distress, by focusing on immediate relief and gratification in favour of long-term goals or consequences. There were no significant differences between individuals who displayed only binge-eating behaviour and individuals who displayed both restrictive and binge-eating behaviours on the two factors. This suggests that having a restrictive component to your binge-eating behaviour does not significantly lessen a relationship to food that revolves around spontaneous eating and eating in response to emotion.

The factors Spontaneous Eating and Emotional Eating were also shown to be more apparent in the disordered eating subgroups (BR, Br, Rb) than the non-eating disordered subgroup (br), although this only reached significance for people who have a binge eating component to their behaviour, again due to the stringent nature of the Bonferroni correction. As these differences were not so apparent when considering the second hypothesis, the results based on the eating disordered subgroups (BR, BR, Rb) could be argued as offering a more accurate representation as regards the comparison between eating disordered individuals and non-eating disordered individuals, based on the issues already discussed around the composition of the two sample groups.

There were no significant differences found between binge and restrictive eaters in terms of a relationship to food that is characterised by obsessive ruminations, planning and thought and
repetitive, ritualistic behaviours around food and eating in order to avoid negative affect. This suggests that these traits are important in both binge and restrictive eating behaviours. Although a substantial difference (though not statistically significant) was seen between individuals who displayed both binge and restrictive eating behaviours and individuals who displayed only restrictive eating behaviours, suggesting that Food Obsession may be more relevant for individuals who have a binging component to their restrictive eating. This did not lend confirmation to the hypothesis which stated that restrictive eaters would display a more significant obsessive type relationship to food, and therefore did not lend support to studies which advocate control and rigidity around food and eating as being specific to restrictive eating behaviours (Rezek & Leary, 1991).

We are already familiar with why these obsessive traits might be apparent in individuals who restrict their eating; the inherently obsessional nature of anorexia nervosa is seemingly obvious, with obsessional calorie counting, body preoccupations and incessant ruminations about food being primary features of the disorder; what is less clear is why might these characteristics also be readily apparent in individuals who binge-eat? It is well recognised that individuals who binge-eat, tend to alternate between behavioural over-control (i.e. displaying restrictive eating type symptomatology) and disinhibition (i.e. binge-eating) (Kaye, 1999). Therefore these obsessive type traits would also be seen in binge-eaters who engage in this cycle, as they do experience the same obsessionality, but temper this with binge-eating episodes. Based on these ideas, we would expect to see Food Obsession to be significantly higher in individuals who display restrictive behaviours in any capacity (i.e. pure restrictors but also individuals who alternate between binge and restrictive behaviours). This pattern was found, but Food Obsession was also seen to be significant in individuals who displayed only binge-eating behaviour, suggesting that a significant restrictive component is not essential, and therefore supporting the studies that have recognized the link between OCD type symptomatology and binge-eating (e.g. Von Ranson et al. 1999) as well as OCD symptomatology and restrictive eating (e.g. Vitousek and Manke, 1994).

As the factor Food Obsession was higher in the disordered eating subgroups (BR, Br, Rb) than the non-eating disordered subgroup (br), this added confirmation to results found in hypothesis 2, which showed a relationship governed by food obsession to be more significant in eating disordered individuals, than non-eating disordered individuals.

The current study found that there were no significant differences between binge and restrictive eaters in terms of experiencing a relationship to food that is based around gaining
pleasure and enjoyment from food. There were also no significant differences between binge and restrictive eaters and the non-eating disordered subgroup on the factor Pleasure from Food. As no significant differences were found, this lends support to the researcher’s decision that a relationship to food that consists of gaining pleasure and enjoyment through food, is not pathological in nature. However, the results did not replicate those found for hypothesis 2, in that the factor Pleasure from Food was not seen to be significantly higher in a non-eating disordered subgroup (br). This suggests that gaining pleasure from food is something that is apparent in both eating disordered and non-eating disordered populations.

Lastly, the third aim of the research was to explore any potential co-morbidity between impulsive and compulsive relationships to food across disordered eating behaviours. Current research in the general literature suggests that compulsive and impulsive traits can exist at the same time in one individual, or appear at different times during the course of a disorder (McElroy et al. 1994). The eating disorder research presents a mixed picture around this issue, with no real consensus as to potential co-morbidity issues. In respect to this, the principal components analysis highlighted how impulsive and compulsive relationships to food were not easily separated into two distinct, measurable constructs. Instead, the results portrayed these relationships to food as multi-faceted, involving overlaps between the two concepts. The resulting factor structure highlights why this lack of clarity might currently exist in the eating disorder literature, but also adds weight to the evidence of the co-morbidity of impulsive and compulsive traits in disordered eating behaviour (although they are conceptualised in terms of four factors as opposed to two). The current study showed that all three pathological relationships to food, which were derived from impulsive and compulsive traits, existed in individuals who displayed binge and restrictive eating behaviours to a greater extent that those individuals who displayed no eating disorder psychopathology.

**General Discussion**

The findings of this major research project suggest that the concepts of impulsivity and compulsivity in respect to an individual’s relationship to food cannot be conceptualised in terms of two distinct processes. Instead the results portrayed impulsive and compulsive relationships to food as multi-faceted, involving some overlap between the two concepts. Rather than two distinct factors emerging from the analysis, four factors were produced which highlighted different ways of relating to and interacting with food: Spontaneous Eating, whereby there is a lack of planning and forethought connected to food and eating; Emotional
Eating, whereby food is consumed in response to negative feelings or emotions and incorporates a sense of urgency; Food Obsession, which is governed by rigid planning, organisation and routine around food and eating behaviours, and obsessional ruminations about food; lastly, Pleasure from Food which is not conceptualised as pathological, but representing a healthy enjoyment of food and eating.

Individuals who restrict their eating have been shown to have a relationship to food that is characterised by all three of the more pathological relationship to food factors, compared with individuals who display no significant restrictive or binging behaviour. However, they display a relationship to food that is governed more significantly by obsessional and rigid rituals around food and eating, rather than lack of planning and eating in response to emotion, suggesting that a relationship to food that is based around Food Obsession is more relevant in restrictive eaters.

Individuals who binge-eat have also been shown to have a relationship to food that is characterised by all three of the more pathological relationship to food factors, compared with individuals who display no significant restrictive or binging behaviour. In comparison to restrictive eaters, they have demonstrated higher levels of lack of planning and forethought around food and eating in response to emotion, and have shown a similar level of obsessional and rigid rituals around food. This suggests that Food Obsession, Emotional and Spontaneous Eating are all relevant to binge-eating behaviour.

Clinical Implications
As this study has demonstrated that individuals with disordered eating psychopathology possess relationships to food that involve both the reduction and attempted avoidance of negative affect, it highlights the importance of targeting these underlying processes in treatment if clinicians are to achieve long-term gains.

Teaching individuals with binge and restrictive eating behaviours how to modify their experiences may therefore be useful elements of treatment. Traditional cognitive behavioural approaches point to the importance of modifying uncomfortable physical states and dysfunctional thoughts associated with distress or anticipated distress (Hayes et al. 1996) by using techniques including relaxation exercises such as diaphragmatic breathing or progressive muscle relaxation to enable the client to cope better with physical tension (Lindsey & Powell, 1995) and helping the client identify and challenge negative thoughts to change the resulting emotion (Beck et al. 1979). However, some of these techniques may
actually be counterproductive in terms of the underlying processes identified in this study. Hayes et al. 1996, emphasise that cognitive and behavioural techniques have tended to target change rather than the acceptance of private experiences. They propose that ‘instead of encouraging clients to use more clever ways to fight and win this war with their own thoughts, feelings and bodily sensations, the ubiquity of problems associated with affect avoidance suggests that it might be safer to help clients step out of this war altogether’ p1163. The suggestion being that learning to stay with and tolerate emotions may be more effective (Hayes et al. 1996). Mindfulness therapy encapsulates this idea, teaching the individual to observe their emotions, and focus on the present and sensory aspects of the situation, rather than acting on them, blocking them or becoming overwhelmed. Through these experiences the individual learns to tolerate their private experiences, which enhances the likelihood of their following actions being thoughtful rather than impulsive or compulsive in nature (Young et al. 2003).

The growing recognition of the role of affect avoidance and reduction in a range of disorders has led to the development of a number of therapies to help address these issues, including Dialectical Behaviour Therapy (DBT: Linehan, 1993) and Acceptance and Commitment Therapy (ACT; Hayes, 1987). The recent adaptation of DBT for eating disorders has been applied in both group and individual formats (Telch, et al. 2000, 2001). DBT is designed to improve participants’ ability to manage negative affect adaptively and includes training in: mindfulness, emotion regulation, and distress tolerance. Several clinical trials have provided strong support for the efficacy of DBT as adapted for the treatment of bulimia nervosa (BN) and binge-eating disorder (BED). Telch et al. (2000) describe an uncontrolled trial with 11 women diagnosed with BED who participated in the group form of this treatment. Results showed that 9 of the 11 women had completely stopped binge-eating by the end of treatment and no longer met criteria for BED. Substantial reductions in the urge to eat when experiencing negative affect were observed, as were increases in self-reported ability to regulate negative moods. Safer et al. (2001) report an additional randomised control trial in which DBT was applied to bulimia nervosa. At post-treatment, binge-eating had stopped for 29% of treatment participants, and had been greatly reduced for an additional 36% of participants. Substantial decreases in the tendency to eat when experiencing negative affect also were observed. Further research is needed however to consider the potential role of DBT in the treatment of anorexia nervosa.

Acceptance and commitment therapy (ACT) has also been evaluated in terms of the treatment of anorexia nervosa. This therapy promotes the ability to observe cognitions nonjudgmentally.
and with acceptance, rather than engaging in anorexic behaviours in reaction to such thoughts. The useful application of ACT to anorexia nervosa has been described in a recent clinical case study (Heffner et al. 2002) and a recently published self-help manual (Heffner & Eifert, 2004).

In relation to these considered therapies, Fairburn et al. (2003) have also recommended the use of techniques to address 'mood intolerance' in their transdiagnostic cognitive behavioural treatment. Also included in this approach to treatment (across the range of eating disordered behaviour) is the establishment of a regular eating pattern so as to avoid either chaotic, unplanned eating patterns (as seen in the Spontaneous Eating relationship to food) or the rigid, over-controlled emphasis on food and eating (as seen in Food Obsession relationships). The results from this study emphasise the importance of the incorporation of this aspect of the approach into intervention sessions, and support the importance of further research into these alternative treatment approaches.

Limitations
There were a number of limitations in the current study.

The literature review process:
It is important to acknowledge that the initial literature review was conducted in a manner that did not reflect an entirely systematic approach. Reflecting back on the process, there are several reasons why it cannot be stated that the researcher engaged in a stringent systematic review. Davies and Crombie (1998) state that in order to conclude that a systematic process has been undertaken, various steps need to have been addressed which focus around; the direction of the review, the type and scope of the review, the manner in which information is sought and how thoroughly the information has been appraised. They propose that fundamentally the review needs to be based on a defined idea or concept, and on reflection, the initial searches for the current research were not based around a particularly strong central idea and so lacked a sense of structure and direction at times. This was also seen in the manner in which the information was sought, as systematic search strategies were not rigidly adhered to. Although recommended search engines were utilised, these were limited to Medline, PsycINFO and YourJournals@Ovid, which may not have provided the researcher with a sufficiently wide enough search base. The researcher also placed a significant emphasis on the use of less systematic means of searching the literature base, specifically the use of Google Scholar. This was due to the researcher's familiarity with the approach, rather than a consideration of the most appropriate manner in which to conduct a review. As this type of
approach does not lend itself to a structured means of searching the literature, it is feasible that
the scope and content of the searches and therefore the content of the resultant measure was
not exhaustive and may represent a biased view of the literature. Also on reflection, a critical
stance in respect to the literature was not always fully adopted; the emphasis instead being
focused on the search for communalities. So although increased clarity was gained around the
frequency of certain findings, a critical stance towards the validity and reliability of studies
was not always consistently considered.

The development of the hypotheses:
Leading on from the review of the literature, the research aims and hypotheses were
established. On reflection, the aims suggested that the research needed a more exploratory
approach to the work than was adopted. The essence of the literature review captured a
confused picture emerging around the conceptualisation of impulsive and compulsive
behaviour in respect to food and eating, and therefore the initial aim focused around the need
to gain increased understanding in this area. Although this lack of clarity had been emphasised
by the researcher, the related hypothesis was still very prescriptive in nature. It stipulated that
impulsive and compulsive relationships to food could be conceptualised separately, based on
descriptions from the general literature around the differentiation between impulsive and
compulsive behaviours. If this had been the only element to the research, then the results
could have been discussed in terms of a rejection of the original hypothesis, therefore the fact
that it was less exploratory and more prescriptive would have had less of an impact. However
the research also aimed to consider these ‘two’ factors in respect to disordered eating
behaviours, and subsequent hypotheses were formed based on the assumption that two factors
would emerge from the analysis. When this was not realised hypotheses 2, 3 and 4 needed to
be adapted to co-incide with these results. This created a lack of continuity within the
research, with the ‘newly formed’ hypotheses having a tenuous link to the initial literature
review. Also, hypotheses 3 and 4 were based on biases within the literature (impulsive
behaviour as being more associated with binge-eating and compulsive behaviour with
restriction). The rigidity of the hypotheses reflected this bias, but again (as with the first
hypothesis) dismissed the researcher’s findings on the lack of consensus in this area. On
reflection, having hypotheses that emphasised the exploratory nature of the research and
perhaps considered potential differences in relationships to food rather than stipulating exactly
what those relationships might be, would have allowed greater flexibility and clarity within
the study.
Measurement scales:
There were limitations arising from the reliance on self-report measures in this study. Researchers in the eating disorders field have highlighted limitations with self-report questionnaires developed to assess eating disorders and associated symptomatology. Although the EDE-Q has been shown to be a useful measure of eating disorder psychopathology, showing a high level of agreement with the Eating Disorders Examination (EDE; Fairburn & Beglin, 1994) interview in the assessment of attitudinal features of eating disorders, the validity of assessing for actual binge-eating behaviours is less well established (Black & Wilson, 1996; Fairburn & Beglin, 1994). These findings are more likely to reflect the inherent difficulty of assessing binge-eating behaviours by self-report rather than a particular failing of the EDE-Q (Meadows et al. 1986), as the EDE-Q has been shown to discriminate well between cases and non-cases of objective bulimic episodes, diagnosed according to the EDE, and appears to be superior to that of other self-report measures (Mond et al. 2004).

There were also a number of limitations in terms of the development of the researcher designed measure. As discussed, the lack of a systematic approach to the literature review may mean that the measure produced is not representative of all the potential information available and may in turn offer a biased representation of the concepts being conceptualised by the researcher. There were also drawbacks to the way content validity was established for the measure. Although expert sampling was undertaken - whereby professionals within the field of eating disorders were asked to review and suggest changes to the measure – this strategy produced a limited amount of feedback, and consequently no significant changes to the original measure were adopted. On reflection, it may have been more appropriate to seek out this advice prior to the actual establishment of the measure and gain consultation from more than one individual (the research supervisor) around how the impulsive and compulsive descriptors could be considered in terms of eating related behaviour. This would have offered significantly more scope for professionals to consult and advise around the construction of the measure. This level of response was also replicated in the feedback gained from the general population, whereby only minor changes to the readability of the measure were suggested. Also the researcher did not seek to consult with service users around their perceptions and ideas on establishing items for the measure, which would have provided a significantly greater level of face validity (Minogue et al. 2005).

Sample:
Firstly, there were limitations based on the size of the clinical sample recruited. The sample did not meet power criteria when testing hypothesis 2 (23 participants were recruited as
opposed to the 24 required for the establishment a large effect size), therefore any results gained needed to be interpreted with caution. Also power criteria were not met in terms of sample size for the initial analysis stage of hypotheses 2 and 3. The Kruskall Wallis analysis required a minimum group size for each of the four binge/restrict subgroups of 22 (the Br group in this study achieved a sample size of 13).

Relating to sample size, there were also issues around the specificity of the study in terms of participants. By joining the population samples in part 2 of the analysis, the eating disordered subgroups were not comprised purely from an eating disordered sample. Although the groups were established by scores on the Eating Disorder Examination-Questionnaire (EDE-Q), by placing eating disordered individuals and non-eating disordered individuals together, valuable information about binge and restricting behaviours across the two populations may have been lost. Based on this, questions around how applicable the findings are to a clinical context could be raised.

As the majority of participants were of White British origin, findings cannot be generalised to other ethnic populations. The clinical sample was also 100% female and therefore the findings are not representative of males with eating disordered psychopathology.

**Analyses:**

In part 1 of the study, a principal components analysis was used to analyse relationships between scale items. There are problems with this technique. It is a subjective process that is vulnerable to researcher bias. For example, interpretation of the resulting factor structure is the responsibility of the researcher, and it is notable the factors derived from such analysis represent combinations of variables that correlate with each other, and do not necessarily reflect underlying processes (Tabachnick & Fiddell, 1996).

As the data did not meet assumptions for parametric analysis, non-parametric techniques were adopted. There are disadvantages to using these techniques however, as methods may lack power as compared with more traditional approaches, and this is a particular concern if the sample size is small.

**Directions for Future Research**

Future research could help address the limitations in the current study. The research could be replicated with a sufficiently large clinical population sample size to enable the establishment of the binge/restrict subgroups for both a clinical and a general population. The study could be
repeated in populations with greater ethnic diversity and a more representative sample in terms of gender could be sought.

Although this study has produced a scale that has identified four distinct ways of relating to food and shown their relevance in disordered eating populations, more research is needed to continue to establish and test the relationship to food pathways identified, in order to ensure that subjectivity of the researcher was not a significant bias. The scale could also be used as a starting point to consider further, the processes behind why an individual may relate to food in a particular way. For example, there is current research which considers the process of escaping from negative affect (as demonstrated in Emotional Eating) by engaging in particular 'impulsive' behaviours. These theories focus around the concept of 'impairment' and negative affect and include the idea that high arousal impairs individuals' ability to think about the consequences of their actions and their capacity for self-control (Leith & Baumeister, 1996). 'Impairment' may also arise from the idea that under certain conditions, emotional distress makes people cease to care about pursuing positive long-term goals, or rebel against socially appropriate forms of behaviour (Tice et al. 2001). These theories would be interesting to explore in terms of an individual’s relationship to food and eating.

Another avenue for further research might be to consider whether eating disordered individuals actually experience an increased level of negative affect (as issues around negative affect were central to both Emotional Eating and Food Obsession). A questionnaire could be developed to determine whether eating disordered individuals actually experience more negative affect or find private experiences generally more adversive. Fairburn et al. (2003, pp.517) state that at the present 'it is not clear whether these patients actually experience unusually intense mood states or whether they are especially sensitive to them….often both appears to be the case'.

It would also be interesting to consider the background behind why certain relationships to food get established and what maintains these processes? Qualitative investigations of the accounts of individuals with disordered eating about their engagement in various relationship to food related behaviours would provide valuable first hand information about their experiences and help shed light upon the potential processes involved.

Lastly, the current study divided participants into binge or restrictive eating behaviours. It would be valuable in terms of clinical application to consider relationships to food across the specific eating disordered behaviours; anorexia nervosa (both restricting and binge-
eating/purging type); bulimia nervosa (purging and non-purging type) and Eating Disorders not Otherwise Specified (EDNOS), particularly binge-eating disorder. It would also be useful to consider whether there are any relationship to food patterns among obese individuals, as this is an area that can be excluded in eating disorder research.

Conclusions

In conclusion, the research has helped to identify that attempting to conceptualise impulsive and compulsive relationships to food in terms of two distinct processes is not helpful, and goes some way to explaining why there is a lack of consistency around the definitions and understanding of these two concepts within the eating disorder literature. Instead, considering them as multi-faceted, overlapping concepts enables a more accurate understanding of how individuals may relate to food. The research has produced four factors which demonstrate different ways of interacting and relating to food, based on impulsive and compulsive traits.

In respect to disordered eating behaviours, the research supports the literature which suggests individuals who engage significantly in either binge or restrictive eating would display higher levels of impulsive and compulsive traits in comparison to non-eating disordered individuals (Claes et al. 2002; Vervaet et al. 2003), with the research establishing this link in respect to food and eating. The research also demonstrated that binge-eaters, in comparison to restrictive eaters have been shown to demonstrate higher levels of Emotional Eating (eating urgently in response to negative affect) and Spontaneous Eating (unplanned, chaotic eating) and similar levels of Food Obsession (obsessional behaviour around food to avoid negative affect). This suggests that both Emotional and Spontaneous Eating and Food Obsession are relevant to binge-eating and restrictive eating behaviours, but that Food Obsession is more pertinent for restrictive eaters. Lastly, the research has contributed to the evidence base that conceptualises impulsivity and compulsivity as non-mutually exclusive (McElroy et al. 1994), but has identified this dynamic in respect to food and eating.

Further research is required to substantiate the initial findings around the relationships to food that have been identified, clarify the nature of the underlying processes and develop treatments to help individuals with disordered relationships to food tolerate and manage distress, and engage in regular, healthy eating patterns.
References


Cooper, J.E. (1970). The Leyton Obsessional Inventory. *Psychological Medicine, 1*, 48-64.


Appendix A

DSM-IV-TR Criteria (APA, 2000):

i. Anorexia Nervosa
ii. Bulimia Nervosa
iii. Binge Eating Disorder (suggested research criteria)
iv. Obsessive Compulsive Disorder
Diagnostic Criteria for Anorexia Nervosa

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

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

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

D In postmenarcheal females, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles.

Types

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour (i.e. self induced vomiting or the misuse of laxatives, diuretics or enemas).

Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e. self induced vomiting or the misuse of laxatives, diuretics or enemas).
ii.

**Diagnostic Criteria for Bulimia Nervosa**

A Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:

1. eating, in a discreet period of time, (e.g., within any two hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

2. a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control, what or how much one is eating).

B Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications; fasting, or excessive exercise.

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

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

E The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

**Types**

**Purging Type:** during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.

**Nonpurging Type:** during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.
Recall criteria for Binge Eating Disorder*

Recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviours characteristic of Bulimia Nervosa

Research criteria:
Recurrent binge eating (at least twice per week for 6 months)
Marked distress with at least three of the following:

- Eating very rapidly
- Eating until uncomfortably full
- Eating when not hungry
- Eating alone
- Feeling guilty or disgusted after a binge

No recurrent compensatory purging, exercising, or fasting and an absence of anorexia nervosa.

*Binge Eating Disorder currently only has a suggested diagnosis in the DSM-TR-IV, rather than a definitive classification like anorexia or bulimia nervosa.
iv.

Diagnostic Criteria for Obsessive Compulsive Disorder

To be diagnosed with Obsessive-Compulsive Disorder, one must have either obsessions or compulsions alone, or obsessions and compulsions, according to the *DSM-IV-TR* diagnostic criteria. The Quick Reference to the diagnostic criteria from *DSM-IV-TR* (2000) describes these obsessions and compulsions:

**Obsessions are defined by:**

1. Recurrent and persistent thoughts, impulses, or images that are experienced at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress.
2. The thoughts, impulses, or images are not simply excessive worries about real-life problems.
3. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.
4. The person recognises that the obsessional thoughts, impulses, or images are a product of his or her own mind, and are not based in reality.
5. The tendency to haggle over small details that the viewer is unable to fix or change in any way. This begins a mental pre-occupation with that which is inevitable.

**Compulsions are defined by:**

1. Repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
2. The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralise or prevent or are clearly excessive.

In addition to these criteria, at some point during the course of the disorder, the sufferer must realise that his/her obsessions or compulsions are unreasonable or excessive. Moreover, the obsessions or compulsions must be time-consuming (taking up more than one hour per day), cause distress, or cause impairment in social, occupational, or school functioning. OCD often causes feelings similar to those of depression.
Appendix B

Questionnaire Pack Items:

i. Invitation Form
ii. Information Forms: General Population
   Eating Disorders Service Sample
   Eating Disorders Association Sample
iii. Consent Form
iv. Demographics Form
v. Eating Disorder Examination-Questionnaire (EDE-Q)
vi. Impulsive and Compulsive Relationships to Food Questionnaire
Major Research Project

INVITATION TO PARTICIPATE IN A CLINICAL RESEARCH STUDY

Study Title:
Relationship to Food: The role of impulsivity and compulsivity in disordered eating

Researcher:
Eleanor Evans (Trainee Clinical Psychologist)

Supervisor:
Dr Martin Carroll

I am conducting research into the role of impulsivity and compulsivity in respect to a person’s relationship with food, for my PSYCHD Practitioner Doctorate in Clinical Psychology at the University of Surrey.

This investigation aims to contribute to the existing knowledge and understanding of the experience of disordered eating and hopes to gain greater clarity around the role of both impulsivity and compulsivity.

I would be grateful if you would be willing to participate by completing the enclosed questionnaire pack, which will take approximately 40 minutes.

I have enclosed an information sheet, which explains the study in more detail, and two consent forms for you to sign if you are happy to take part (one for your own records and one to return to myself).

If you are interested in taking part in the study please return the questionnaire pack and consent form in the addressed envelope provided, if possible within three weeks of receiving it.

If you have any further questions about the study, do not hesitate to contact me on [redacted] or alternatively E-Mail me at [redacted]

Thank you for taking the time to read this
ii. Information Forms

General Population Sample

Participant Information Sheet

Principal Investigator: Eleanor Evans (Trainee Clinical Psychologist)
Research conducted as part of a PsychD Clinical Psychology Training Programme at the University of Surrey.

Supervisor: Dr Martin Carroll

Study Title: Relationship to Food: The Role of Impulsivity and Compulsivity in Disordered Eating.

Invitation Paragraph
You are being invited to take part in a research study that is being undertaken as part of an educational qualification for a Doctorate in Clinical Psychology at the University of Surrey. Before you decide to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about your participation if you wish. Please ask if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?
This study is interested in obtaining greater understanding and clarity around the roles of impulsivity and compulsivity in terms of people's relationship with food. Specifically it aims to contribute to the existing knowledge and understanding of disordered eating and look to explore potential differences between eating disordered populations in terms of their differences in impulsive/compulsive relationships to food. This study will run from September 2006 to September 2007.

Why have I been chosen?
You have been selected to participate in the first phase of the study which seeks to gain more clarity around the specific differences between impulsivity and compulsivity in respect to an individual’s relationship to food. 250 participants from the general population are required for this initial analysis. To ensure reliability a small number of original participants will be asked to repeat the questionnaires for a second time (this will be done roughly one week apart).

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign two consent forms (one for your own records and one to return to the researcher). You are still free to withdraw at any time and without giving a reason.

What would taking part entail?
Alongside this information, you will have received a research pack containing two identical consent forms, a demographics sheet and two questionnaires. The questionnaires will invite you to reflect on your experiences around eating and food. If you choose to take part, you will be asked to complete all of these sources of information and return them to myself in the addressed envelope provided, via the University postal system.

As explained, for the purposes of ensuring reliability you may be asked to complete the questionnaires on a second occasion. Your research pack will contain a unique identification number and you will be asked to supply a point of contact on the demographics form, where you may be sent a second identical questionnaire pack for completion. There is however no obligation to partake in this.
What are the advantages and disadvantages of taking part?

There are no anticipated disadvantages of taking part in the study. However you are free to choose not to participate or withdraw at any point.

It is hoped the study will contribute to a greater understanding of the reasons behind disordered eating. If you would be interested in the results of the study we would be happy to share these at a later date (please indicate this on the consent form).

What if I become distressed?

There is a minimal possibility that some people may become distressed when thinking through their experiences. If this is the case, then we would encourage you to discuss your concerns with your usual support networks. If you feel that you need further information, advice and support about issues surrounding eating disorders, then the Eating Disorder Association (EDA) has a useful website which supplies contact details for further support and advice. The link is www.edauk.com and their helpline telephone number is 0845 6341414.

If you have further concerns as a result of the study, then I have provided contact details for myself as the Chief Investigator and my research supervisor.

Will my taking part in this study be kept confidential?

All information collected during the study will be kept strictly confidential, and nobody other than the Chief Investigator will have access to identifiable information. Following completing the research, the demographic, consent forms and questionnaires will be stored at the University of Surrey for at least 5 years following which, they will be destroyed. All data will be kept in accordance with the Data Protection Act 1998.

Who has reviewed the study?

This study has been submitted to the .......... Research Ethics Committee and given a favorable ethical opinion.

Contact Details

If you would like any further details or have any concerns please contact:

Eleanor Evans
Trainee Clinical Psychologist
PsyChD Clinical Psychology
Psychology Department
University of Surrey
Guildford
GU2 7XH
E-Mail: [REDACTED]
Telephone: [REDACTED]

This research is being supervised by:

Dr Martin Carroll
Clinical Psychologist
E-Mail: [REDACTED]
Telephone: [REDACTED]

Thank you for taking the time to read this information sheet, you are welcome to keep it. If you decide to participate in the study, please fill in all other documentation (keeping one consent form for your own records) and return it within 3 weeks in the envelope provided.
Participant Information Sheet

Principal Investigator: Eleanor Evans (Trainee Clinical Psychologist)
Research conducted as part of a PsychD Clinical Psychology Training Programme at the University of Surrey.

Supervisor: Dr Martin Carroll

Study Title:
Relationship to Food: The Role of Impulsivity and Compulsivity in Disordered Eating.

Invitation Paragraph
You are being invited to take part in a research study that is being undertaken as part of an educational qualification for a Doctorate in Clinical Psychology at the University of Surrey. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about your participation if you wish. Please ask if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?
This study is interested in obtaining greater understanding and clarity around the roles of impulsivity and compulsivity in terms of people’s relationship with food. Specifically it aims to contribute to the existing knowledge and understanding of disordered eating and look to explore potential differences between eating disordered populations in terms of their differences in impulsive/compulsive relationships to food. This study will run from September 2006 to September 2007.

Why have I been chosen?
You have been selected to participate in the second phase of the research. I am working in conjunction with .................. NHS Trust and individuals who have been in recent contact with the eating disorder service will have been asked by their clinician for their participation.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign two consent forms (one for your own records and one to return to the researcher). You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What would taking part entail?
Alongside this information, you will have received a research pack containing two identical consent forms, a demographics sheet and two questionnaires. The questionnaires will invite you to reflect on your experiences around eating and food. If you choose to take part, you will be asked to complete all of these sources of information and return them directly to myself at the ..........Eating Disorder Service in the addressed envelope provided.

What are the advantages and disadvantages of taking part?
There are no anticipated disadvantages of taking part in the study. However you are free to choose not to participate or withdraw at any point. It is hoped the study will contribute to a greater understanding of the reasons behind disordered eating. If you would be interested in the results of the study we would be happy to share these at a later date (please indicate this on the consent form).
What if I become distressed?
There is a minimal possibility that some people may become distressed when thinking through their experiences. If this is the case, then we would encourage you to discuss your concerns with your usual support networks. If you have further concerns as a result of the study, then I have provided contact details for myself as the Chief Investigator and my research supervisor.

Will my taking part in this study be kept confidential?
All information collected during the study will be kept strictly confidential, and nobody other than the Chief Investigator will have access to identifiable information. Following completing the research, the demographic, consent forms and questionnaires will be stored at the University of Surrey for at least 5 years following which, they will be destroyed. All data will be kept in accordance with the Data Protection Act 1998.

Who has reviewed the study?
This study has been submitted to the .......... Research Ethics Committee and given a favorable ethical opinion.

Contact Details
If you would like any further details or have any concerns please contact:

Eleanor Evans
Trainee Clinical Psychologist
PsychD Clinical Psychology
Psychology Department
University of Surrey
Guildford
GU2 7XH
E-Mail: [REDACTED]
Telephone: [REDACTED]

This research is being supervised by:

Dr Martin Carroll
Clinical Psychologist

E-Mail: [REDACTED]
Telephone: [REDACTED]

Thank you for taking the time to read this information sheet, you are welcome to keep it. If you decide to participate in the study, please fill in all other documentation (keeping one consent form for your own records) and return it within 3 weeks in the envelope provided.
Eating Disorders Association Sample

Participant Information Sheet

Principal Investigator: Eleanor Evans (Trainee Clinical Psychologist)
Research conducted as part of a PsychD Clinical Psychology Training Programme at the University of Surrey.

Supervisor: Dr Martin Carroll

Study Title:
Relationship to Food: The Role of Impulsivity and Compulsivity in Disordered Eating.

Invitation Paragraph
You are being invited to take part in a research study that is being undertaken as part of an educational qualification for a Doctorate in Clinical Psychology at the University of Surrey. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about your participation if you wish. Please ask if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?
This study is interested in obtaining greater understanding and clarity around the roles of impulsivity and compulsivity in terms of people’s relationship with food. Specifically it aims to contribute to the existing knowledge and understanding of disordered eating and look to explore potential differences between eating disordered populations in terms of their differences in impulsive/compulsive relationships to food. This study will run from September 2006 to September 2007.

Why have I been chosen?
You have been selected to participate in the second phase of the research, where I am recruiting individuals from the Eating Disorders Association research pool who have specific experience of an eating disorder.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign two consent forms (one for your own records and one to return to the researcher). You are still free to withdraw at any time and without giving a reason.

What would taking part entail?
Alongside this information, you will have received a research pack containing two identical consent forms, a demographics sheet and two questionnaires. The questionnaires will invite you to reflect on your experiences around eating and food. If you choose to take part, you will be asked to complete all of these sources of information and return them to myself in the stamped addressed envelope provided.

What are the advantages and disadvantages of taking part?
There are no anticipated disadvantages of taking part in the study. However you are free to choose not to participate or withdraw at any point.

It is hoped the study will contribute to a greater understanding of the reasons behind disordered eating. If you would be interested in the results of the study we would be happy to share these at a later date (please indicate this on the consent form).
What if I become distressed?
There is a minimal possibility that some people may become distressed when thinking through their experiences. If this is the case, then we would encourage you to discuss your concerns with your usual support networks. If you have further concerns as a result of the study, then I have provided contact details for myself as the Chief Investigator and my research supervisor.

Will my taking part in this study be kept confidential?
All information collected during the study will be kept strictly confidential, and nobody other than the Chief Investigator will have access to identifiable information. Following completing the research, the demographic, consent forms and questionnaires will be stored at the University of Surrey for at least 5 years following which, they will be destroyed. All data will be kept in accordance with the Data Protection Act 1998.

Who has reviewed the study?
This study has been submitted to the ........ Research Ethics Committee and given a favorable ethical opinion.

Contact Details
If you would like any further details or have any concerns please contact:

Eleanor Evans
Trainee Clinical Psychologist
PsyChD Clinical Psychology
Psychology Department
University of Surrey
Guildford
GU2 7XH
E-Mail: 
Telephone: 

This research is being supervised by:

Dr Martin Carroll
Clinical Psychologist
E-Mail: 
Telephone: 

Thank you for taking the time to read this information sheet, you are welcome to keep it. If you decide to participate in the study, please fill in all other documentation (keeping one consent form for your own records) and return it within 3 weeks in the envelope provided.
iii. Consent Form

CONSENT FORM

Title of project: Relationship to Food: The Role of Impulsivity and Compulsivity in Disordered Eating

Investigator: Eleanor Evans (Trainee Clinical Psychologist) Supervisor (Dr Martin Carroll)

Please initial box to indicate agreement

1. I confirm that I have read and understand the information sheet dated 07.07.2006 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

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

3. I agree to take part in the study

4. I would like to receive an electronic copy of the summary of the findings, my E-Mail address is:

[Name and E-Mail address]

Name of Participant Date Signature

Name of Person taking consent Date Signature
(if different from Investigator)

Investigator Date Signature

When completed: 1 for participant; 1 for Chief investigator
iv. Demographics Form

Demographics Form

The following information is collected so that people who read the final report can know more about the people who have taken part. However, none of this information will be used to identify you as this research is completely confidential.

1. How old are you? .............................

2. Are you male or female? (circle appropriate response)

3. How much do you weigh? ..................

4. What has been your maximum weight? ..................

5. What has been your minimum weight during your adult life? .........

6. What is your height? .........................

7. How would you describe your ethnicity?

Choose one section from (a) to (e) and tick the appropriate response to indicate your cultural background.

(a) White
   British
   Irish
   Any other White background, please write in below.
   ...................................................

(b) Mixed
   White and Black Caribbean
   White and Black African
   White and Asian
   Any other mixed background, please write in below.
   ...................................................

(c) Asian or Asian British
   Indian
   Pakistani
   Bangladeshi
   Any other Asian background, please write in below.
   ...................................................
(d) Black or Black British
Caribbean
African
Any other Black background, please write in below.

(e) Chinese or other ethnic group
Chinese
Any other, please write in below.

8. Have you ever received a diagnosis of anorexia nervosa? Yes / No
9. Have you ever received a diagnosis of bulimia nervosa? Yes / No
10. Have you ever received a diagnosis of binge eating disorder? Yes / No
11. Would you describe yourself as (please tick appropriate statement)
A person with an eating disorder
A person recovering from an eating disorder
Neither

As explained in the participant information sheet, it may be necessary to contact you to complete a second questionnaire. It would be helpful if you could supply either a postal or E-Mail address that the Chief Investigator may use to contact you:

Thank you for taking the time to provide this useful information.
**v. Eating Disorders Examination Scale**

**EDE-Q**

The following questions are concerned with the PAST FOUR WEEKS (28 days). Please read each question carefully and circle the appropriate number on the right. Please answer all the questions.

<table>
<thead>
<tr>
<th>On how many days out of the past 28 days...</th>
<th>No days</th>
<th>1-5 days</th>
<th>6-12 days</th>
<th>13-15 days</th>
<th>16-22 days</th>
<th>23-27 days</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2. Have you gone for long periods of time (8 hours of more) without eating anything in order to influence your shape of weight?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>3. Have you tried to avoid eating any foods which you like in order to influence your shape or weight?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4. Have you tried to follow definite rules regarding your eating in order to influence you shape or weight; for example, a calorie limit, a set amount of food, or rules about what or when you should eat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5. Have you wanted your stomach to be empty?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6. Has thinking about food or its calorie content made it much more difficult to concentrate on things you are interested in; for example read, watch TV, or follow a conversation?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7. Have you been afraid of losing control over eating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>8. Have you had episodes of binge eating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>9. Have you eaten in secret?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>10. Have you definitely wanted your stomach to be flat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>11. Has thinking about shape or weight made it more difficult to concentrate on things you are interested in; for example, read, watch TV, or follow a conversation?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
### On how many days out of the past 28 days ...

<table>
<thead>
<tr>
<th>Question</th>
<th>No days</th>
<th>1-5 days</th>
<th>6-12 days</th>
<th>13-15 days</th>
<th>16-22 days</th>
<th>23-27 days</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Have you had a definite fear that you might gain weight or become fat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>13. Have you felt fat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>14. Have you had a strong desire to lose weight?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

### Over the past four weeks (28 days) ...

<table>
<thead>
<tr>
<th>Question</th>
<th>None of the times</th>
<th>A few of the times</th>
<th>Less than ½ the times</th>
<th>Half the times</th>
<th>More than ½ the times</th>
<th>Most of the times</th>
<th>Every time</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. On what proportion of times that you have eaten have you felt guilty because of the effect on your shape and weight? (Do not count binges.)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>16. Over the past four weeks (28 days), have there been any times when you have felt that you have eaten what other people would regard as an unusually large amount of food given the circumstances?</td>
<td>No (0)</td>
<td>Yes (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. How many such episodes have you had over the past four weeks?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. During how many of these episodes of overeating did you have a sense of having lost control over your eating?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Have you had other episodes in which you have had a sense of having lost control and eaten too much, but have not eaten an unusually large amount of food given the circumstances?</td>
<td>No (0)</td>
<td>Yes (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. How many such episodes have you had over the past four weeks?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Over the past four weeks have you made yourself sick (vomit) as a means of controlling your shape or weight?</td>
<td>No (0)</td>
<td>Yes (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. How many times have you done this over the past four weeks?</td>
<td></td>
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<tr>
<td>23. Have you taken laxatives as a means of controlling your shape or weight?</td>
<td>No (0)</td>
<td>Yes (1)</td>
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<td>24. How many times have you done this over the past four weeks?</td>
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<tr>
<td>25. Have you taken diuretics (water tablets) as a means of controlling your shape or weight?</td>
<td>No (0)</td>
<td>Yes (1)</td>
<td></td>
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</tbody>
</table>
26. How many times have you done this over the past four weeks?

27. Have you exercised hard as a means of controlling your shape or weight?  
   No (0)  Yes (1)

28. How many times have you done this over that past four weeks?

<table>
<thead>
<tr>
<th>Over the past four weeks (28 days)</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Markedly</th>
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</thead>
<tbody>
<tr>
<td>29. Has your weight influenced how you think about (judge) yourself as a person?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>30. Has your shape influenced how you judge yourself as a person?</td>
<td>0 1 2 3 4 5 6</td>
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<tr>
<td>31. How much would it upset you if you had to weigh yourself once a week for the next four weeks?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>32. How dissatisfied have you felt about your weight?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>33. How dissatisfied have you felt about your shape?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>34. How concerned have you been about other people seeing you eat?</td>
<td>0 1 2 3 4 5 6</td>
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<tr>
<td>35. How uncomfortable have you felt seeing your body; for example, in the mirror, in shop window reflections, while undressing or taking a bath or shower?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>36. How uncomfortable have you felt about others seeing your body; for example, in communal changing rooms, when swimming or wearing tight clothes?</td>
<td>0 1 2 3 4 5 6</td>
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</tbody>
</table>

Please check you have answered all the questions.

Thank you for taking the time to fill in these questions.
**vi. Impulsive and Compulsive Relationships to Food Questionnaire**

Thank you for completing this research questionnaire. There are no right or wrong answers. Please respond truthfully. All answers will be confidential.

For each question, circle the number that you feel best describes you.

1. **I jump at the chance to try new types of food**

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2. **I think about food a lot**

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3. **I feel uncomfortable when my plans to eat change unexpectedly**

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4. **When I’m sad I eat to make me feel better**

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5. **I feel anxious if I am unable to eat at set times of the day**

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6. Food provides me with a sense of security

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7. I find myself eating on impulse when I haven’t planned to

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8. When overeating I do not think about the consequences, but later regret my actions

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9. I feel compelled to eat food if it smells or looks really good

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10. I spend time dwelling on what I'm going to eat

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11. I urgently need to eat when I start to feel hungry

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12. I feel reassured when I plan what I'm going to eat

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13. I find myself preoccupied by food

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14. I eat impulsively with no thought to what I’m doing

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15. When I feel the urge to eat I often grab the nearest thing there is to eat

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16. I eat to manage everyday tensions

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17. I feel more comfortable if I think carefully before choosing what to eat

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18. I use food to help avoid facing difficult issues in my life

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19. I have set routines around when I eat and feel uncomfortable when they’re broken

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20. I turn to food for comfort

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21. My decision to eat is frequently spontaneous

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22. My eating patterns are chaotic

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23. I try new types of food because I feel I will gain a lot of pleasure from them

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24. I like to know when I'm going to eat next

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25. I find myself eating for no reason

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Thank you for your time.
Appendix C

Ethical Approval Documentation:

i. LREC Ethics Committee
ii. NHS Trust Ethics Committee
iii. School of Human Sciences Ethics Committee
28 August 2006
Miss E Evans
Trainee Clinical Psychologist
University of Surrey
Department of Psychology
Guildford, GU2 7XH

Dear Miss Evans,

Full title of study: Relationship to Food: The Role of Impulsivity and Compulsivity in Disordered Eating

REC reference number: 06/Q1502/102

Thank you for your letter of 18 August 2006, 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.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

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>
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<tbody>
<tr>
<td>Application</td>
<td>1</td>
<td>12 July 2006</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td>07 July 2006</td>
</tr>
<tr>
<td>Protocol</td>
<td>1</td>
<td>25 November 2005</td>
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<tr>
<td>Covering Letter</td>
<td></td>
<td>10 July 2006</td>
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<tr>
<td>Covering Letter</td>
<td></td>
<td>16 August 2006</td>
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<tr>
<td>Letter from Sponsor</td>
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<td>27 June 2006</td>
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</table>
Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REG application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

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.

| Item | Date
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<td>31 January 2005</td>
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<tr>
<td>Questionnaire: Non Validated</td>
<td>07 July 2006</td>
</tr>
<tr>
<td>Questionnaire: Validated</td>
<td>07 July 2006</td>
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<tr>
<td>Letter of invitation to participant</td>
<td>07 July 2006</td>
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<tr>
<td>Participant Information Sheet: EDA Sample</td>
<td>16 August 2006</td>
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<td>Participant Information Sheet: EDS Sample</td>
<td>16 August 2006</td>
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<td>Participant Information Sheet: Uni of Surrey Sample</td>
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<td>Participant Consent Form</td>
<td>07 July 2006</td>
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<tr>
<td>Response to Request for Further Information</td>
<td>16 August 2006</td>
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<td>CV for Martin Carol (Supervisor)</td>
<td>07 July 2006</td>
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<td>Demographics Form</td>
<td>07 July 2006</td>
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<td>Summary, synopsis – Research Process Form</td>
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<td>Statement of indemnity arrangements – Insurance Policy</td>
<td>28 July 2005</td>
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Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Chair

Email:

Endorsements: Standard approval conditions

Copy to: Sponsor - Professor Terri Desombre, University of Surrey
Guildford, Surrey, GU2 7XH

R&D Department for NHS care organisation at lead site
Miss E Evans  
Trainee Clinical Psychologist  
Department of Psychology  
University of Surrey  
Guilford  
GU2 7XH

Dear Miss Evans,

Relationship to Food: The Role of Impulsivity and Compulsivity in Disordered Eating

We have recently received a copy of the LREC application approval letter and are satisfied that all of the criteria of the Research Governance Framework have been complied with. 

I can confirm that the NHS Trust will provide management approval for the above study. The project has been registered with the Trust and added to the R&D database.

I must remind you of your responsibilities as a researcher, including adherence to the Data Protection Act. Should any changes take place in any aspect of the project, such as dates of completion, protocol or recruitment, the R&D Department must be informed immediately and supplied with any amended documentation as necessary.

In addition, I enclose a proforma for reporting to the Trust any publications that arise from this research. The Trust needs this information for reporting purposes.

I wish you every success with the study.

Yours sincerely,

Trust Research Management & Governance Committee

12 September 2006

Research Dossier: Major Research Project
Dear Eleanor,

Reference: 43R-PSY-06

Relationship to Food: The role of impulsivity and compulsivity in disordered eating.

Thank you for your submission of the above proposal.

The School of Human Sciences Ethics Committee has given a favourable ethical opinion.

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

Yours sincerely,

Dr Kate Davidson