Ambivalence and Readiness to Change in Anorexia Nervosa

by

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Volume 1

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Introduction to the Portfolio

The portfolio contains three dossiers: an academic dossier, a clinical dossier and a research dossier.

Volume 1 contains the academic dossier, a summary of the confidential clinical dossier and the research dossier. The academic dossier consists of four essays relevant to a range of clinical issues. The summary of the clinical dossier consists of an overview of clinical experience across the six placements and a summary of each of the five clinical case reports demonstrating clinical work carried out. The research dossier consists of the service related research project, the major research project and a research checklist.

Volume 2 is a confidential clinical dossier that contains five clinical case reports based on client work during placement and placement documentation for all six placements. This includes the placement contract, evaluation forms of myself and the placement and a placement summary and logbook of the range of clients I have worked with.
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Academic Dossier
Adult Mental Health Essay

Psychotic experiences (e.g. auditory hallucinations and delusions) are not understandable or meaningful. Critically discuss this statement and any implications for treatment.

Year 1

January 2004
Introduction
To assess whether psychotic experiences are understandable and meaningful a selection of research studies will be examined. The majority of research has concentrated on cognitive models of auditory hallucinations and delusions, so this will be the main focus. The aim is to critically evaluate the evidence and establish possible implications for treatment.

The question is open to interpretation. The interpretation for this purpose regards understandable and meaningful as having different definitions thus the evidence provided will reflect this. Initially, important definitions will be outlined.

Definitions
Psychosis
Conducting an extensive literature search has not been successful in identifying a single profile of definitions. There are many definitions of psychosis and not one is universally accepted. Current definitions pay attention to symptoms whereas previous definitions have focused more on the severity of functional impairment (Diagnostic & Statistical Manual of Mental Disorders: Fourth Edition (DSM-IV), American Psychiatric Association (APA), 1995). Even within the DSM-IV there are different definitions of ‘psychotic’ depending on the disorder it is associated with.

The DSM-IV describes three levels of definitions for ‘psychotic’. The narrowest definition is restricted to “delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature” (p.279). A less restricted definition also includes “prominent hallucinations that the individual realises are hallucinatory experiences” (p.279). The broadest definition also includes “other positive symptoms of Schizophrenia (i.e., disorganized speech grossly disorganized or catatonic behaviour)” (p.279).
Research studying psychotic experiences has mostly reviewed those associated with Schizophrenia (e.g. Johns & van Os, 2001) thus, the broadest definition will encompass all experiences. However, the research evaluated here will concentrate specifically on the central experiences of delusions and hallucinations.

**Delusions and Hallucinations**

Definitions of delusions and hallucinations have faced similar difficulties in being universally accepted. The DSM-IV definitions of 'delusion' and 'hallucination' are used for a diagnosis of Schizophrenia. These definitions are therefore referred to in most research papers (e.g. Baker & Morrison, 1998) where delusions or hallucinations are studied.

Delusions are defined as

*erroneous beliefs that usually involve a misinterpretation of perceptions or experiences. Their content may include a variety of themes.... The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends on the degree of conviction with which the belief is held despite clear contradictory evidence.... Delusions are deemed bizarre if they are clearly implausible and not understandable and do not derive from ordinary life experiences.*


Hallucinations

*may occur in any sensory modality (e.g. auditory, visual, olfactory, gustatory and tactile).... Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person's own thoughts. The content may be quite variable.... The hallucination must occur in the*
context of a clear sensorium.... Hallucinations may also be a normal part of religious experience in certain cultural contexts.  


Throughout the evidence presented, it is important to remember that most studies, although including the DSM-IV definitions, may also have their own definitions. These may influence criteria for subjects included in the study and the results obtained, making the findings not representative of others with delusional or hallucinatory experiences.

Understandable and Meaningful

Before continuing, it is important to clarify the author’s understanding of ‘understandable’ and ‘meaningful’ in relation to the question. The Oxford Talking Dictionary (1998) defines ‘understandable’ as

Able to understand: capable of understanding; that can be understood: intelligible; for understandable reason; in a manner that can be understood; ‘she approached the ... subject with understandable caution.’

And ‘meaningful’ as

Full of meaning or expression; significant, amenable to interpretation; having a recognizable function in a language or sign system; able to function as a term in such a system.

The author interprets delusions and hallucinations as being or not being understandable in terms of the formation, process and maintenance of the symptom and as being or not being meaningful in terms of the content or significance of the experience. This distinction can be used with the presented research. Firstly, research focusing on the formation, process and maintenance (understandable) of psychotic experiences will be discussed, followed by a discussion into the meaning of the experiences.
Understanding Definitions

Attempts have been made to understand delusions. Disagreements about the definition alone imply differences in opinions as to whether they are understandable as each definition will give a different understanding.

Jaspers (1913, cited in Garety, 1985, p.25) suggested that “... a delusion is a primary phenomenon-experiencing and thinking that something is real: this constitutes a transformation of one’s total awareness of reality.” He argued that delusions like all other false judgements are ‘held with extraordinary conviction; are maintained imperviously to other experiences and compelling counter-arguments; and their content is impossible.’ He also argues that a delusional perception or true delusion is ‘... a primary experience which cannot be understood as arising from some other psychological event.’ Whereas a secondary delusion or delusional idea is understandable. ‘It emerges understandably from preceding affects, from experience, from false perceptions or from an experience of derealization in states of altered consciousness.’ Therefore, according to Jaspers’ definition, a primary or true delusion is not understandable.

Garety (1985) disagreed with this definition, arguing that the intensity, that is degree of conviction and fixity that is maintenance over time of the belief is needed to differentiate it from ‘over-valued ideas’. She argued that these aspects must be included for an operational definition of delusion for measurement purposes during studies. Garety studied two participants and measured the intensity and fixity of their delusions. She showed they could be measured and therefore subject to manipulation which led her to argue for the rethink of the concept of delusion. Garety put forward that delusions were no longer ‘discrete discontinuous entities’ but instead ‘beliefs with characteristics situated towards one end of various dimensions’ (p.33). The DSM-IV definition now includes the idea of ‘the degree of conviction’ in relation to a delusion.
Heinimaa (2002), however, describes the DSM-IV definition as ambiguous. He pays particular attention to the line “delusions .... involve misinterpretation of perceptions or experiences....” (DSM-IV, p.281). Heinimaa argues that to be able to judge something as misinterpreted implies that there is a clear interpretation to judge it against. However, it is often difficult to formulate the problem in a delusion and there is not always something to interpret. This means there cannot be a misinterpretation. Therefore describing delusions in terms of misinterpretation has difficulties. Heinimaa argues that this questions the DSM-IV definition of delusion and its validity.

The present author would argue that Heinimaa’s concerns regarding the DSM-IV definition of delusion supports the notion that delusions are not understandable in terms of this definition.

**Category versus Continuum**

Mullen (2003) reports that there is often a debate about an appropriate definition of delusion based on whether delusions are regarded as categorically different from other beliefs or whether they are part of a continuum. Historically people have been viewed as either deluded or not. This clear categorisation has supported the rationale of medication in psychiatry as people are either ill or not. However, there is growing evidence to suggest that delusions form a continuum with other normal beliefs. This has major implications for clinical practice and treatment.

Studies identifying delusional beliefs in the general population give evidence for delusions being on a continuum. Peters, Joseph and Garety (1999) designed a psychometric tool to measure delusional ideation in the normal population. Participants completed the Peters’ Delusional Inventory (PDI), which measured conviction, distress and preoccupation of the delusion. Nearly 10% of the normal sample scored above the mean of the deluded sample. Peters et al (1999) argued that this is consistent with a continuum from ‘mental health to ill health’ and that the results confirmed that within a sample of normal individuals, they were able to identify and measure
delusion-proneness. However, this raised the issue that some healthy people score higher than those who are deluded but are able to live in society without difficulty, therefore it is more than just the experience or mental event. It will also depend on the emotional impact, the strength of the interpretation and how much the individual thinks about it.

This study does not completely support the suggestion that delusions are on a continuum with normal beliefs. The authors changed a deluded belief to an idea that was normal. This makes it difficult to conclude that these people are prone to delusions based on beliefs that were not delusional.

Garety and Hemsley (1987) have investigated the ideas discussed by Peters et al (1999) about the experience of delusions depending on other factors (e.g. emotional impact, strength of interpretation etc). They assessed 55 psychiatric patients and asked them to rate their delusions on 11 characteristics. The most characteristic feature of a delusion was a high degree of conviction, that is, the extent to which the delusion is believed. Eighty percent of participants expressed high levels of conviction towards their delusion. They found mixed levels for the other characteristics. These results suggested that delusions can take different forms. This supports the hypothesis that delusions are multi-dimensional, they are characterised by conviction but take many forms. This has implications for the understanding and meaningfulness of delusions. To understand a person's delusion and identify its meaning for that person, all aspects of the delusion must be assessed. This includes the concern and distress experienced by the individual, the obtrusiveness and the strength of the belief.

Brett-Jones, Garety, and Hemsley (1987) have also developed measures to evaluate delusional experiences. They asked about the conviction and preoccupation of the belief and how it interfered with their life. Results from nine-single case studies suggest that a multi-dimensional approach should be taken when discussing delusions. This view can also be seen to support the continuum theory. Everyday beliefs will be held with different levels of
conviction and cause different levels of distress so delusions can be understood as being multi-dimensional and along a continuum with all other beliefs.

Examining the similarities between delusions and religious beliefs can also offer support for a continuum theory. Religious beliefs fall on a continuum like other beliefs. Religious beliefs have caused problems for researchers when defining delusions. Freud (1961 cited in Pierre, 2001) believed that all religious beliefs were delusional. However, disagreements with this have led to the exclusion of religious beliefs in the DSM-IV. It does not include beliefs that are shared by cultures or subcultures. Religious beliefs cannot be said to be true or false and so cannot be diagnosed as delusions. It would also be down to the clinical judgement of the clinician to decide whether a religious belief is delusional or not. Pierre (2001) discusses the idea that if a belief is shared by others then it is not delusional. However, he identifies problems with this as a belief may be seen as delusional in one culture but not another. There are also issues around subcultures such as cults, when a leader may have a delusional idea that then becomes accepted because other people follow the leader and begin to believe it, so according to the DSM-IV criteria this would no longer be a delusion as it is shared with others. Pierre argues that a belief is not delusional dependent on whether it is shared by other but rather by how it is formed.

Jones and Watson (1997) studied delusional and religious beliefs of people with schizophrenia, anorexia and normal controls. Delusional beliefs were held in a similar way to religious beliefs whose content would not be said to be abnormal. This supports the notion that delusions form part of the continuum with religious beliefs and other normal beliefs. These results are different to Pierre's who concluded among other things that delusional refers to the manner in which the belief is held rather than the content. This may suggest that delusions are held in a different way to other beliefs or they may just be further along the continuum.
Implications of the Continuum Theory

Viewing delusions along a continuum with other beliefs has implications for clinical practice and those diagnosed as having delusions. Firstly, if there are similarities between deluded and normal beliefs, the stigma attached to deluded beliefs may be reduced. It may also help the deluded person understand their illness and experiences in relation to normal beliefs. Being on a continuum will also support the notion that there can be changes throughout a psychotic episode where delusions will be held with different convictions and cause varying levels of distress. Finally, it can facilitate the creation of screening tools and measurements for early identification of symptoms as normal beliefs can be used to assist with the process (Mullen, 2003).

Johns and van Os (2001) reviewed a number of studies that support the continuum approach and conclude that both delusions and hallucinations lie on a continuum with normal beliefs and both are dimensional phenomena. Similarly, to Mullen, they suggest that the dimensional definitions are not as stigmatising as the categorical definitions as they imply that people experiencing delusions or hallucinations are not that different from non-patients. Whereas the categorical view would see the person as qualitatively different and as the illness, that is deluded or schizophrenic.

Mullen concludes that defining delusions as categorical or along a continuum may not be useful. Both provide frameworks within which the cause, treatment and nature of delusions can be hypothesised. Mullen argues that it is more helpful to measure a belief or experience against the individual to determine if it is delusional or not.

Like Mullen, the current author agrees that defining psychotic experiences along a continuum or categorically may not be useful for understanding them. The theory cannot explain how and why they occur, only that they may be more extreme than normal beliefs.
Theoretical Explanations
Researchers have attempted to explain and understand psychotic experiences in terms of their particular theoretical framework. Freud (1915 cited in Miller & Karoni, 1996) argued that paranoid delusions emerge out of unconscious and repressed homosexual urges. De Masi (2000) also linked the unconscious and psychosis when he reviewed psychoanalytic theories. He discusses Freud's views about how the unaware conscious of the self is damaged during psychosis; it is the emotional conscious that transforms, forfeiting all its functions. Although Freud applied a psychoanalytic model to psychosis, he suggested that analytic treatment was not suitable. De Masi suggested that more research was needed in the field.

Zubin and Spring (1977) reviewed a number of models to form a stress-vulnerability model of schizophrenia where people have different levels of vulnerability combined with different stressors and different coping resources. All of this affects the duration and type of episode and symptoms. Treatment could focus on the vulnerability of the individual through psychopharmacology or by psychologically intervening with the individual's coping ability. This model does not necessarily help with the understanding of psychotic symptoms.

Maher and Ross (1984) reviewed the literature on delusions, which led them to disprove some explanations and explain a delusion as arising

whenever an individual undergoes anomalous experience.... These experiences give rise to delusions whenever the correct explanation is not available to the individual concerned. The delusional explanation.... offers relief from the distressing sense of puzzlement that anomalous experience conveys, and this relief militates against the abandonment of the explanation even in the face of counterevidence and public contradiction.... The delusion is developed to answer certain questions.... Answers to these
questions tend to be drawn from the personal and cultural background of the patient (p.406).

This account of the forming of a delusion has implications for therapy. This involves providing the correct explanation for the patient about the experiences they are experiencing so that the need for the delusion will no longer exist. The more advantageous treatment would be to cure the condition that causes the experiences. Giving a biomedical account of the problem is thought to be useful, as the patient does not have to explain the delusion. Maher and Ross (1984) suggest that it might be more helpful to find early warning signs of psychiatric problems that lead to delusions so an appropriate explanation can be given before the explanatory sequence that leads to the delusion begins.

Cognitive Processing Explanations

Researchers have criticised Maher and Ross's (1984) model and proposed that there are abnormal reasoning processes occurring during delusions and that there is evidence that individuals who experience delusions do not have normal reasoning processes.

One suggestion is that individuals who experience delusions have a selective bias in processing certain types of information. Bentall, Kaney and Bowen-Jones (1994, cited in Miller & Karoni, 1996) asked deluded, depressed and normal control participants to recall threat related, depression related and neutral words. The deluded group were more likely to recall threat and depression related words compared to the control group, whereas the depression group showed a bias to depressed words only. This study supports the idea of a selective bias being involved when deluded people process information. However, it is unclear whether the selective bias is a cause or consequence of being deluded.

An alternative view is that the attribution process of the individual is distorted. Kinderman, Kaney, Morley and Bentall (1992) found that deluded participants
showed a self-serving bias in their attributions. Their attributions were internal for positive events and external for negative events. This idea is similar to the self-monitoring deficit described by Frith (1992). It has been suggested that people need to be able to distinguish between events caused by themselves and those caused by external agents. Frith suggests that if a person suffering from schizophrenia is not aware of their efforts which go into their thoughts then the thoughts may be experienced as ‘alien’ and thus attributed to external agencies. He argues that this deficit in self-monitoring may underlie some delusions, especially ones of control when patients feel their thoughts or actions are determined by external sources. However, it is not clear how this concept applies to other delusions such as paranoid delusions.

Miller and Karoni (1996) suggest that delusions are phenomena that reflect cognitive processes because they represent the ideas deluded people have about themselves and the world. The present author would argue that this would make them understandable in terms of their cognitive processes. However, it is not clear which cognitive process are involved. Miller and Karoni (1996) having reviewed the research put forward two views regarding links between delusions and certain distortions of thinking or the making of attributions. Firstly delusions occur because there are distorted processes which underlie the drawing of inferences or making of attributions and secondly the processes which cause delusions also independently produce distortions in reasoning or attribution. Miller and Karoni (1996) suggest that longitudinal studies are needed to establish whether cognitive distortions precede the occurrence of delusions or whether they occur at the same time. Until there is substantial evidence for either hypothesis, it can be argued that delusions are not understandable in terms of their cognitive processes.

Cognitive processing theories have also been put forward to explain hallucinations. Bentall, Haddock and Slade (1994) would argue that there is a consensus about the nature of hallucinations, suggesting that the nature of hallucinations is understandable to most researchers. All theories propose that hallucinations occur when the individual attributes their internal 'mental
events’ to an external source rather than oneself (Bentall, 1990; Frith, 1992; Morrison, Haddock & Tarrier, 1995). However, researchers differ in their views about which abnormalities are responsible for individuals’ inability to attribute the mental event as self-generated.

Bentall (1990) proposed that hallucinations result from a problem discriminating between real and imaginary events. Hallucinators make ‘hasty and over-confident judgments about the source of their perceptions’ and are biased towards attributing their perceptions to an external source. Bentall argued that the misattribution reflected a deficit in monitoring internal events. Discriminating between self-generated and external events is a meta-cognitive skill. If the skill fails people may misattribute an internal event to an external event, this will cause hallucinations. Therefore, treatment should concentrate on the individual becoming aware that the voice is self-generated. However, this could have devastating consequences if the person does not want to know the voice is self-generated.

Based on this theory, Bentall et al (1994) introduced focusing techniques with six participants to reduce the voices and/or distress associated with them. The idea was to gradually attribute the voice to the self. The techniques only reduced the frequency of voices and distress associated with them in some patients because the techniques did not address other causes of hallucinations.

Frith suggested that a different internal monitoring deficit causes hallucinations, the mechanism that regulates inner speech. The mechanism fails to recognise the inner speech or verbal thoughts as the self. Johns and McGuire (1999) asked participants to read aloud single words. When their speech was distorted, patients with auditory hallucinations misidentified their voice as someone else’s. There has been mixed support for this idea.

Some neuroimaging studies support this. Stein and Richardson (1999) showed that when schizophrenic patients hear voices, their whole speech
perception and production network including Broca's area is activated. McGuire, Shah, and Murray (1993) also found that blood flow was significantly greater in these areas during hallucinations, suggesting the association between inner speech and auditory hallucinations. McGuire et al (1996) later suggested it was a failure to activate the areas concerned with the monitoring of inner speech rather than the activation.

Lennox, Park, Medley, Morris, and Jones (2000) suggest that there have been inconsistent results found in neuroimaging studies because they all use different imagery techniques, lots of them cannot examine the whole brain and they use a mixture of participants and experimental designs. Lennox et al (2000) examined functional anatomy of auditory hallucinations using functional magnetic resonance imaging. They studied four participants and found consistent involvement in the middle and superior temporal lobes during the experiences of hallucinations. There was no activation or decrease in activation in Broca's area. This therefore does not support the theory that hallucinations occur because of abnormalities in inner speech.

These studies make it difficult to conclude that hallucinations are understandable in terms of deficits in inner speech. This is supported by David (1999) who argues that neuroimaging studies cannot show all the neurological changes that occur during an auditory hallucination and so it is still unclear which areas are associated with the experience and whether an association means a cause. Feinstein and Ron (1990) also examined 65 patients and found that there was no association between the site of brain pathology and the psychotic experiences. This would suggest that at present, hallucinations cannot be understood in terms neurological changes in areas associated with inner speech or other brain sites.

Morrison et al (1995) have also given an alternative explanation. They have developed a model based on auditory hallucinations being linked to intrusive thoughts. Hallucinations occur when intrusive thoughts are attributed to an external source to reduce cognitive dissonance, which is an uncomfortable
state when two cognitions (thoughts or beliefs) contradict one another (Festinger, 1957 cited in Morrison et al, 1995). Baker and Morrison (1998) have supported this model by comparing hallucinating schizophrenics with non-hallucinating schizophrenics and non-psychiatric controls on a word association task. The hallucinators had a bias to misattribute unwanted words to an external source. From this, they suggested that intrusive thoughts might be particularly prone to misattribution.

This model suggests that psycho-education is important in treatment. Patients should learn about intrusive thoughts and hallucinations. Cognitive techniques such as self-monitoring and behavioural experiments are also suggested to complement modifying beliefs to those closer to their overall belief system.

Garety, Kuipers, Fowler, Freeman and Bebbington (2001) have developed one model for both delusions and hallucinations, linking together previous models. They allow two possible routes for the development of symptoms after a vulnerable person experiences a triggering event. During the first route, a cognitive disturbance leads to anomalous experiences, which are combined, with emotional changes. Biased processing then judges the experience as external. During the other route, a triggering event causes disturbed emotional change. This activates biased appraisal processes and negative schemas, which then produce an externalising appraisal. Although this model appears comprehensive, it gives options about different routes and possible cognitive processes and biases. Therefore, it can be argued that it is not clear which processes are involved during the experiences. Thus, psychotic experiences are not understandable in terms of this model.

The Meaning of Psychotic Experiences

Until now, the meaning of these experiences has not been important to the studies discussed. This is like psychiatric practice where little attention is paid to the content of psychotic experiences (Aschebrock, Gavey, McCreanor &
This maybe because the biomedical model considers the content of delusions and hallucinations to be irrelevant (Read & Argyle, 1999).

Many researchers and professionals will argue against this and say that the content is relevant. Nayani and David (1996) conducted semi-structured interviews with one hundred patients. Seventy-two percent were able to give an explanation for the reason of their voices. The content was personalised to the voice-hearer. Haddock, Bentall and Slade (1993) have also found that the content of auditory hallucinations is personally salient.

This is supported by a study by Chadwick and Birchwood (1994). They found that the belief about the voice affected the distress and voice-driven behaviour and this was independent to the described content of the voice. This suggests that the meaning the individual attributed to the voice was important. Thus, the experience was meaningful for the individual. The meaning of the voice is also then meaningful for therapy. Cognitive therapy can challenge the beliefs about the voices by hypothetical contradiction, which is asking patients to react to evidence that is contrary to their belief (Brett-Jones et al, 1987) and verbally challenging them (Chadwick & Lowe, 1990).

Cultural differences and beliefs also appear to give different meanings to delusions and hallucinations. Yip (2003) conducted a small-scale phenomenological study looking at the cultural implications of traditional Chinese religious beliefs and superstitions on psychotic experiences. He found that beliefs and superstitions had significant impacts on the subjective experiences, including the content and meaningfulness. Individuals put their experiences into the beliefs and superstitions and this gave them meaning about their situations. Yip concluded that it is important for professionals to have the knowledge to communicate with and understand patients’ experiences. This suggests that the content of the experience is personal to the individual and so is meaningful for them.
Professionals also seem to view delusions and hallucinations as meaningful for the individual involved and for the therapeutic process. Aschebrock et al (2003) conducted an international survey to get the views of professionals concerning the importance of the content of psychotic experiences. There was a poor response rate, however the majority commented on the benefits of attending to content. It gave a greater understanding of the person’s difficulties so helped with formulation and they found that the content was understandable within the context of the person’s lives. This suggests it was meaningful to both the professional and the individual.

Implications for Treatment
As already discussed, each theory or model has its own implications for treatment. As the cognitive models have been at the forefront of research into psychotic experiences, it is not surprising that cognitive-behaviour therapy (CBT) is a popular alternative to medication. However, each model highlights different benefits of CBT. A dimensional approach also encourages CBT because one of the aims of the therapy is to normalise the symptoms thus it is not stigmatising and explains to patients that their experiences are similar to others (Johns & van Os, 2001).

The main techniques suggested include belief modification (Brett-Jones et al, 1987; Morrison et al, 1995) and attributing the voice of an auditory hallucination to the self (Bentall et al, 1994). Turkington and Siddle (1998) argue that therapy is based on actually understanding the belief and change can only occur once the exact belief and its associated emotional and behavioural aspects are discussed. So this is needed before the techniques can be used.

There have been studies conducted to assess the effectiveness of CBT for psychotic symptoms, but they are still in their early stage. Kuipers et al (1997) conducted a randomised control study in three centres with medication-resistant psychosis. Sixty participants were randomly allocated to standard care or CBT plus standard care. Tarrier et al (1998) randomly allocated
eighty-seven participants to standard care, supportive counselling plus standard care or CBT with standard care. Both studies resulted in the CBT group having significant improvements over the controls. Both studies had some methodological problems so more research into the effects of CBT is needed.

Therefore, although there is not a consensus on the cognitive processes involved during delusions and hallucinations, the models have suggested promising techniques for the treatment of the symptoms. So maybe the experiences do not need to be understood to be able to treat them.

Conclusion
Several models have been presented. Although cognitive models are at the forefront of research, there are still disagreements as to the cognitive processes involved during psychotic experiences. The studies are also methodologically flawed with small numbers of participants, discrepancies in definitions used and outcome measures. At present, there is not sufficient evidence to support any model completely, suggesting the experiences are not understandable. This does not mean the models have not provided useful treatment techniques or that the experiences are not meaningful.

The evidence provided supports the author’s personal experiences in finding that delusions and hallucinations are meaningful in terms of the beliefs about them and the content. They are meaningful for the individual experiencing them, the therapist for formulating about the experiences and for the therapy process. The research has also supported the author’s observations of how an individual’s cultural beliefs can aid in the understanding and the meaning of a psychotic experience.

In conclusion, delusions and hallucinations can be understood in terms of the meaning attributed to the experience however, it is still not understood how and why the experiences occur. More stringent research is needed to aid this understanding.
References


How can Bowlby's attachment theory assist us in understanding challenging behaviour in people with a learning disability?

Year 1

August 2004
Introduction
This essay will begin by describing attachment theory and how it has been applied to the general population. The focus will then shift to looking at attachments in people with learning disabilities and more specifically how it has been used to understand challenging behaviour and the role it might have in informing interventions. Finally, there will be a consideration of the limits of attachment theory.

What is attachment theory?
Attachment theory is based on the work of John Bowlby. An attachment relationship initially develops between a child and his/her main caregiver (usually the mother) within the first year of life and is present throughout the lifespan. Bowlby (1977) proposed that attachment relationships have a biological and developmental function. The biological function is for the mother to protect the child from predators and to keep the child safe; and the developmental function is to help influence later emotional relationships and the child’s personality.

Bowlby (1969/1997) suggested that attachment is mediated by many behaviours, for example; crying, babbling, smiling, clinging, following and seeking. These behaviours are part of the attachment behaviour system which has the predictable outcome of increasing proximity to the attachment figure. They are known as attachment behaviours which are:

"conceived as any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual, who is usually conceived as stronger and/or wiser" (p203, Bowlby, 1977).

Being in close proximity to the attachment figure provides protection and at the same time provides a safe opportunity to explore the environment. Attachment figures can only provide security if they are readily available and
responsive to the child’s needs and can identify when the child is anxious or experiencing difficulties.

Bowlby (1978, cited in Janssen, Schuengel & Stolk, 2002) suggested that the attachment system acts as a kind of homeostatic mechanism to modulate anxiety and stress. The infant seeks his/her attachment figure for security and protection. The goal of attachment behaviours is therefore to help modulate the anxiety, and the function of the attachment figure is to provide a secure base and modulate any anxiety. Infants often seek their attachment figure when they are hungry, ill, tired or alarmed or when they do not know where their attachment figure is. Once found the attachment figure modulates the infant’s anxiety and distress and the infant wants to remain close to the attachment figure. This experience and reduction in anxiety is reinforced so the child learns to seek out the attachment figure when anxious or experiencing difficulties in the future.

Early relationships with an attachment figure influence later patterns of attachment behaviour through ‘internal working models’ (Bowlby, 1969/1997). These are mental representations which are constructed from the early interaction patterns with the attachment figure.

‘They serve to regulate, interpret, and predict both the attachment figure’s and the self’s attachment related behaviour, thoughts and feelings.’
(p89, Bretherton & Munholland, 1999)

Internal working models represent early experiences of the availability and responsiveness of the attachment figure which are internalised and used to provide views of the self, others and the world which then guides the infant’s strategies for modulating stress and dealing with other relationships. Bowlby (1977) suggested that if infants did not form secure attachments, this could lead to psychopathology and problems with future relationships.
Attachment classifications
developed Bowlby’s attachment theory. They created the ‘Strange Situation’
to assess individual differences in the organisation of attachment behaviour.
They observed mother-infant pairs during the first 12 months of life in a
sample of American white middle class families. The Strange Situation aimed
to examine the differences in children’s responses to a series of separations
and reunions with their mother. The situation is used to study differences
children have in using their attachment figure as a base for exploration and
their ability to derive comfort from their attachment figure in various situations.
From the observations three main patterns of attachment were derived: one
secure and two insecure.

| Pattern B – securely attached to the mother. (This is a majority in most samples) |
| The child is active in play and in seeking contact with the mother when distressed after a brief separation. The child is easily comforted and soon returns to play. |

| Pattern A – anxiously attached to the mother and avoidant. (20% in most samples) |
| The child avoids his/her mother during the reunion, especially after the second separation. Many anxious avoidant infants will be friendlier to a stranger than their own mother. |

| Pattern C – anxiously attached to the mother and resistant. (approximately 10% in most samples) |
| The child changes between seeking proximity and contact with the mother and resisting contact and interactions with her. |
The authors found that classifications in the Strange Situation related to differences in children’s functioning at home; securely attached children showed less anxiety and distress, particularly in stressful situations than insecurely attached children. The classifications have also been validated in the United States. Van Ijzendoorn and Kroonenberg (1988) looked at cross-cultural differences in attachment classifications. They found that intra-cultural difference was nearly 1.5 times the cross-cultural variation but that there was a higher prevalence of Pattern A in Western European countries and a higher prevalence of Pattern C in Israel and Japan. They concluded that there was no reason to doubt the cross-cultural validity as the global distribution would hardly change if the United States sample was excluded from the results.

There were however some children in the Strange Situation study (Ainsworth et al, 1978, cited in Wilson, 2001) who did not fit any of the three categories and some children with a history of abuse and neglect were classified as secure, which was contradictory to the basis of attachment theory. This resulted in Main and Solomon (1986, cited in Wilson, 2001) creating the D or disorganised category. Infants in this group lacked a coherent strategy for managing their arousal during separation in the Strange Situation. They were disorganised and disorientated and engaged in odd behaviours which were described as inexplicable except in the context of being scared or confused when in the presence of their mother. Main and Hesse (1990) found an association between infant disorganisation and their mother’s traumatic and unresolved loss of an attachment figure.

**Attachment theory – predictions**
Attachment theorists argue that failure in the development of attachment behaviour or a variation in the development results in psychiatric disturbances (Bowlby, 1977). Bowlby suggested that the security of the mother-infant attachment would have long-term implications for the child throughout their life in terms of their intimate relationships, self-understanding and psychological well-being. Many researchers have used attachment theory and the security of mother-infant attachments to help explain both positive and negative
attributes, for example, positive self-concepts (Cooper, Shaver & Collins, 1998) and aggressive behaviour (Lyons-Ruth, 1996).

Secure attachments are usually associated with positive characteristics and outcomes at all ages. Matas, Arend and Sroufe (1978) found that at 24 months, secure children showed significantly more symbolic play, were more enthusiastic, their affect was more positive and they were more persistent and showed less non-compliance than insecure infants. Bretherton (1985) reviewed a number of studies and found that the children who displayed secure patterns of attachment behaviour also displayed more positive social behaviours towards their parents and peers during the preschool years. Secure adolescents were also reported to be generally superior at functioning across many developmental domains (Cooper et al, 1998).

Studies have also found relationships between insecure attachments and behaviour problems. Lewis, Feiring, McGuffog and Jaskir (1984) found that attachment classification of boys at one year was significantly related to psychopathology at age six. Insecurely attached males showed more psychopathology than securely attached males, but the attachment classification only partly predicted behaviour problems as environmental factors were also relevant. Waters, Posada, Crowell and Lay (1993) found an association between attachment classification and behaviour problems. They also found that the same family variables associated with behaviour problems also affected the type of attachment between the mother and child. This complicated the association between attachment classification and behaviour problems.

Lyons-Ruth (1996) reviewed a number of studies. Initially she concluded that early avoidant attachment behaviours appeared to be present among children who later become aggressive. After reviewing more recent studies she concluded that it was the infant's disorganisation of attachment rather than avoidance per se that was associated with later aggressive behaviour. Moss, Parent, Gosselin, Rousseau and ST-Lauren (1996) also found with teacher's
ratings of children at age 3-5 years and then at 5-7 years, children with disorganised attachments were more likely to have behaviour problems than securely attached children.

Rutter (1995) suggested that early insecure attachments were a risk factor and may interact with other vulnerability and resilience factors to either increase or decrease the risk of psychiatric disorder in adulthood. Most research investigating attachments in the psychiatric population has been retrospective, e.g. Brown and Harris (1978, cited in Adshead, 1998), in a study of depression in adulthood found that the depression was associated with a loss of an attachment figure in early life.

**Attachment classifications and people with learning disabilities**

So far the discussion has focused on attachment theory and how it has been applied to children and clinical populations. To be able to comment on whether attachment theory can assist in the understanding of challenging behaviour, it is important to consider whether attachment classifications can be applied to people with learning disabilities as the original classifications were based on children of normal intelligence.

A number of studies suggest that children with Down syndrome and autism have the same attachment classifications as normally developing children. For example, Cicchetti and Serafica (1981) found that children with Down syndrome displayed similar amounts of attachment related behaviour to the normally developing children. Dissanayake and Crossley (1996) reported that children with autism displayed the same proximity seeking behaviour and stranger anxiety as normally developing children and those with Down syndrome. These studies suggest that these children with disabilities make attachments that are functionally similar to those without disabilities. There are however limitations to Dissanayake and Crossley’s (1996) study; they did not use the standardised Strange Situation and they had difficulties finding a comparison group that was able to control for developmental factors.
Other researchers (e.g. van Ijzendoorn, Schuengel & Bakermans-Kranenburg, 1999) have disagreed with these findings and found a higher prevalence of insecure attachments in people with learning disabilities. Smith and McCarthy (1996) created a semi-structured interview to assess adults with learning disabilities and their attachment experiences. Based on whether they sought comfort in significant others when they were distressed, it was found that there was a higher incidence of insecure attachments (59%) compared to Ainsworth's study (33%; Ainsworth et al, 1978 cited in van Ijzendoorn Goldberg, Kroonenberg & Frenkel, 1992). However these studies used different measures of attachment and compared adults with children making a comparison difficult.

Al-Yagon and Mikulincer (2004) studied Israeli children with learning disabilities and their non-disabled classmates. Only 45% of the children with learning disabilities received a secure attachment classification compared to 71% of their classmates. The children were asked to complete three self-report scales. The results suggested that the children with learning disabilities experienced less attachment security and more attachment avoidance and anxiety in close relationships than their peers. The children with learning disabilities in this study had an IQ between 85 – 115 and had identified difficulties in reading, writing or mathematics. These results cannot be generalised to the UK where one of the three core criteria for a learning disability is a significant impairment of intellectual functioning (British Psychological Society, 2001). The attachment relationships were also based on peer relationships rather than with an attachment figure which limits the results.

Many of the more recent studies have found particularly high rates of disorganised attachments in people with learning disabilities. Willemsen-Swinkels, Bakermans-Kranenburg, Buitelaar, van Ijzendoorn and van Engeland (2000) studied children with Pervasive Developmental Disorder,
Pervasive Developmental Disorder and Mental Retardation\textsuperscript{1}, Mental Retardation alone and normally developed children. They found no difference between the groups in the proportion of insecurely attached children but there were increased numbers of children with disorganised classification in the Pervasive Developmental Disorder and Mental Retardation group and a significant under-representation of the disorganised classification in the normally developed group.

Willemsen-Swinkels et al (2000) argued that because the children with a Pervasive Developmental Disorder had autism and were not given a disorganised classification more often than controls, the study demonstrated that disorganised attachment does not reflect autistic behaviour. This study lacked statistical power so the authors were unable to definitely reject their hypothesis that children with Pervasive Developmental Disorder are at an increased risk of an insecure attachment classification. Another consideration was the diagnosis of autism; the authors reported that they were confident in their diagnosis but they did not use a formal diagnosis of autism. The authors also claimed that the Strange Situation is a valid measure of attachment in children with autism, however they used children who were older than the children in the original Strange Situation study and the Strange Situation has not yet been validated with older children. These limitations are important when interpreting the results of the study.

Despite the limitations of Willemsen-Swinkels et al's (2002) study, the idea along with Vaughn, Goldberg, Atkinson, Marcovitch, MacGregor and Seifer (1994) and Ganiban, Barnett and Cicchetti (2000) who found that children with Down syndrome displayed disorganised classifications more frequently than normal developing children was supported by two meta-analyses (van Ijzendoorn, et al, 1992 and van Ijzendoorn et al, 1999). Van Ijzendoorn et al (1999) looked at disorganised attachment classifications across various ethnic, socio-economic and cultural backgrounds. They found in samples of

\textsuperscript{1} Mental retardation as referred to by Willemsen-Swinkels et al (2000).
children with cerebral palsy, autism and Down syndrome, 35% of children had disorganised attachments, which was higher than the standard distribution.

These studies suggest that people with learning disabilities may be more likely to be classified as having a disorganised attachment. However, the studies included within the meta-analyses are from different samples and conducted in different ways so the differences must be kept at the forefront when interpreting the results. These limitations combined with those mentioned regarding the previous studies suggest that more studies are needed to explore how often individuals are labelled as insecure because their behaviour is typical of their learning disability rather than of their attachment.

Another problem in assessing the attachment of people with learning disabilities is whether the Strange Situation is a suitable and valid measure for children with learning disabilities. The research offers differing views. As mentioned previously, Willemsen-Swinkels et al (2000) reported that the Strange Situation was a valid measure of attachment for children with autism, however Vaughn et al (1994) argued that it can not be used for children with Down syndrome because they did not become significantly distressed which meant they did not activate their attachment behaviours. Ganiban et al (2000) agreed that children with Down syndrome displayed less attachment related behaviours but found that the attachment behaviour systems were still activated during separation and reunions in the Strange Situation.

At present the results seem inconclusive. Willemsen-Swinkels et al (2000) used the Strange Situation with older children and as mentioned previously, it has not yet been validated with older children. Vaughn et al (1994) used a comparison group which was not a mental age comparison so could say whether differences reflected differences between the chronological and developmental age of children. Blacher and Meyers (1983) also commented that the Strange Situation has not been validated with severely learning disabled children. If the Strange Situation is used it is therefore imperative to consider the individual involved; whether the child is able to activate their
attachment behaviour system if distressed; what specific attachment behaviours they can display; and what other behaviours are due to their learning disability rather than being signs of attachment anxiety or disorganisation.

When investigating attachment classifications of adults, the Adult Attachment Interview is usually used (George, Kaplan & Main, 1984 cited in Hesse, 1999). Individuals are asked to discuss previous attachment relationships. Smith and McCarthy (1996) used this to help create their interview for people with learning disabilities. Although the interview could assess one aspect of attachment, the authors did not try to assess all aspects of attachment or try to assess the different types of insecure attachments. More research is needed to be able to fully evaluate the attachment classifications given to people with learning disabilities.

Several reasons have been hypothesised about why people with learning disabilities may have insecure/disorganised attachments. A child with a learning disability may be initially rejected by his/her mother (Clegg and Lansdall-Welfare, 1995). Mothers have a strong biological wish to have a healthy child. Having a child with a disability may be a blow to the self for creating a damaged child and may result in the mother feeling loss for the perfect child and rejection may in part be instinctive (Stokes & Sinason, 1992). Sometimes this rejection is never resolved and sometimes the mother feels guilty for rejecting the child and so becomes over-involved. Both situations can result in difficult attachment relationships.

A child maybe rejected because the mother perceives the child as being different and thus finds normal interaction difficult (Blacher & Meyers, 1983). Stone and Chesney (1978) found that when children had difficulties expressing cues their mothers had difficulties understanding their signals and responding to them appropriately. The child’s needs may also not be met if she/he makes excessive demands for attention. This often occurs in children with learning disabilities (Clegg and Lansdall-Welfare, 1995). If the mother
cannot meet the child's needs, it makes the development of a secure attachment difficult.

People with learning disabilities have often spent much of their life in institutions or residential care. If a person was placed in an institution as a child, he/she would be separated from their attachment figure. They would also have had multiple caregivers and a lack of attachment figures while in care, so there would be little opportunity for emotional development and secure attachment relationships (Clegg & Lansdall-Welfare, 1995). Children with Down syndrome are also less emotionally reactive (Cicchetti & Serafica, 1981) which may make them more vulnerable to an insecure attachment.

**Attachment theory and challenging behaviour**

Having reviewed research investigating the attachment classifications of people with learning disabilities and possible reasons for insecure/disorganised attachments, the focus can shift to research linking attachment theory and challenging behaviour. The research is sparse and appears to be based on two ideas, the first suggests challenging behaviour occurs in protest to the separation of a caregiver and is therefore an attachment related behaviour (Clegg & Lansdall-Welfare, 1995) and the second suggests an interaction between an insecure attachment and the stress the person experiences which then results in challenging behaviour (Janssen et al, 2002). These will be discussed with other related research.

Clegg and Lansdall-Welfare (1995) presented three case studies of adults with learning disabilities who displayed a range of challenging behaviours. In all three examples the individuals were separated from carers with whom they had built a relationship. The authors identified key points relating the challenging behaviour to attachment theory. They suggested that transitions are difficult for people with learning disabilities and this can sometimes result in them becoming fixated with a carer. In the example, the individual resisted exploring her physical environment by refusing to go on outings and did not explore intellectually by avoiding tasks she was believed to be capable of.
These behaviours were seen as challenging to the staff. They could also be seen as ambivalent and anxious type responses thus characteristic of attachment behaviours, activated by separation from her attachment figure.

Clegg and Sheard (2002) supported these case studies with a postal survey. They asked staff of a learning disability day placement and carers to rate the young people’s behaviour. A total of 43 students were rated. Staff rated 34% and carers rated 15% of students as over-investing in relationships. Students who did not over-invest were significantly less likely to show challenging behaviour at their placement. Qualitative comments such as ‘a trusted staff member leaving the room caused attacks on other vulnerable students’ helped support the idea that the challenging behaviour was a response to the separation in students with learning disabilities who were insecurely attached.

Janssen et al (2002) suggested that challenging behaviour can be understood within a stress-attachment model. People with learning disabilities are more likely to experience psychological stress and find situations distressing that others would not (Chaney, 1996). In addition, there is a suggested association between the stress-hormone cortisol and challenging behaviour (Neumann, Chi & Flemming, 2000). Janssen et al (2002) used the above evidence to argue that challenging behaviour may be understood as maladaptive responses to stress especially when a person has an insecure attachment. People with learning disabilities are more likely to have insecure attachments. Having an insecure attachment means people have less resources and coping strategies to deal with stress. Janssen et al (2002) suggested that the insecure attachment combined with higher levels of stress and lower levels of resources to deal with the stress could result in a person with learning disabilities displaying challenging behaviour.

Other areas of attachment theory research can also be used to assist in the understanding of challenging behaviour, for example, research into children’s behaviour problems and adult psychiatric problems. Speltz (1990) felt that behaviour problems in children seemed to reflect the child’s attempts to
control the physical and psychological proximity of the caregiver. Bowlby (1969/1997) would argue that this is the function of attachment behaviour. Speltz found that it was often the gaining of more control over the availability of the caregiver that reinforced the problem behaviour. Attachment behaviours have the goal of seeking security and protection from the attachment figure to modulate anxiety, if the child feels the responses from the attachment figure are uncertain, they may become angry and frustrated possibly resulting in aggressive behaviour. This then becomes reinforced as the behaviour that modulates the anxiety and thus the attachment behaviour. The aggressive behaviour also becomes internalised as part of the self so becomes used in other relationships. Challenging behaviour in people with learning disabilities can be seen as having the same function as children’s behaviour problems, that is attempting to control the physical and psychological proximity of the caregiver.

Adshead’s (1998) work within psychiatric settings can offer support for challenging behaviour being used to seek proximity to carers. She suggested that illness generally stimulates attachment behaviour and proximity seeking to care staff because it is anxiety provoking and the attachment figure can then modulate the anxiety. However people with learning disabilities may not have the communication skills to say they are unwell or feel anxious, thus they may display challenging behaviour to seek proximity with their carer. If the carer does not provide the security because they do not read the attachment behaviours correctly and the individual’s needs are not met, the challenging behaviour will continue.

The present author suggests that attachment difficulties may be a factor in the onset of a psychiatric disorder, which is then expressed as challenging behaviour in people with learning disabilities. Rutter (1995) has commented on a failure of early attachment being a possible risk factor for adult psychiatric disorder by interacting with other vulnerability factors and Flynn, Matthews and Hollins (2002) have identified that challenging behaviour is often an expression of psychiatric illnesses such as psychosis and affective
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disorder. Combined together there is a possibility that a person with a learning disability has an insecure attachment, this is a risk factor for developing mental health problems, which may then be expressed as challenging behaviour.

Implications
It appears that attachment theory could be of some help in understanding challenging behaviour and therefore in treating it. The general ideas, which could be applied to people with learning disabilities can be summarised as:

- The attachment figure needs to provide a secure base and modulate the anxiety the individual experiences (Carers need to be readily available to the person with learning disabilities and alert to signs of distress).

- Stability of carers is needed so that the person with learning disabilities has the opportunity to build a secure relationship with their carer without the fear of them leaving. This is not something that is easy to provide but should be considered at a service delivery level so that incentives are put in place to retain staff who work with people with learning disabilities. It is also important that the individual has more than one carer/key-worker so that if a carer does leave there is another close carer the individual can turn to.

- Often carers of people with learning disabilities do not notice their anxiety. Staff training can facilitate this identification so the anxiety is recognised and modulated before challenging behaviour develops. Training can also help carers understand that the behaviour is often a manifestation of severe anxiety. Facilitated discussions with carers about interactions and boundaries and their own attachment relationships can help them think about the individual more positively and develop better strategies to help them.

- Individuals with learning disabilities can be taught to modulate their own anxiety through relaxation training so that they do not always need the carer to do it for them. This may be difficult for those who are less able
so time should be spent with those individuals to find out what helps relax them.

Alternative explanations to challenging behaviour
The above evidence suggests that attachment theory has a part to play in understanding and treating challenging behaviour, however the research is in its early stages so there is still much to learn. Although attachment issues may be a factor in some challenging behaviour there are some incidents of challenging behaviour where the attachment status of the individual does not seem so relevant. For example, challenging behaviour is often viewed as an adaptive response to a difficult situation (Emerson, 1998) or as a way to control the environment (McGill, Clare & Murphy, 1996). Additionally, others argue the behaviour is a function of the individual’s environmental history for example, sexual abuse (Sequeira & Hollins, 2003).

Limitations
The limitations of individual studies have already been discussed but the author feels it would be helpful to highlight some general limitations. The early work on attachment theory was based on white middle class mothers with children with normal abilities. Dunn (1993) criticised the fact that fathers were not included and that emotional security was seen as all or nothing rather than being on a continuum. Fraley and Spieker (2003) have tried to explain that a multivariate dimensional approach can capture the same patterns of behaviour as identified in Ainsworth’s original study. Cummings (2003) further developed the contributions of a continuum approach.

Attachment theory can be criticised for suggesting that independence is a positive attribute. This may not be the case in all cultures. Rothbaum, Weisz, Pott, Miyake and Morelli (2000) found that those attributes considered positive in the United States were not considered positive in Japan, for example, independence. It was suggested that attachment classifications were based on Western ways of thinking and have different meanings in other cultures. Despite these findings, attachment theory has been found to be validated.
cross-culturally, as intra-cultural variations are greater than inter-cultural variations (van IJzendoorn & Kroonenberg, 1988). However more studies are needed to investigate whether the different measures of attachment are consistent across different cultures (Main, 1990), class structures and ethnic groups.

Researchers have had difficulties deciding whether children with disabilities have the same attachment classifications as non-disabled children because it is difficult to know whether a child is displaying insecure attachment behaviours or their behaviour is due to the nature of their disability. There are also questions about the validity of the Strange Situation for children with learning disabilities as discussed earlier. Studies have begun to explore attachment classifications in children with learning disabilities but they use different measures of attachment for example adapting the Strange Situation by using play sessions (e.g. Willemsen-Swinkels et al, 2000). Researchers also have to decide which behaviours should be ignored due to the learning disability rather than an insecure attachment. These points must be considered when interpreting the studies presented.

Within the ‘normal’ population there are also studies which show there is not a link between attachment classification and behaviour problems (Fagot & Leve, 1998) or there are gender differences in the association between insecure attachments and behaviour problems (Fagot & Kavanagh, 1990; Lewis et al, 1984). If there are differences found in the ‘normal’ population it suggests that these points should also be considered when studying people with learning disabilities. Therefore the studies discussed in relation to people with learning disabilities should be interpreted with even more caution.

Few researchers have studied attachment theory and challenging behaviour in people with learning disabilities and the links made were quite tentative and do not necessarily imply causation. More research is needed to address this gap in our knowledge. The research seems to be in its infancy in the area, but this raises the question about why it is in its infancy as there are clearly useful
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links that could possibly improve the lives of people with learning disabilities through more appropriate services. Longitudinal studies are needed to explore the attachment relationships people with learning disabilities have at various points in their life to see if, and when challenging behaviour occurs. Some individuals will have secure attachments to their attachment figure and still display challenging behaviour and others will have insecure attachments and never display challenging behaviour. These occurrences then need to be explored to look at the contributions of other factors such as economic status, family circumstances and available support.

Conclusion
This essay has drawn on various studies to show how attachment theory might assist in understanding challenging behaviour in people with learning disabilities and guiding interventions. However, the research has a number of limitations, which must be addressed if we are to gain a better understanding of the aetiology and maintenance of challenging behaviour in people with learning disabilities.
References


“Divorce is bad for children”. Critically discuss with reference to the literature on the psychological effects on children of divorce and parental conflict.

Year 2

December 2004
Introduction
I decided to write this essay after the first two weeks of my child placement. All the boys I had seen at CAMHS had experienced parental separation so I thought it would be helpful to read the literature to learn more about the impact of the divorce on their psychological well-being and how this could then be integrated into my formulations and interventions.

Divorce rates
In Great Britain divorce is recognised as a common occurrence. In 2003, 153,500 divorces were granted (Office of National Statistics (ONS), 2004). Of the couples who divorced in 2001, over 55% of them had at least one child under 16 years old, which accounted for a total of 147,000 children (ONS, 2002). If the title of the essay proves to be correct it suggests serious implications for these children and the services available to them.

Structure of the essay
When I first approached this essay before having read the relevant literature, I had a vague plan in mind of how I would write it. This changed with nearly every article I read as the literature was so broad and covered a wide range of discussions. Because of this, some researchers have focused on particular areas, for example, differences between short-term and long-term effects (Hetherington, Cox & Cox, 1985); gender or age differences (see Amato & Keith, 1991 for a review); and mediating factors including family processes such as parental conflict (Amato, Loomis & Booth, 1995). I feel that all of the areas are important but have approached this essay based on my interpretation of the question and the relevance of parental conflict mentioned in the title.

Parental conflict is currently prominent in the research literature and this research has the possibility of shifting the longstanding negative view associated with divorce. The focus of this essay will attempt to discuss the statement ‘divorce is bad for children’ by referring to the literature that examines the effects of divorce on children, particularly the psychological
effects. The essay will draw on research that investigates direct effects of divorce, mediating effects of divorce and other factors which have been considered to have more detrimental effects rather than the divorce itself. Some of the research says divorce results in negative outcomes (Wallerstein & Blakeslee, 1989) whereas other research suggests that it is difficult to explain the effects of divorce as they are dependent on the family circumstances. It may also be difficult to separate the consequences of divorce from the contributing factors as these may also impact on the outcomes for children (Cherlin, Chase-Lansdale & McRae, 1998). These ideas will be discussed in greater detail throughout the essay.

**Divorce is a complex process**

Divorce was initially viewed as a single event which occurred when couples separated. Researchers (e.g. Furnstenberg & Kiernan, 2001) now view divorce as a more complex process which begins long before the separation and continues for many years afterwards. There are often other transitions, for example, 80% of men and 75% of women remarry and 25% of children spend time in stepfamilies before they reach young adulthood (Hetherington et al, 1985). These other transitions and experiences may confound the effects of divorce, suggesting that there may be no simple answer to how children are affected by divorce.

**Reasons why divorce may have negative outcomes**

There are several perspectives on why divorce has a negative impact on children. There are long-standing assumptions that parental separation is always traumatic for children and a two-parent family provides a better home environment than a single-parent family (Vandewater & Lansford, 1998). Amato and Keith (1991) wrote about three theoretical perspectives which are used to explain the negative impact of divorce.

1. Parental absence perspective: as mentioned above it has been traditionally assumed that a two-parent family is better than a single-parent family for a child's development. It is presumed that the negative effects of divorce are attributed to socialisation deficits
resulting from growing up in a one parent family; the quantity and quality of the parent relationship is reduced and there is a lack of a parental model so the child is not learning appropriate social skills including compromising, cooperation and negotiation.

2. Economic disadvantage perspective: a decline in income and standard of living rather than the divorce itself is responsible for the lowered well-being of children. A lack of economic resources increases the risk of developmental problems in children.

3. Family conflict perspective: conflict between parents before and during separation is a severe stressor for children. Conflict also stresses the parents, which makes them less effective at dealing with their children. Children in intact families with high levels of conflict display similar problems to children of divorced parents so it is not the divorce per se; it is the level of conflict.

Another idea expands on the stress mentioned in the family conflict perspective. Divorce is a stressful life transition which children and adults must adjust to (Amato, 2000). The process results in events which are stressful and it is these stressors which increase the risk of emotional, behavioural and health problems. Therefore, if the home environment is stressful, divorce may lower the level of stress and lead to improvements, however, if there are no problems at home and a divorce occurs this may create stress and lead to a deterioration in a child's well-being.

These different perspectives are considered when researchers study divorce as they guide the rationale for the research. In recent years the research has advanced theoretically and methodologically and these factors will be drawn on with relevance to particular studies. There have been two main types of studies that have been used to investigate the negative impact of divorce on children. There are large population studies which include many participants but do not include many detailed questions directly related to divorce and there are detailed small scale studies which usually use a clinical sample and allow psychological analysis to see how the child feels and makes sense of
the experience. Each study has its limitations so the types of studies mentioned will be referred to at a later point in the essay.

**Divorce is bad for children**

During the 1950s when divorce was not considered a major problem, research into divorce was based on the parental absence perspective and focused on the adverse effects of ‘broken homes’ and how the absence of the father impacted negatively on adolescents’ behaviour (Kelly, 2003). The researchers used simple measures and simple statistics and the samples were divided into father present and father absent without indicating why the father was absent.

Wallerstein and Kelly (1980, cited in Wallerstein, 1991) wanted to improve on the quality of the research and illustrate the social and psychological experiences of children who experienced divorce at the time of divorce and during the following years through qualitative methods. They started their research in 1971 with 131 children in California. Parents were referred by their attorney and encouraged by the family court judge. They were offered counselling sessions as a reward for participating. The parents divorced in the early 1970s when their children were aged between 3 -18. The parents were well-educated from predominately white middle-class backgrounds. It was suggested that the children displayed no psychological problems at the start of the study. The families were contacted at 18 months, 5 years, 10 years and 25 years after the start of the study for clinical interviews.

Wallerstein and Blakeslee (1989) wrote a book called ‘Second Chances’ which was written for both the public and professionals and received substantial media coverage. The book discussed the 10-year follow-up study and portrayed a very negative picture of the outcomes for children of divorce. The authors wrote that the children were angry, lonely, worried, underachieving, self-depreciating, and could not make satisfactory relationships. Wallerstein (2004) summarised the 25-year follow-up findings as most children whose parents’ divorced found growing up harder during the
post divorce years. The children were highly anxious and worried about their parents. Their parents also struggled to re-establish economic, social and parenting functioning. Wallerstein (2004) claimed that few children reported happy childhoods and that the main finding was that 'parental divorce impacts detrimentally the capacity to love and be loved within a lasting, committed relationship' (p.363). Also, the children's developmental progress was impeded because of the fear of divorce happening to themselves in the future.

**Critique of Wallerstein**

The results of this 25-year study suggest that they support the view that divorce is bad for children in terms of its negative effects on a wide variety of outcomes. This longitudinal study has however been criticised on numerous aspects of the methodology and claims that it makes. Elliott, Ochiltree, Richards, Sinclair and Tasker (1990) reported that there were three problems with the study:

1. The original sample was not representative of the divorced population. Fifty percent of parents were experiencing psychological problems with 15-20% severely disturbed. Only 5% in the general divorcing population experience disturbance at the time of their divorce. It is also suggested that if the parents have problems, the children are more likely to also have problems.

2. It is unclear to what extent the children's difficulties are related to the parents' divorce rather than other factors. It cannot be concluded that the negative outcomes are a direct result of parental divorce as a comparison group is needed to make that conclusion.

3. The study claims that it is longitudinal but there is no longitudinal analysis. It is largely retrospective with the participants and Wallerstein interpreting experiences in light of the divorce.

The study can also be criticised for overlooking the positive outcomes. 'Second Chances' is very blaming of the parents and only discusses the children's problems which are present in less than half the sample, the majority of the sample are ignored. There are also broad statements made which are not backed up with evidence while other evidence is ignored.
Wallerstein also published a special British edition of ‘Second Chances’ but failed to put the findings within a British context (Elliott et al, 1990). She made the assumption that Californian data can automatically be applied to divorced families everywhere. She does not consider any socio-cultural, legal or economic differences that may shape divorce differently in different countries.

The negative impact of divorce may not be so bad
These points are important and question the reliability and validity of Wallerstein’s study. They suggest that the negative consequences of divorce may not be as bad for children as is portrayed by Wallerstein and her colleagues. Other researchers (e.g. Hetherington, 1989) would agree that divorce is not as detrimental as suggested by Wallerstein and Blakeslee (1989).

Hetherington (1989) discussed the 6-year follow-up from the Virginia longitudinal study that started in 1982. The original sample included 144 well-educated, white middle-class parents and children. They compared divorced and non-divorced families from when the children were four until they were ten years old on standardised tests, interviews and observations from parents, teachers, peers and the child. At the 6-year follow-up, more families were included to provide 30 sons and 30 daughters in the remarried, non-remarried and non-divorced group. During the first two years following divorce, most children experienced emotional distress, relationship problems and problems with their behaviour. After two years the majority of children were adapting reasonably well with great improvements providing there was no further adversity or stress. However boys were more likely to continue to have some externalising problems which decreased if their custodial mother remarried whereas girls experienced some behavioural problems if their custodial mother remarried. Although children experienced difficulties following divorce, Hetherington found that generally there were improvements over time, suggesting the negative impact was not as detrimental as Wallerstein and Blakeslee (1989) suggested.
Hetherington's longitudinal study is not without its limitations, including the use of only well-educated white middle-class families, which are not representative of the general divorcing population. Only part of the study is longitudinal as the new participants introduced at the 6-year follow-up could only be studied cross-sectionally. The children are also fairly young at aged 10 and their behaviour may improve or deteriorate during their adolescence. The study also does not examine pre-divorce behaviour problems so it is unclear whether the problems are a result of the divorce or pre-existing behaviour difficulties.

Due to differing conclusions between qualitative and quantitative research Amato and Keith (1991) conducted a meta-analysis using quantitative methods to estimate the impact of parental divorce on children's well-being across all available studies. The 92 studies varied in their use of control variables and matching participants. However, in two thirds of the studies, it was found that children with divorced parents had lower levels of well-being than children from intact families. The magnitude of the effect sizes were however weak and were smaller for the more recent studies which were methodologically stronger with large random or clinical samples, multiple item measures and the use of controls. The more sophisticated studies produced smaller differences suggesting that the weaker studies overestimated the effects of divorce on children. For example, for psychological adjustment there was a stronger effect size in studies which used a convenience sample, which is weaker methodologically than a random or clinical sample.

The results of the meta-analysis suggest that the data does not support the view that there are no lasting effects on the children following a parental divorce, but the weak effect sizes may be considered trivial. Therefore the view that divorce results in long-lasting detrimental effects on children is also not supported. Amato (2001) updated the meta-analysis by including studies in the 1990s which were methodologically more sophisticated. Again the larger studies and more methodologically sophisticated ones revealed narrower differences between children of divorced and intact families. The
data does however suggest that the gap in psychological and emotional adjustment between children from divorced and intact families was wider in the 1990s than earlier decades. However, the studies are still very unrepresentative of the divorcing population and there are many factors not controlled for and the differences are still relatively small. This may reflect the diversity of outcomes among children in both groups and suggests that the adjustment of children following divorce depends on a variety of factors.

When discussing these results one must consider that there is a bias to publish only studies that have significant results, often researchers ignore the outcomes that are not significant. By focusing on significant findings they can give the impression that the differences between divorce and intact families are greater than they are. This means it is even more important to acknowledge that these studies cannot predict how a child will adjust to divorce, some children may improve in functioning, there may be a modest decline that improves over time in others, there may be a substantial long-term decline in functioning in others or there may be little change.

**Pre-divorce problems**

The above studies suggest that there appears to be a difference in the functioning and psychological well-being of children who experience divorce and those who do not. But the differences are small and there maybe other factors contributing to the differences. One suggestion is that emotional problems are present before the divorce occurs and may even be a contributing factor to the divorce.

Cherlin, et al (1998) and Furnstenberg and Kiernan (2001) studied a British cohort of children born in the first week in March in 1958 until they were 33 in 1991. Cherlin et al (1998) found that there was a statistically significant pre-divorce effect: those whose parents divorced had emotional problems at age seven before the divorce occurred. However, they also found that the difficulties widened as the individuals became older even when controlling for the emotional problems at age seven. This suggests that divorce may have
effects that persist into adulthood. However, the increase in emotional problems may have also been caused by unmeasured characteristics that are correlated with divorce and emotional problems. Furnstenberg and Kiernan (2001) also found that by the time the children of divorce were 33, the effects of the divorce on their mental health were attributable to both differences before the divorce and the events associated with the separation. They concluded that they needed better data to separate the pre-divorce and post-divorce factors.

Mediators, moderators and protective factors

Researchers now accept that divorce has an impact on children but they are unclear about the factors that moderate and mediate an individual’s well-being including possible protective factors. This has led researchers to investigate other contributing factors such as age, gender and nature of the parent-child relationship (Amato and Keith, 1991).

Some of the factors that mediate the long-term outcomes of divorce for children appear to be the multiple life changes that occur following divorce, including changes in economic status, living arrangements, child care arrangements, social relationships, social support networks, family relationships and physical and mental health (Hetherington et al, 1985). One idea is that children may not be able to deal with the stress caused by these events that leads to psychological adjustment problems (Kelly, 2003). Hetherington, Bridges and Insabella (1998) collated the theoretical perspectives linking divorce and remarriage with children’s adjustment into 5 categories of mediating factors.

1. Individual risk and vulnerability, including pre-divorce problems, temperament, age and gender and culture.
2. Family composition, including parental absence, frequency of contact, custody arrangements and step-parents.
3. Stress including socio-economic disadvantage e.g. lack of income and life changes e.g. moving house and school.
4. Parental distress, including ability to care, diminished well-being, response to stress rather than the stress itself.
5. Family process, including conflict and affect and relationship with parents.

It is beyond the scope of this essay to discuss these mediating factors in detail but I feel that it is important to draw on some of the research. There has been a large amount of research looking specifically at the parent-child relationship and the parents' ability to function adequately enough to provide a parenting role and how this may mediate the impact of divorce.

Dunlop, Burns and Bermingham (2001) conducted a longitudinal study in Australia as part of a larger sample. It was found that optimal parenting was significantly related to self-image irrespective of the family structure and that adolescents of divorced families perceived their relationship with their father as poorer than those from intact families. It was found that children from divorced families were more independent and had more awareness of financial reality. They were also just as well adjusted as children from intact families. The authors concluded that if parents provide a positive nurturing role after divorce, adolescents can adapt well but if there is a poor relationship, self-image is likely to suffer. Dunlop et al (2001) reported that it may be these factors that underlie the small differences found in Amato and Keith's (1991) meta-analysis. However, the authors used a small sample size, collected information from only one source, and parents may have given a different view of their relationship with their child.

Kelly and Emery (2003) support the view that a competent, adequately functioning parent is a protective factor and is associated with a positive outcome. Hetherington (1989) found that control and a warm but firm response in a parent was important and having a supportive, predictable parent-child relationship is also a protective factor. These ideas suggest that a poor parent-child relationship combined with a divorce results in an increased likelihood of the child experiencing problems, but due to the parent-
child relationship rather than a direct response to the divorce. This has been evident in an eight year old boy who I am working with in CAMHS. After assessing him for behavioural problems at home and at school it became apparent that his problems started at school a year after his parents separated. His parents thought that this may have been the trigger but after obtaining a more detailed assessment it became clear that he had a very negative relationship with his mother and this was the root of the problem.

Culture is also an important factor but little research has addressed culture as most of the studies are with white middle-class families. Amato and Keith (1991) found that effect sizes are weaker for black children than for white children suggesting that cultural or situational factors may lessen the adverse effects of divorce. Gohm, Oishi, Darlington & Diener (1998) found similar results in a large international study. They looked at ‘individualist’ countries that promoted the individual and ‘collectivist’ countries which promoted having a wide network of support and dependence. Living in a ‘collectivist’ country appeared to lessen the impact of parental divorce and removed the adverse effects of conflict when parents remarried, suggesting that an extended social network provides psychological and emotional support. There are however many other aspects of culture which should be studied to provide greater evidence for the protective element.

Through three longitudinal studies, Hetherington (2003) found that the majority of children are resilient and are able to cope with divorce and become well-adjusted adults. Amato (2000) found that when the protective factors were not present, divorce affected the individuals through the same mediating factors that would be protective factors for others. It is therefore difficult to estimate the relative contributions of all of these factors as all studies vary in their results and risk factors for some may be protective factors for others. So in response to the statement ‘divorce is bad for children’ it appears to have some kind of negative impact but the extent of this is mediated through other factors which make the child either more or less vulnerable to the effects of divorce.
Parental conflict
At the beginning of this essay I mentioned that I would focus particularly on parental conflict. This is a mediating factor mentioned above but it feels to me to be slightly different from the other mediating factors because it has the potential of giving divorce a positive view.

Emery (1982 cited in Jakielek, 1998) suggested that parental conflict may produce childhood problems through 4 processes:

- Child models parents' ineffective conflict resolution styles (aggression or withdrawal in communication with others)
- During the problems, parents practice more inconsistent and harsh discipline which increases children's behaviour problems
- Parental conflict disrupts parental attachment bonds with their children
- Parental conflict serves as a general stressor to a child's environment which can then threaten a child's sense of security

Amato et al (1995) added that parental conflict may also have negative consequences on children because:

- There is an increase in violence between the parent and child
- Stress from the conflict interferes with concentration – and a lack of achievement at school
- The child may blame themselves resulting in a lack of self-esteem and guilt
- The child may be drawn into the conflict which affects relationships in the family

Amato et al (1995) used a 12 year longitudinal study between 1980 and 1992. During the 12 years 42 couples divorced. They found that conflict was negatively associated with children's well-being, but only for children from non-divorced families. Psychological well-being, the quality of intimate relations and support from relations and friends were lowest when low marital conflict was followed by divorce and when high marital conflict was not followed by divorce. They found that the adverse outcomes associated with
high marital conflict that did not result in divorce were more severe than those associated with a high marital conflict that dissolves. This study suggests that the long-term consequences of divorce depend on the level of parental conflict prior to the separation; if conflict between parents is relatively high, children are better off in early adulthood if their parents divorced than if they stayed together. If conflict was relatively low, children were worse during early adulthood if their parents divorced. It is suggested that this may be because the children were unaware of their parent's problems so the divorce was unexpected and the children are therefore more likely to react negatively (Wallerstein & Kelly, 1980, cited in Wallerstein, 1991). Amato et al (1995) concluded that divorce can remove children from a hostile, dysfunctional and perhaps abusive environment.

In this study there were however only a small number of divorce cases and they did not include the experience of divorce before the age of 9. They also did not address the prevalence of pre-divorce childhood behavioural or emotional problems. Booth and Amato (2001) extended the study to have a larger sample with more outcome measures and more sophisticated analysis. During the 17 years there were 85 divorce cases. They found that 20-25% of the participants experienced high conflict during their parent's marriage. They found similar results to Amato et al (1995); when conflict was low divorce was associated with relatively low levels of psychological well-being whereas when conflict was high, divorce was associated with relatively high levels of psychological well-being. They also found that the control variables were not significantly associated with psychological well-being and concluded that most of the effects of divorce were moderated by the level of conflict preceding the divorce. The authors reported that they felt the results may be relatively conservative as not all eligible children were included in the study.

the likelihood of anxiety and depression but it was lower for those whose parents divorced than for those whose parents stayed together. Thus children who remained in high conflict environments had more internalising problems than children whose high-conflict parents divorced. But like Amato et al (1995), Jekielek did not consider the children’s well-being before the divorce or include a very long post divorce time scale. She also used only one source of information and a single measure of conflict.

Buehler, Krishnakumar, Stone, Anthony, Pemberton, Gerard and Barber (1998) and Vandewater and Lansford (1998) studied the association between parental conflict and internalising and externalising problems in children. Buehler et al (1998) found that managing conflict in a hostile way placed children at a greater risk of both internalising and externalising problems. Vandewater and Lansford (1998) found that parental conflict was negatively associated with these problem behaviours and problems with peers whereas whether the parents remained together or divorced did not impact on the children’s well-being. Vandewater and Lansford (1998) however ignored other family processes in their study such as family cohesion, social support and sibling relationships.

Schmidtgall, King, Zarski and Cooper (2000) studied specifically the relationship between the level of family conflict and the prevalence of depression for female adult children of divorced parents. They found a statistically significant relationship between reported levels of family conflict and depressive symptoms but parental conflict was a weak predictor as it explained only 6% of the variance of depressive scores, suggesting that many other factors as well as parental conflict may be contributing to depression in female adults of divorced parents.

Morrison & Coiro (1999) used the same longitudinal sample as Jakielek (1998). They found an association between conflict and divorce and divorce and subsequent behaviour problems. Children whose high conflict parents remained together had a larger increase in behaviour problems than those
whose parents divorced, but among children whose parents divorced, there was an increase in behaviour problems post divorce regardless of whether the child experienced high or low conflict. This study suggests that conflict impacts negatively on children if the parents remain together but had little impact if the parents divorce. This however was not a very representative sample as children were born to young disadvantaged mothers so other factors may have also been contributing to the behaviour problems. This also does not support Gohm et al (1998) who found that being raised by divorced parents was associated with greater life satisfaction than being raised by married parents who engaged in high levels of conflict.

Like all studies there are methodological problems with the studies investigating parental conflict. There are problems with retrospective measures of conflict as they may be biased by a time lapse and the measures often vary between studies. The samples as with most of the divorce literature have not been representative which makes generalisations difficult and they are limited in the controlled variables they use. Amato and Booth (1997, cited in Amato, 2000) also found that only a minority of divorces appear to be preceded by a high level of conflict so divorce is probably beneficial to fewer children than the research implies.

Conclusion
From the presented research it appears that there are differing conclusions but generally there is an interaction between parental conflict and divorce and that divorce may result in a better outcome for children if the alternative option is staying with parents who remain together but are constantly in conflict with one another. However, more sophisticated research is needed that is valid, reliable and representative of the divorcing population. Family structure cannot be ignored in understanding children’s psychological well-being. The negative effects of divorce on children are found consistently, but they are often small and vary depending on other variables. There also appears to be an improvement over time, divorce impacts negatively on the children in the first two years, but in the following years, children begin to function normally.
Kelly (2003) suggests that the current consensus in the United States is that the majority of children whose parents divorce are not distinguishable from children whose parents remain married, and that while divorce clearly increases the risk of negative outcomes for children, differences remain small. In response to the statement 'divorce is bad for children' it appears that over the years the effects of divorce have become more understood but are still complex. Divorce can be bad for children if combined with adversity and other stressors but the majority of children and young adults (75-80%) do not suffer major psychological problems (Kelly & Emery, 2003).
References


Older People Essay

What psychological models, theories and practices are helpful to clinical psychologists when working with instances of suspected and/or actual abuse of older people?

Year 2

August 2005
Older People Essay

Introduction
When I initially conducted a literature search for the topic of abuse of older people, I found numerous articles however, on closer inspection I discovered they were mainly social work and nursing journals and psychology journals played a small role. This surprised me due to the importance of psychological factors in instances of abuse. It appears that research into abuse of older people or elder abuse as I will often refer to, is still in its infancy especially within Britain. It has only been considered a problem since 1988 (Penhale & Kingston, 1997) and in 1991, the minister of health stated that abuse of older people was not a major issue (Richardson, Kitchen & Livingston, 2002). Now there is both general and governmental acceptance that abuse of older people is a problem, which has resulted in the Department of Health document 'No Secrets' (Department of Health; DoH, 2000) which gives guidance on developing and implementing multi-agency policies and procedures to help protect vulnerable adults from abuse. This document is for all adults over the age of eighteen who are vulnerable, so is relevant to older people.

Before I discuss how psychological theories and clinical psychologists can help in instances of suspected and actual abuse it is important to say that although research is limited, the topic is extremely broad and an essay could be written regarding the definition of elder abuse alone or risk factors of victims and perpetrators. These discussions are important however, I will only give an overview so I can focus on the contribution of psychology to the topic area.

Definition of elder abuse
There have been difficulties defining elder abuse. Hallett (1995, cited in Kingston & Reay, pp.427, 1996) explains the difficulties in terms of: ‘ideas of what constitutes abuse change over time and vary from place to place, reflecting differing national problems and professional and societal preoccupations.’ There is no consensus over a single definition so research studies use different definitions. This makes comparisons and developing others’ work almost impossible (Nerenberg, 2000). Recently there has been a
trend to greater inclusiveness in defining abuse (Nerenberg), but as there are many situations in which abuse can occur, Ogg & Munn-Giddings (1993) question how appropriate it is to define several different problems under a single category of elder abuse. Moon and Williams (1993) state that regardless of how elder abuse is defined, it is the perception of the older person of the behaviour and cultural context in which it takes place that are salient factors.

The American Medical Association Council on Scientific Affairs (1987, cited in Welfare, Danzinger & Santoro, p285, 2000) defined elder abuse as 'any act of commission or omission that results in harm or threatened harm to the health and welfare of an elderly person'. Within the UK the Department of Health (2000) suggest that

'Abuse is a violation of an individual's human and civil rights by any other person or persons. Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.' (P. 9, DoH, 2000)

The Department of Health propose that the main types of abuse include physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect and acts of omission, and discriminatory abuse (See figure 1 for summary). Each type can be perpetrated as a result of deliberate intent, negligence or ignorance. Elder abuse suggests the victim is an elderly person. This raises questions about how elder abuse and other types of abuse are different and seems to ignore the complexity and context within which abuse occurs. However this discussion is beyond the scope of this essay.
Figure 1: Summary of forms of abuse (p.9 DoH, 2000)

- Physical abuse - Including hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions
- Sexual abuse - Including rape and sexual assault, or sexual acts to which the vulnerable adult has not consented, or could not consent, or was pressured into consenting
- Psychological abuse - Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks
- Financial/material abuse - Including theft, fraud, exploitation, pressure in connection with wills, property, or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits
- Neglect and acts of omission - Including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating
- Discriminatory abuse - Including racist sexist, that based on a person’s disability, other forms of harassment, slurs or similar treatment

Prevalence of elder abuse

As with defining elder abuse, researchers have experienced problems establishing its extent. Studies have not been generalisable which is partly due to methodological problems, including studies using different definitions (Wilber & McNeilly, 2001), with unrepresentative, small samples, unreliable and invalidated measures and no control groups (Kingston & Reay, 1996). Difficulties estimating the extent of elder abuse have also arisen from a lack of individuals reporting abuse. At present there is no single recording site for agencies to keep a record of those who have experienced abuse.

The few prevalence studies available have found similar results: in Britain, Ogg & Bennet (1992) found 2% of older people experienced physical abuse, 5% experienced verbal abuse and a further 2% experienced financial abuse; and in the US, Wolf (2000) reported that 4-6% of elderly people report experiencing domestic elder abuse, neglect or financial exploitation. These
studies have not looked at all forms of abuse. There has been little reference to ethnicity within prevalence studies (Ogg & Munn-Giddings, 1993). Moon (2000) specifically studied people from ethnic minority groups and reported a high prevalence of psychological abuse and neglect within many of these groups. When studying perpetrators, one study found that approximately two thirds of perpetrators against older adults are family members (NCEA, 1998, cited in Welfare, Danzinger & Santoro, 2000). Generally, studies investigating elder abuse are in relation to abuse within a family context. Abuse also occurs within institutions and self-abuse is also important to consider. Abuse within institutions is rarely studied (Wilber & McNeil, 2001) and the research available is not empirical or scientifically credible (Lachs & Pillemer, 2004). Therefore, for the purpose of this essay I will mainly focus on abuse within the family context.

Role of the clinical psychologist
The diverse skills of clinical psychologists mean that they can be involved at various stages of suspected or actual abuse, so depending on their role they will draw on different theories, models and practices. They can be involved at both clinical and service levels. At a clinical level, when clinical psychologists are working with older people or even families in general they can suspect abuse is occurring, so can be involved at the identification stage. Once abuse has been identified either by themselves or others, psychologists can help manage the risk and provide suitable interventions for the older person, perpetrator, both or the whole family system. At a service level, clinical psychologist can be involved in the development of policies, research into abuse of older people and the dissemination of information through training and consultation with other professionals and agencies. Within this essay I will explore how psychological models, theories and practices can assist clinical psychologists at each of these stages in relation to abuse of older people. Firstly though, I will discuss the theories that have been suggested to help explain and understand abuse of older people as the theory will influence both the assessment and the intervention used.
Theories of elder abuse

Much of the research conducted to understand abuse of older people has been based on research regarding child abuse and domestic violence (Wilber & McNeilly, 2001). Initial studies attempted to establish a typical victim or perpetrator by exploring risk factors. Early studies suggested that characteristics of the older person (Ogg & Munn-Giddings, 1993) were associated with abuse then later studies consistently reported that it was the characteristics and circumstances of the carer that were more predictive of abuse (Marriott, 1997). Many of the risk factors identified have been developed into theories to help understand elder abuse. However, there are conflicting findings and as the theories are still in the early stages of development caution must be taken with interpretations.

The situational stress theory, thought to be the leading cause of abuse, suggest that the risk factor stress, is associated with caring for an older person. A carer becomes overburdened with demands and stress and cannot deal with it, so resorts to abuse. This model blames the victim. There is however, little evidence to support this theory. Grafstrom, Nordberg and Winblad (1992, cited in Kingston & Reay, 1996) were the only researchers to find a higher level of stress in those who had been abused compared to the control group, however this was in the context of difficult patients who were also violent and aggressive. Wolf (2000) suggests that there is evidence that caregiver stress is not a core factor leading to abuse. She notes that it is important but should be incorporated into a wider context. Whittaker (1997) argues that the model is not an adequate theoretical framework to explain abuse of older people because it locates the abuse firmly in the family and fails to connect the personal or interpersonal dynamics of the abuse to the wider environment including political and structural processes which reinforce and support the abusive situations. Brandl (2000) follows the domestic violence literature and suggests that responding to a carer stress model could cause more damage as it reinforces and colludes with the abuser that the older person is difficult to manage and it is their fault. Brandl argues that
stress is not an acceptable justification for abusive behaviour and so cannot explain abuse.

A second theory has developed out of the dependency of older people on their carers and what this means for their relationship. Social exchange theory explains how individuals attempt to maximise rewards and minimise punishments in their interactions and they expect rewards to be reciprocated. When this does not happen the relationship is likely to end, however within family relationships this is often not possible and can result in conflict or abuse which may be seen as justified, especially if an older person is dependent, vulnerable and powerless and has little to contribute or reciprocate (Gelles, 1983, cited in Suitor & Pillemer, 1988). This model fits the child abuse framework which assumes the victim is vulnerable and dependent on family caregiver for physical, emotional and financial support. Pillemer (1985), however argued that because abuse only occurs in a small number of families, a direct correlation between dependency of an older person and abuse cannot be assumed. Pillemer found that those who were abused were no more impaired or dependent than those in the control group. Instead the abuser was found to be more dependent on the victim in four areas: housing, household repair, financial assistance and transportation. He found that financial dependency of the abuser may be an especially crucial predictor of violence. Finkelhor, (1983, cited in Pillemer, 1985) noted that abuse can occur in response to perceived powerlessness, so linking this family violence literature with the carer’s dependency on the older person the carer may feel that they lack control and power due to their dependency so attempt to restore power, but have few resources to do this so resort to violence.

An alternative theory has developed from the carer experiencing abuse themselves. Social learning theory explains how behaviour is learned within the family and transmitted from one person to another. The intergenerational transmission of violence suggests that abuse is a learned behaviour, the carer having grown up in an abusive family learns to deal with situations with violence so re-enacts the cycle of violence once their parent become
dependent on them. This idea is based on the child abuse and domestic violence literature. But there is little evidence of this within elder abuse studies (Wilber & McNeilly, 2001) as none of the studies involving control groups have substantiated this finding. Homer and Gilliard (1990) found that instead of an intergenerational transmission of violence there was a history of long-standing abusive relationships that continued into later life.

Studies that have included comparison groups all seem to find support for the psychopathology of the caregiver theory (Wilber & McNeilly, 2001). There is evidence that the psychopathology of the carer is associated with them abusing the older person they are caring for; caregivers having mental health or alcohol problems (Homer & Gilliard, 1990) puts older people at risk from abuse. However, it is still unclear the direction of the difficulties, Anetzberger, Horbin and Austin (1994, cited in Kingston & Reay) queried whether alcohol removes inhibitions which results in abuse or whether the individual's tendencies towards alcoholism mean the individual turns to alcohol to deal with the stress of the caring situation.

Two other theories which have been studied but less often commented on are the double-directional violence theory where both the carer and older person are abusive to each other; and the social isolation theory which suggests that those socially isolated are more at risk from abuse. Homer and Gilliard (1990) looked at both theories and found that a violent behaviour by an older person with dementia was associated with a violent response by the carer but did not find evidence for the social isolation theory, others have found support so more research is needed.

Kingston and Reay (1996) concluded from four US studies, one British study and one Swedish study that there is substantial evidence that both the intra-individual dynamics of the carer (psychopathology) and the dependency of the carer on the older person are risk factors in terms of possibly abusing older people. They concluded that intergenerational transmission of violence and stress were not risk factors however a potential risk factor was longstanding
domestic violence that continues into later life. There was very mixed evidence about whether social isolation was a risk factor so further research is needed. Homer and Gilliard (1990) also found that different types of abuse were attributed to different explanations so the findings are still inconsistent which may be due to their cross-sectional and retrospective nature. Clinical psychologists are likely to hold several of these theories in mind when meeting clients so they can be alert to possible high risk situations whatever theory they are attributing to the situation.

Assessment Stage
The first stage that clinical psychologists are likely to become involved with instances of abuse is during the assessment. If abuse is suspected it is hoped that the multi-disciplinary team will work together and involve relevant outside agencies and follow the local team’s procedures. Therefore, if a psychologist suspects abuse they would refer it to the team and discuss the situation in supervision rather than attempting to investigate it alone. It is important that all relevant information is shared appropriately and that the allegations are examined thoroughly and professionally. Clinical psychologists have a role at this stage both in terms of assisting with the assessment but also in thinking about the processes that are occurring within the team and also within the family. There may be assumptions made about the family and the reasons for the abuse that may wrongly direct the investigation. Using psychological theories and knowledge psychologists can think about why the referral has happened now and whether there are stereotypes or ageism occurring within the team or family members. Having the skills to self-reflect means that psychologists are aware of their own feelings regarding the abusive situation but can also then relate these feelings to how others may be feeling. Psychologists will be aware that cognitive dissonance (Festinger, 1962) may be occurring either within professionals or family members where they know the abuse is occurring but it does not match their view of the family so they try to reduce the discomfort these feelings cause by ignoring that the abuse is occurring. It is also important to consider how the system itself is working and in whose benefit the system is aimed at.
By considering all these systemic issues and processes, psychologists are in a good position to act as an advocate to ensure that the needs of the older person and their family are met. Social impact theory (Latane, 1973, cited in Marriott, 1997) proposes that individuals in groups may make less effort than if working alone, therefore it is important at the assessment stage that responsibility is shared and all team members are aware of who is doing what and the timescale for the investigation, psychologists can facilitate this role or take the extra effort needed for something to happen so that all views and suggestions are considered.

Clinical psychologists will follow procedures for assessing abuse but will be able to draw on their professional skills and knowledge to enhance the assessment process. Drawing on the models mentioned earlier and being aware of risk factors, psychologists use this background information to ask certain questions to gather the relevant information. The assessment process including who is present, the language used and questions asked may depend on the orientation of the psychologist, for example a clinical psychologist who works systemically may see all family members together and ask circular questions to explore what each family member thinks about the situation, alternatively a psychologist who works within a cognitive behaviour framework may ask about thoughts, feelings related to the identified behaviour, whereas a behavioural psychologist would conduct a functional analysis assessment enquiring about antecedents, behaviours and consequences. Regardless of the model used to guide the assessment, clinical psychologists will work in a way that will gather all the important information to understand the context and assess the risk while at the same time building a rapport with the older person and/or their family or carer. Clinical psychologists are regarded as having good assessment skills and these are vital in instances of suspected and/or actual abuse. From my own clinical experience there are skills that I feel are particularly helpful in these instances. Psychologists can play a significant role in establishing a relationship with the family by creating a safe space for discussing difficulties in a non-threatening, non-blaming environment. Using basic counselling skills such as listening, empathy, warmth and genuineness,
psychologists allow the client to feel listened to and not judged. This is very important in situations where people do not want to admit to doing or feeling something that they may perceive as being seen as wrong by others. This therapeutic relationship creates opportunities for open discussions so that the psychologist and client can explore relevant information that may have not been discussed before because it was considered too difficult.

Psychologists ask open questions to obtain a full understanding of the problem and the context surrounding the problem, this is important with instances of abuse so that appropriate action can be taken. A thorough psychologically lead assessment would include enquiring about a lot of information. See figure 2 for a summary of the information required. Cultural aspects of the older person and his/her family are particularly important to collect, especially values or practices that may hinder the safety, dignity or well-being of older people or those that contribute to the well-being (Moon, 2000). Cultural practices and beliefs may determine the definition of abuse, whether it is reported and what is considered an acceptable intervention (Nerenberg, 2000). It is therefore important to be aware of differing views to one's own, or the system within which one works to be able to meet the needs of the client. During the assessment the psychologist would be aware of what was not said as well as what was said, s/he would observe the person’s non-verbal language and would draw on the transference relationship, that is paying attention to the feelings brought about in oneself that the client may be projecting on to the psychologist.
Figure 2: Summary of information collected during an assessment

- Problem behaviour – what it is, in what form, duration, frequency, intensity, antecedents, consequences and maintaining factors
- Coping strategies – what helps, what does not help
- Thoughts, attitudes and beliefs surrounding the abuse – intent of the abuser, reasons attributed by the victim, the meaning attached to the abuse, cognitive coping strategies for dealing with the abuse
- History of victim and abuser including psychological/psychiatric problems and functioning
- Relationship history – changes, dependency, roles within the relationships and power balance
- Family rules – how they function and communication systems within the family
- Social context – living arrangements, environmental strains, financial situation, other family members and friends involved
- Cultural context – practices, cultural beliefs surrounding abusive behaviour
- Other relevant information

A core skill of a clinical psychologist is formulating (Harper, 2003) this is integrating knowledge of the problem from the assessment process, and is often based on certain theories and models, such as those mentioned in the previous section. Formulating is an ongoing process which involves developing hypotheses, testing them out and developing new hypotheses. The hypotheses will depend on the theory that is influencing the thinking. As psychologists hold many theories in mind at one time, the formulation is often very flexible and changes regularly. If the hypothesis is wrong, psychologists will draw on other theories and the provided information to develop new hypotheses. The problem with this is that often psychologists try to fit the assessment information into a particular model rather than using multiple models to understand the behaviour. A way of formulating which I have found useful is to have a more general formulation including predisposing, precipitating, maintaining and protective factors and for each, think about the personal, interpersonal, situational, social and socio-cultural factors that may interact or link with the other factors. In addition to this model, I would explore all relevant specific models that may assist in the understanding of the
problem. This approach to formulating may be helpful in instances of abuse so that they can be discussed with the client to see which one they think best explains their situation. They can then guide the intervention.

**Intervention Stage**

Once the initial assessment process is completed the findings should be fed back to the team for discussion regarding the most appropriate intervention. This should be guided by the assessment and formulation, however it is good practice to involve other team members so that interventions are not duplicated or omitted. At this stage it is also important to consider whether the criminal justice system is likely to be involved. At present within Britain there are no laws for professionals to report elder abuse to the police. This is because older people are considered to have the capacity to decide what actions they want taken themselves. There is much discussion about this idea, but unfortunately beyond the scope of this essay. If legal action is however taken it may result in an intervention having to wait until the legal procedures are completed.

All interventions should be tailored to the individual needs of the family. Moon (2000) suggests that in ethnic minority communities combing cultural specific with general prevention and treatment may be most effective. The aim of the intervention may be to facilitate change or maintain safety in the current situation by providing extra resources. Although interventions should be tailored to individual needs, the theory guiding the formulation will often direct the intervention. Figure 3 gives examples of interventions that could be offered based on the theories mentioned earlier. Anetzberger (2000) suggests that through protecting, empowering and advocacy, professionals need to react to the emergency, offer support, rehabilitate and prevent future abuse. Using psychological theories, models and practice clinical psychologists are able to respond at all of these levels.
In addition to the interventions mentioned above, clinical psychologists can use their knowledge of recommended treatments for other problems and apply these to older people and their families. If the older person or carer is reluctant to treatment, motivational interviewing techniques (Miller & Rollnick, 2001) can be implemented to explore the ideas about changing and the benefits and costs of accepting treatment. Clinical psychologists may be asked to work individually with older people, which may involve treating psychological difficulties resulting from living in an abuse environment such as feelings of depression, post-traumatic stress disorder, learned helplessness or alienation (Wolf, 1997). Wolf suggests that these stem from maltreatment however there have been no investigations in relation to elder abuse. Psychologists should still consider these hypotheses and treat appropriately. Cognitive-behavioural therapy is the recommended treatment for depression (National Institute of Clinical Excellence, 2004) and has also been found to be effective at treating the elderly (Dick, Gallagher-Thompson & Thompson, 1996). Assertiveness training and problem solving based on cognitive and behaviour ideas could also benefit older people in preventing future abuse by creating confidence in them. A psychologist’s role may also be to empower older people to take back some control and power (Brandl, 2000), a strong therapeutic relationship and empathic listening can assist with this. Other work with older people may involve processing the abuse and coming to terms with the abuse, again psychologists can draw from the child abuse and

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**Figure 3: Interventions led by theories**

- **Situational stress theory** – sympathises with carer/abuser: offers carers support, aims to reduce stress
- **Social exchange theory** – offers social support for both carer and older person; attempts to combat ageism and the devaluation of older adults
- **Social learning theory** – focus on family counselling and support
- **Psychopathology of abuser** – involvement of the criminal justice system, treat alcohol problems or depression
domestic violence literature to assist in this type of intervention (Nerenberg, 2000).

If the intervention is with the carer only, there are a number of psychological models that can guide the intervention. Stress management techniques and relaxation and/or attempts to improve coping skills (Homer & Gilliard, 1990) can be taught if the carer reports difficulties with stress. If the carer has psychological problems such as anger, depression or alcohol addiction then appropriate treatments and models can be used. Psycho-education such as teaching carers about the development of ageing and what is typical of people in older age would be particularly important with the aim of carers viewing older people more positively. By acknowledging the difficulties of caring and providing support there should be an improvement in the quality of the carer (Giordano & Giordano, 1984).

Marriott (1997) suggests that understanding and supporting the psychological aspects of the elder/carer relationship may be as necessary as providing practical support which is why a systemic approach to working with the family or elder/carer in instances of elder abuse is likely to be suitable. Psychologists can help family members share and understand elders' difficulties, expectations, disappointments and misunderstandings to help generate specific plans to improve relationships (Moon, 2000). This approach does not see older people as the problem; instead it is the context of the family and relationships which is the problem. The family as a system contains the problem but also the resources to solve the problem (Gilliard, 1996). Having worked with older people I can imagine that working with relationships rather than abuse may be more inviting for families because it reframes the reason for their attendance more positively.

Service level
In addition to intervening at a clinical level, clinical psychologists have the skills to influence the service level. They can have a central role in developing theories and conducting research to provide a greater understanding and
evidence-based treatments for elder abuse. Using psycho-education and group processing theories (Yalom, 1995) psychologists can provide suitable groups and training events to teach professionals how to work with reluctant or resistant clients (Nerenberg, 2000) in addition to the phenomenon of elder abuse. Richardson et al (2002) found that an educational course was superior in increasing knowledge to printed information sheets about ways to deal with elder abuse. Brandi (2000) also suggests the importance of teaching the family violence literature to social workers so that they do not always assume the carer-stress model, which she describes as being detrimental on some occasions.

If clinical psychologists become involved at a policy and service provision level they can suggest that psychological input is always available when families are considering becoming carers. Often carers are unaware of the difficulties and commitments involved. Psychologists can inform families about how to care for people age appropriately and manage associated stress. Having the opportunity to discuss concerns and expectations in a supportive therapeutic relationship before the role begins, may be a way of preventing abuse from occurring. Menio and Keller (2000) agree that it is not just about managing stress it is also important to change attitudes, making them more positive towards older people.

Ethical considerations
When researching for and writing this essay I was struck by how many ethical questions were raised but answers not available. Although my essay structure does not allow complete exploration I feel it is important to mention my concerns with regards to these issues. Firstly, my own experience of working within older adult services has been one which is heavily dominated by the medical model; there is also a lack of psychologists working within this area. This raises my concerns about whether we as a profession are in fact neglecting the psychological needs of older people and whether psychologists within the teams need to be more assertive in ensuring psychological needs are met. Secondly, as already mentioned the cultural context influences every
part of elder abuse from the definition to societal response (Lachs & Pillemer, 2004), therefore it is likely that a psychologist and the service will have differing views of abuse to older people and their family or carers. In such instances of differing views and suspected abuse it is crucial that other professionals are consulted so the team agrees an action. It may raise questions that challenge one's own views and these should be discussed in supervision. Similarly, with there being no laws regarding elder abuse, psychologists may struggle with wanting to help older people who do not want help so these issues will need to be worked through. I am also aware that I have only briefly mentioned that institution abuse and self-abuse occur. Much of what I have mentioned can be applied to these areas especially training, but further research in the area is warranted. The last point I would like to make is related to services and how they are set up. Usually within older adult services professionals work with the older person alone or jointly with the family, if the family alone needs input this may have implications for funding.

Conclusion
Within this essay I have attempted to show how particular psychological theories, models and practices have a role within instances of suspected and actual abuse while at the same time trying to raise issues related to the lack on knowledge on elder abuse. All countries appear to be at different stages in terms of understanding, prevention and interventions of elder abuse (Sijuwade, 1995). It is acknowledged that research is in its infancy but that psychologists still have a role. However clinical psychologists promote evidence-based practice and as the evidence is not available does it suggest that they should not see clients, and are in effect neglecting older people themselves by not providing a service? I do not think so because despite the lack of research in elder abuse and the need for longitudinal and empirical studies, there is plenty of research in other areas that can be adapted and this should not be discounted. It just means that psychologists still have a long way to go to provide evidence-based practice in all areas of their work.
References


Older People Essay


Clinical Dossier
Summary of Case Reports
**Summary of Adult Mental Health Case Report**

**A cognitive-behavioural intervention for a 48-year old female with depression and an associated somatic problem.**

**Presenting problem**
Mrs Smith was a 48 year old White British lady referred to the Community Mental Health Team by Liaison Psychiatry for cognitive-behavioural therapy (CBT) for her anxiety and depression. Mrs Smith presented with an involuntary movement, experienced in the form of her arms, fingers, legs and feet shaking and making jerking movements. She also experienced voice loss for up to 3 days at a time during what she described as a ‘full-blown flap’, which was when she had no control over very extreme shaking and jerking of her whole body. These ‘flaps’ occurred when she had no control or something unexpected happened, including loud noises such as fireworks. She reported that a continuous moving of the leg was a release which stopped the movements becoming more pronounced. Mrs Smith acknowledged that her mood was low and that she was a worrier, but she found it difficult to truly express her feelings and emotions.

**Formulation**
Mrs Smith’s problems were best described within a general cognitive model (Beck, 1995).

*Predisposing factors*
Mrs Smith was raised in a strict family; her father was violent when disobeyed. She learnt early in life that she needed to protect herself and her mother from her father. She did this by complying and volunteering to do things that pleased him. As she grew up, she became the person who her family could rely on as she had learnt that pleasing others made her own life easier, this included doing everything for her husband and children. This meant her family took advantage of her not wanting to say no. Mrs Smith never spoke about her emotions. She would shut off her emotions to herself and others so everyone saw her as the strong one.

*Precipitating Factors*
Mrs Smith was experiencing a number of stresses in her life including her husband wanting to move house and her children constantly bickering. Mrs Smith’s siblings were also making requests of her and Christmas was approaching. Beck et al (1979) would argue that these stressful events were in parallel with the experiences which were initially responsible for Mrs Smith’s negative thoughts and so the negative assumptions were activated by these precipitating factors.

**Trigger**

Mrs Smith had an argument with her husband. She became angry, threw objects around the house and screamed at her husband. The shaking started in response to her calming down.

**Maintaining Factors**

Mrs Smith had a number of negative automatic thoughts in response to her problems, for example, 'I should cope with things better', 'I should be stronger' and 'I am lazy'. These with her other responses set up the vicious circles. She continued to try to do everything for her family and would not say no to requests from her siblings. Mrs Smith’s shaking also became worse in situations when she felt overwhelmed so she avoided seeing or speaking to people so that she did not have to cope with the situation.

All of the above factors resulted in Mrs Smith feeling depressed and annoyed about her situation. Her mood remained low and her shaking continued especially in situations when she had no control. This was also confounded with her general anxiety.

**Intervention**

Mrs Smith attended 10 of the 11 sessions offered. Sessions were not always kept to plan as it was important to keep Mrs Smith engaged. Mrs Smith was very resistant to change, therefore the resistance had to be worked through and treatment goals were continually revaluated. After socialising Mrs Smith to the CBT model behavioural strategies were discussed. We discussed an activity schedule to increase enjoyable activities rather than just doing chores for the family. Mrs Smith was adamant this was not possible. This was also reflected in the BDI-II and BAI she was given to do at home but did not
complete because they were something for her and others’ needs came before hers. Mrs Smith had difficulty accessing her thoughts so she practiced self-talk at home so was gradually able to identify her thoughts. Mrs Smith found challenging her negative thoughts very difficult, she was able to decide on an alternative thought but it did not make her feel better because her thinking was still with her original thought. She also did not complete the behaviour experiments or homework tasks. Two major themes discussed in therapy were guilt and avoidance.

Outcome
Mrs Smith engaged very well in therapy and learnt to describe her thoughts and emotions. This meant she was able to recognise her symptoms of depression. During the initial sessions, Mrs Smith’s legs and fingers would constantly move. Gradually this stopped, resulting in Mrs Smith attending full sessions without involuntary movement. Mrs Smith appeared more comfortable in sessions, she was also expressing her emotions verbally so her body did not need to do it for her. Mrs Smith’s ‘flaps’ did not disappear but she learnt strategies to avoid them and to calm herself down, for example, leaving situations when the twitching began to stop it escalating. Mrs Smith and I felt that she had improved remarkably; she was able to talk about her emotions and link her feelings to her thoughts and behaviours. She knew she needed to make certain changes in her life which would affect others but lift the depression. Mrs Smith returned to the psychology waiting list to be seen by my supervisor for long-term therapy. In the meantime she was referred to massage therapy to reduce some of the muscle tension from the shaking and agreed to practice the cognitive techniques learnt during therapy to maintain her improvements. Although Mrs Smith was unable to challenge her negative thoughts in the time available, she was aware of the skills needed. Therapy resulted in her seeing that change was needed all around and that it was not solely her problem. Mrs Smith completed the BDI-II and the BAI during the final session. Her BDI-II score remained within the severe depression range whereas the BAI scored reduced from severe anxiety to moderate anxiety.
Summary of People with Learning Disabilities Case Report

A Behavioural Social Skills Group for Adults with Mild to Moderate Learning Disabilities

Nine clients with learning disabilities were referred to a social skills group because they were experiencing particular social skills difficulties. The clients were assessed for the group to ensure that it would meet their needs. The individual difficulties ranged from inappropriate body language to not interacting with their peers.

Formulation

Individual formulations for each group member would be purely speculative therefore the formulation presented focuses on why people with learning disabilities need social skills training and how this is best delivered including the benefits of a group and the specific techniques used.

It is unclear why people with learning disabilities have social skills deficits, Kavale and Forness (1996) found 75% of students with a learning disability had social skills deficits when compared to non-disabled peers. Social skills deficits are important to recognise because they can have such a negative impact on many areas of a person’s life, for example social and academic achievement (Parker and Asher, 1987). They have often been the cause of people with learning disabilities being unable to establish and sustain meaningful relationships (Holley, 1980). It has also been found that social deficits could result in long-term psychological and social adjustment needs (Gresham and Elliot, 1989, cited in Brown, Hedinger and Mieling, 1995). Extensive research has demonstrated that social skills training is both practical and effective, (Andrasik and Matson, 1985). Howlin & Yates (1999) looked at the effectiveness of social skill groups for adults with Autism. One year after the group, the families reported improvements in conversational and social skills, appearance, self-confidence and general independence. Howlin & Yates (1999) concluded that social skills training groups can play significant roles in developing more appropriate social skills.
Social skills training based on behavioural techniques has been found to be successful. Bornstein, Bach, McFall, Friman and Lyons (1980) looked at improving eye contact, posture or quality of speech whereas Matson and Senatore (1981) looked at more complex tasks, for example asking and answering questions, introductions and listening to others. Both studies found improvements in the skills. Groups can work well for people with learning disabilities because each individual learns from the other group members, this reduces the power struggle that can sometimes be present between a client and therapist and moves the individual away from being in a dependant role. The group also empowers individuals because they are not in a dependent role (Cole, 1989).

**Intervention**

The social skills group ran for 6 weekly sessions of two hours. There was a follow-up session one month after the final session. The sessions included a definition of social skills, how and why we communicate, non-verbal communication, expressing feelings, conversation skills, listening and relationships. All sessions included introductions and a game, reviewing goals, a review of the previous week, the main topic, a summary of the topic and a key point to take away.

Modelling and role-play was used as well as continually repeating what was discussed. We demonstrated a bad social skill and asked the group how to improve it before group members demonstrated an effective way of using the skill. Frith and Frith (1982) used this method because they found that demonstrating the problem helped the clients see what the problem was so they could make it better. One session was also spent going into the community to practice the skills in-vivo. Howlin and Yates (1999) suggested that a limitation of social skills groups is that the skills are not transferable into the natural environment. We tried to transfer the skills by using the community in the group.
Outcome

Nine clients attended the first session. There were five men and four women. Over the course of the group there was a 75% attendance rate. General observations of the clients showed that there was an overall improvement in confidence and concentration for all clients. They listened more as the group progressed with less inappropriate interruptions. Anxiety also improved for two of the clients which resulted in them making comments without being prompted, which would have previously been too difficult. All group members made steps towards achieving their goals but future teaching was needed to help them maintain and improve on their achievements.

Six of the nine clients completed a feedback questionnaire. All six clients reported to enjoy the group and found the role-plays useful. Five said they would like to come to another group and would tell their friends to come along. They were all able to remember some of the things we discussed during the group and when asked for other comments five clients made a comment about the usefulness of the group. Comparing the pre- and post-group assessments there were mixed results. Very little could be interpreted from the results because of the subjective nature of the assessment.
Summary of Case Reports

Summary of Child and Young People Case Report

An Extended Assessment of a Thirteen Year Old Boy Experiencing Multiple Difficulties at Home and School.

Presenting problem

Ishmael Monks was a twelve year old boy who described his ethnicity as White British and his religion as Muslim. His first language was English and he also spoke Arabic. Ishmael was referred to the CAMHS team by his GP for an assessment of dyspraxia and by the school for an assessment of his social and communication difficulties.

Dyspraxia was not mentioned by Mrs Monks. She was concerned about Ishmael’s behaviour being difficult to manage, particularly his obsessions with cars and buses and his anger. Mrs Monks was also worried that Ishmael had difficulties understanding what was said to him and taking on information. The school were concerned about Ishmael’s increasingly obsessive behaviour and his pacing of the corridors. They were also concerned about his lack of understanding and anger and felt that his mood was unpredictable. Ishmael’s class teacher had difficulty managing him.

Formulation

Ishmael was a twelve year old boy with significant language difficulties. It was thought that his communication difficulties were more problematic in unstructured settings than in structured ones. It was clear that Ishmael had language difficulties however it was not clear whether these difficulties were commensurate with his cognitive skills or whether he had specific language impairments. Ishmael’s behaviour problems may have resulted from his language difficulties but they could also result from deficits in social development (Carr, 1999), therefore further investigations were needed.

More information was needed about Ishmael’s comprehension difficulties and his overall cognitive functioning to understand where his particular difficulties lied. A more thorough assessment was also needed to explore whether there
was an underlying social and communication disorder that could better explain Ishmael's language problems, behaviour difficulties and obsessions, as a triad of deficits in social development, language and behaviour typifies an autistic spectrum disorder (Carr, 1999).

Extended assessment
Understanding Ishmael's social and communication skills, behaviour and anger, involved a lengthy process and included: a cognitive assessment, a school observation, discussions with school staff, meeting with Ishmael, an interview with Mrs Monks and a multi-disciplinary meeting.

The cognitive assessment was completed in three sessions. Initially Ishmael was reluctant to engage, after much encouragement he engaged in the tasks but needed continual prompting and praise. On the WISC-III, Ishmael performed within the extremely low to average range suggesting a large variability in his cognitive skills. This large variability in his scores meant the full scale IQ score would not be a meaningful measure of his overall ability. His verbal skills were mostly in the extremely low range including his understanding of vocabulary, general knowledge and abstract verbal reasoning, and his non-verbal skills ranged from extremely low to average and did not form a unitary construct. Ishmael's literacy skills indicated by the WORD were poor, showing a 5-6 year delay in reading comprehension. These test results supported the speech and language assessment; although Ishmael had cognitive difficulties, he had specific language difficulties indicated by his low verbal and literacy skills.

The school observation was to gain insight into the difficulties Ishmael was displaying at school. I observed Ishmael for 30 minutes during his lunchtime and one hour of a lesson. Ishmael's behaviour was reported to be no different from any other time so it was thought that the observation was a reliable source of information. The observation demonstrated that Ishmael responded better to structured time than unstructured situations. During unstructured time Ishmael struggled in his interactions with peers. During the lesson there
were no outbursts, but it was noticeable that Ishmael had difficulties expressing his emotions appropriately when frustrated, and that the situation could easily escalate out of control if he did not feel the teacher acknowledged his stress.

I had lengthy conversations with Ishmael’s class teacher, learning support worker, and the deputy head to understand in greater detail their concerns regarding Ishmael. These discussions helped to inform the formulation. Engaging Ishmael was difficult, however when I mentioned cars he became animated and described complex details about car engines and how bus doors work. He was chatty and able to follow the conversation but struggled to answer directly to questions. Ishmael gave very little eye contact throughout the conversations but used appropriate facial expressions when he became excited or distressed.

My supervisor and I conducted an interview to obtain more general background information and specific information regarding his social and communication skills. In addition to gathering the relevant information about Ishmael’s social and communication skills we explored the family history and current situation in greater detail. There appeared to be cultural differences within the household that resulted in inconsistent management of Ishmael’s behaviour as well as Ishmael using his father’s background against him if he disagreed with him. During the interviews it became clear that Ishmael had many longstanding social and communication difficulties that were less noticeable at school and could not be picked up in a short structured formal setting.

**Outcome and recommendations**

After the information was collected there was a meeting between myself, my supervisor, the speech and language therapist and the psychiatrist. We discussed our separate assessments and came to a joint decision, agreeing that Ishmael met the criteria for an autistic spectrum disorder. We met with Mrs Monks to discuss the findings and offered to meet with Ishmael, however,
Mrs Monks said she would prefer to speak with him. Mrs Monks was not surprised with the findings and expressed her frustration and anger that it had taken 13 years to diagnose. She also expressed some relief that she now understood his difficulties better.

Mrs Monks was provided with an information pack about autistic spectrum disorder and invited to attend a parent support group. She was also offered psychology sessions for psycho education and to discuss behaviour management and given guidelines for communicating with Ishmael based on his cognitive and language difficulties. Ishmael was also referred to an occupational therapist for assessment of coordination and motor skills in response to the suggestion of dyspraxia.
Summary of Older People Case Report

A neuropsychological assessment of a 75-year-old Irish gentleman who was concerned he had Alzheimer’s disease.

Presenting problem
Mr Murphy, a seventy-five year old Irish man was referred to the psychology team of the community mental health team for older people for a psychometric assessment because Mr Murphy expressed concerns that he could be at the early stages of Alzheimer’s disease. Mr Murphy said his mother and maternal uncle had died with Alzheimer’s disease and was worried that his memory difficulties were indicative of him developing Alzheimer’s disease as well. He reported to suffer from word finding difficulties, for example remembering only two of four alternative names of a flower. Mr Murphy reported that he becomes extremely frustrated with his memory difficulties. He has been aware of his memory difficulties for the past three to four years but there has been no indication of deterioration over this time. Mr Murphy reports that his wife and children did not think he had significant memory problems. They attribute it to him getting older.

Background information
Mr Murphy was medically well; he had worn a hearing aid for twelve years and wore glasses. He was married with three children. He had a successful career in management and sales training and continued to lecture for charities and took tours at local gardens after he retired.

Hypothesis
It was hypothesised that Mr Murphy would have no significant memory difficulties that would be indicative of Alzheimer’s disease instead his word finding difficulties would be in line with an age-related decline in memory.

Assessment
The 'neuropsychological battery' created by the Trust in which I worked was used. This was created as a standard procedure combined with the WAIS-III
(Wechsler Adult Intelligence Scale – Third Edition; Wechsler, 1997) and was based on the neuropsychological literature. Nussbaum (1998) suggested that a brief neuropsychological evaluation should assess general intellect, attention and concentration, memory, visuoconstructional skills, language, executive functions, motor skills and mood. All areas of functioning except for mood are included within the battery. This battery was able to give a general understanding of Mr Murphy's functioning and allow his memory skills to be compared with his other areas of functioning. In addition, the WAIS-III was chosen to assess Mr Murphy's current cognitive functioning.

Findings
Mr Murphy was well groomed and wore smart-casual clothes. He was articulate and able to follow conversations easily. The results of the WAIS-III indicated that Mr Murphy was a highly intelligent man obtaining a very superior full scale IQ score, better than 99.5% of the population. These scores were higher than Mr Murphy's predicted premorbid intellectual functioning based on the NART, on which he performed at a level of high average.

On the neuropsychological battery, Mr Murphy's performance ranged from average to very superior, so further testing was conducted including the Behavioural Assessment of the Dysexecutive Syndrome (BADS), which assesses executive functioning. This was because the initial symptoms of Alzheimer's disease are often memory impairment and executive functioning deficits (Fields, 1998). In addition, Mr Murphy's working memory was significantly lower than his verbal comprehension and working memory deficits and difficulties learning can be due to executive functioning deficits (Malloy, Cohen & Jenkins, 1998). The WTAR (Wechsler Test of Adult Reading; Wechsler, 2001) was also used as it is standardised with the WAIS-III and Mr Murphy's performance on the NART was well below that of his performance on the WAIS-III. It was hoped that the WTAR would produce a score closer to that of Mr Murphy's functioning on the WAIS-III. Mr Murphy performed at
average ability on the BADS and his WTAR score was not helpful in predicting a WAIS-III score.

Results from the CT scan showed that Mr Murphy had bilateral patchy ischaemic areas in the corona radiate, but more extensively on the right. There are also mild involutional changes present and heavy calcification of the internal carotid. Mr Murphy was told that these results were nothing to worry about at present as they are often seen in the aging population, however, the doctor would wait for the neuropsychological results before completely eliminating dementia.

Discussion
The results suggested a deterioration in Mr Murphy's functioning. His overall cognitive ability was very superior however some areas of his memory and executive functioning were below this. Particularly, working memory was significantly worse compared to his verbal skills. Mr Murphy's organisational and planning skills were not as good as they were in the past given Mr Murphy's occupation and past career successes that relied often on his organisational and time management skills. Executive functioning deficits can result in working memory difficulties (Malloy et al, 1998), but the memory difficulties may have been more noticeable to Mr Murphy because organisation and planning had not been a large part of his life since he retired in 1992.

At this stage there was no indication that Mr Murphy is suffering from Alzheimer's disease. Although I hypothesised that he did not have Alzheimer's disease, I suggested that his difficulties were age-related which does not appear to be the case given the results. The ischaemic patches on the CT scan may suggest that there are some vascular changes which could indicate the beginning of vascular dementia, however at this stage it is still unclear. Mr Murphy's word-finding difficulties had been present for 3-4 years without deterioration so it is unknown whether these areas of functioning will
decline further in the future. The results were passed on to Dr Matthews to diagnose if she felt it was appropriate and to monitor any future changes.

**Recommendations**

Mr Murphy had the intellectual ability to compensate for his difficulties, however strategies such as repetition, reducing distraction, using memory aids, breaking tasks down and relaxation were thought to be beneficial to help Mr Murphy overcome his frustration with regards to his memory difficulties. A repeat assessment in one year was suggested.
Relapse prevention using cognitive and behavioural techniques for a
34-year-old White British lady with a Dihydrocodeine addiction.

Presenting problem
Ms Sally Peters, a 34-year-old, White British lady was referred to the Drug
Outpatient Clinic for her addiction to Dihydrocodeine. She was referred for
Psychology input by the Associate Specialist within the team, to complement
the medical treatment she was receiving. Ms Peters was prescribed
Dihydrocodeine for endometriosis, which was diagnosed approximately ten
years previously. She noticed that Dihydrocodeine had become a problem
when her youngest daughter was critically unwell. She began to take the
tablets for other purposes as well as pain relief including feeling anxious,
stressed or having lots to do.

Ms Peters had previously attempted to become abstinent from
Dihydrocodeine. Her first attempt was in April 2002, however she was
discharged in December 2002 due to an increase in pain. Ms Peters re­
genengaged with the team in December 2003 and reduced her dose to two
tablets a day. She was discharged back to her GP in August 2005. She
managed this dose while on a daily prescription, however, when the
pharmacist changed and the prescription became weekly, Ms Peters
experienced difficulties managing the prescription and finished the prescription
before the end of the week so took painkillers in addition to the
Dihydrocodeine.

Formulation
Ms Peters’ use of Dihydrocodeine is best described by the cognitive model of
substance misuse by Beck et al (1993). This model of addiction suggests that
an individual is most likely to use drugs after experiencing particular triggers,
which may include internal triggers such as emotions, physical states or
external triggers such as interpersonal conflict. The triggers may activate
believes that result in a process leading to drug use. According to Beck et al’s (1993) model Ms Peters appears to have three different sets of beliefs that lead to the use of Dihydrocodeine. The first set of beliefs are core beliefs about herself based on past experiences e.g. ‘I am a failure’. These may also be drug related, developed through repeated Dihydrocodeine use and maybe relief-orientated, that is, expecting to cope better with drugs e.g. ‘I can cope if I take the tablets’. Once Ms Peters’ core beliefs are activated by internal or external triggers, she experiences negative automatic thoughts (2nd set) about her reaction to the situation, such as ‘don’t be so stupid’. These automatic thoughts may lead to increased urges and cravings for Dihydrocodeine, so Ms Peters experiences the third set of beliefs (‘permission-giving thoughts’) that give her permission to take the tablets, such as ‘just take the tablets and you will feel better’. Ms Peters then takes the tablets which reinforces the belief that they make her feel better and that she needs them to cope, thus strengthening the cycle.

**Intervention**

Ms Peters was offered six sessions due to time constraints, she attended five of these. She engaged well with therapy and we built a good therapeutic relationship in a short period of time. Combining Beck et al’s (1993) cognitive model of substance misuse and Marlatt and Gordon’s (1980, as cited in Marlatt, 1985) relapse prevention model the sessions focused on a number of strategies. This included: cognitive restructuring of Ms Peters’ negative automatic thoughts, specifically those related to Dihydrocodeine; and skills training, assessing high-risk situations and building a repertoire of alternative coping strategies. There was also a focus on pain management, which involved relaxation training and applying the cognitive restructuring to thoughts related to pain. Two themes evolved during therapy; firstly, it appeared that anxiety was very closely linked with Ms Peters’ high-risk situations and her concerns around reducing the dose and secondly, Ms Peters felt that she did not have a good relationship with her eldest daughter and that she was a bad mother to her; this was explored.
Outcome
Ms Peters appeared more relaxed as each session progressed and could give examples of times when she had challenged her thoughts. Ms Peters no longer used other tablets in addition to her Dihydrocodeine and managed to refrain from using the Dihydrocodeine when she was on morphine following the operation. Ms Peters had also learnt to put herself first in terms of her relationship with her partner. She asked him to leave as he refused to get a job and was causing her stress. In the past she would not have been able to be so assertive, as the separation would have caused her distress. However, she reported that she now had skills to manage her distress which she previously lacked. Ms Peters also enquired into a cake decorating course at college and was waiting to hear about returning to work part-time.

Ms Peters completed the BDI-II and the BAI at the beginning of therapy and during the final session. Her BDI-II score reduced from ‘moderate’ depression to ‘mild’ depression and her BAI score reduced from a ‘mild to moderate’ level of anxiety to anxiety within ‘normal range’. Ms Peters was very pleased that there was such a change in a short period of time.
Overview of Clinical Experience
Overview of Clinical Experience

**Adult Mental Health Placement**

**Setting**
This placement was set in a Community Mental Health Team.

**Models**
The main theoretical model was cognitive behavioural.

**Range of experience**
Clients were both male and female, from mixed cultural and socio-economic backgrounds and their age ranged from eighteen to sixty-two. Presenting problems included anxiety, depression, unresolved grief, psychosis, anger problems, self-harm, personality issues, self-image, vomit phobia and psychosomatic difficulties. I spent a shift on the acute psychiatric ward. I conducted a service-related audit into the ethnicity of referrals to the psychology and psychiatry services. I attended child protection training, risk assessment training and a training day exploring team working and working with change.

**People with Learning Disabilities Placement**

**Setting**
This placement was set in a Community Team for People with Learning Disabilities, and was split between two different teams.

**Models**
The models used included behavioural, cognitive behavioural and systemic.

**Range of experience**
Clients were both male and female and their age ranged from nineteen to seventy-nine. All clients were White British except for one person who described herself as Black-Caribbean. Presenting problems included challenging behaviour, bereavement, anger, depression, ADHD, deterioration in skills, anxiety, relationship issues and social skills. I conducted a number of cognitive assessments including assessments of dementia. I co-facilitated a social skills group with a community nurse, I was also involved in consultations with residential staff and I attended an inter-agency vulnerable adults meeting.
**Overview of Clinical Experience**

**Child and Young People Placement**

**Setting**
This placement was set in a Child and Adolescent Mental Health Service.

**Models**
The models used on this placement included cognitive behavioural, social learning, systemic and attachment theory.

**Range of experience**
Clients were both male and female from mixed cultural and socio-economic backgrounds and their ages ranged between three and fourteen. I conducted assessment and interventions with children and their families. Presenting problems included posttraumatic stress disorder, anxiety, behaviour problems, social and emotional difficulties, ADHD, autism and anger problems. I conducted observations in school. I gave a case presentation at the psychology meeting and I was involved in teaching teachers about selective mutism. I attended a workshop on motivational interviewing with adolescents.

**Older People Placement**

**Setting**
This placement was set in a Community Mental Health Team for Older People.

**Model**
The models used on this placement were lifespan perspective, cognitive behavioural, and systemic.

**Range of experience**
I worked in the community and on a functional ward and organic ward with both males and females who were predominately White British and Middle Class and their age ranged from sixty-six to ninety-four. Presenting problems included depression, psychosomatic pain, bereavement, memory loss, anxiety and obsessive-compulsive disorder. I conducted neuropsychological assessments and co-facilitated a dementia group with an occupational therapist. I gave a presentation at the psychology CPD meeting and taught residential staff about mental health problems and behavioural management.
Specialist Placements

Setting – first specialist placement
The placement was within addiction services and split between an outpatient team, a community drug team and a detoxification in-patient ward.

Model
The models used on this placement included cognitive behaviour, psychodynamic and motivational interviewing.

Range of experience
Clients were both male and female from a diverse socio-economic background but predominantly White British. Ages ranged from twenty-one to fifty-six. As well as individual assessments and interventions, I co-facilitated a coping skills group. Most clients were seen for motivational interviewing followed by relapse prevention for a variety of drug addictions including heroin, cocaine, cannabis and alcohol. Associated difficulties were also addressed including dual-diagnosis, anxiety and relationship difficulties.

Setting – second specialist placement
The placement was split between a Child and Adolescent Mental Health Service and an Independent Service, funded jointly by health and social services that assesses whether children should be returned to their parents' care.

Model
Both settings apply attachment theory to the presenting problems. Cognitive behaviour therapy is the main model of therapy used at the CAMHS setting.

Range of experience
CAMHS – I conducted assessments and interventions with children and their families aged between four and sixteen years old. I have conducted joint work with my supervisor, a child psychotherapist and a systemic family therapist. Presenting problems included temper tantrums, sleep difficulties, anxiety, self-harm, behaviour difficulties and family relationship difficulties.

Independent service – I have been involved in joint interviews with parents, children and relevant others and have observed children’s play and interactions with others.
Research Dossier
Service Related Research Project

An investigation into the ethnicity of those referred to psychiatry and psychology services within a community mental health team.

Year 1

June 2004
Acknowledgements

The author would like to thank a number of people for their assistance and time dedicated to helping with the study. Firstly, many thanks to the community mental health team in which the study took place, particularly the administrators for helping gather information and locating case notes. Thank you to the manager for allowing the study to occur and to field supervisor for all his support. The author would also like to thank university supervisors and tutors for their support and assistance with the overall project.
Abstract

The government has made reforms implemented by the Department of Health to improve the accessibility of services for people with mental health problems. Black and ethnic minority groups have been found to be disadvantaged in their access to services (Bhugra, La Grenade, and Dazzen, 2000, cited in DoH, 2003). Black service-users are also more likely to be medicated than referred for talking therapies such as psychological therapy (Fernando, 1988).

This study hypothesised that within a community mental health team, black and ethnic minority groups would be less likely to be referred to psychology services than their majority white counterparts.

The study involved a clinical audit of all 327 referrals made to the community mental health team between January 1st 2003 and December 31st 2003. Information was collected from the relevant case notes. Details of participants' ethnicity, gender and age at date of referral were collated along with reason for referral and who referred the participant to the service.

Statistical analysis using a chi square test found there was no significant difference between the ethnicity of participants (that is white or non-white) and whether they were referred to psychiatry alone or both psychiatry and psychology. This implies that the hypothesis is not supported and white and non-white service users are equally represented within the service. Further analysis found a significant result between the age of participants and whether they were referred to psychiatry or psychiatry and psychology. The results were discussed with their implications for the service and wider system.
Introduction
There is evidence suggesting that services are not adequately meeting the mental health needs of all ethnic groups (Department of Health (DoH), 1999) and that there are significant barriers to certain groups of people seeking and successfully accessing these mental health services, including ethnic minorities (Bhugra, La Grenade, and Dazzen, 2000, cited in DoH, 2003). This issue is an important part of the National Health Service (NHS) reforms.

National Service Framework
The National Service Frameworks (NSF) (DoH, 1999) are part of the government's agenda to improve health and social services. The NSF for Mental Health sets standards to address the mental health needs of adults and is founded on 'knowledge-based practice' by both those who provide and use the services. It has 3 aims:

- 'Sets national standards and defines service models for promoting mental health and treating mental illness
- Puts in place underpinning programmes to support local delivery.
- Establishes milestones and a specific group of high-level performance indicators against which progress within agreed time-scales will be measured.'

(DoH, 1999, P5.)

NSF Standards
The NSF sets standards in five areas which are evidence-based and supported by examples of good practice and service models. For example, Standard one is about mental health promotion and reducing the discrimination against people with mental health problems. Standard two suggests that anyone who contacts their primary care team with a mental health problem should be offered effective treatments which includes referrals to specialist services for further assessment and treatment and Standard three wants anyone with a mental health problem to be able to make round the clock contact with the local services that will meet their needs. These NSF
Service Related Research Project

standards require that everyone should have equal access to mental health services. The other standards are not relevant to the current study.

Prevalence of Mental Illness

Once ethnic minority groups have made contact with their general practitioners and have been referred on to specialised services there appears to be an over-representation of African-Caribbean men being diagnosed with a psychotic illness. Bhui, Brown, Hardie, Watson and Parrott (1998) conducted a study in Brixton Prison and found that Black British, Black Caribbean and Other groups showed a significantly higher prevalence of schizophrenia in comparison with the White group. As well as having higher rates of psychotic illnesses, African-Caribbean men are also more likely to be admitted to hospital under the Mental Health Act and admitted to secure units relative to the white population (Nasroo, 1998 cited in DoH, 1999). Fernando (1995) sees the over-diagnosis of schizophrenia among Black people as a racial bias.

Inequality in Accessing Talking Therapies

The Department of Health suggest that people should have a choice in the type of treatment they receive. Within most community mental health teams, psychology input is available as well as psychiatry input so that service users can access talking therapy in addition or as an alternative to medication. However, there appears to be a discrepancy in the ethnicity of those who are referred to and access talking therapy. African-Caribbean men are more likely to be treated by medication rather than therapies such as psychotherapy and counselling (Fernando, 1988). Faulkner (1997, cited in Bird, 1999) conducted a survey for the Mental Health Foundation and found that 70% of respondents had received talking treatments which included 75% of the white respondents compared with only 45% of the African Caribbean respondents. Littlewood and Cross (1980, cited in Littlewood and Lipsedge, 1988) also found that West Indians were seldom offered psychotherapy but were more likely to be given electroconvulsive therapy and higher doses of medication.
Ways Forward
The NSF suggested that in order for mental health service to meet all ethnic groups’ needs, the services must work in partnership with the local communities and involve the service users. However, the government felt that the NSF standards did not adequately address the needs of black and minority ethnic groups so they produced a document, ‘Inside Outside’ (DoH, 2003) which aimed at making proposals to improve the mental health services for black and minority ethnic groups.

Current Study
The author felt that because equal access to services particularly for ethnic minority groups is an important topic, especially within the NHS and that she was working within a diverse community, it would be useful for the service to investigate whether the diverse community were using the service. The current study will examine the referrals to a local community mental health team and look at the representation of ethnic groups referred to the service. In relation to the audit cycle (Barker, Pistrang and Elliott, 2002) this study will be at the third stage, that is comparing practice with standards so that necessary changes can be made for the service.

This study will aim to assess whether people from black and ethnic minority groups are at a disadvantage. It will investigate whether they are being referred to talking therapies in terms of psychology input as well as psychiatry input, within a service which has both services available. The study will hopefully enable the service to continually improve in meeting the needs of the local community by identifying areas which may benefit from a change in practice.

Hypothesis
Service users from black and ethnic minority groups are less likely to be referred for psychology input than the majority white service users.
Exploratory Research Question
The community mental health team was also interested in participants’ age, gender, why they were referred and who they were referred by, to gain a greater understanding of the population they were reaching.

Method
Design
The study was a case note audit.

Setting
The study was based at a community mental health team, a second tier service offering assessment, treatment and support to service users with severe and enduring mental health problems. All of the data was collected from case notes in the team base or from the medical records department.

Participants
Every person who was referred to the community mental health team between January 1st 2003 and December 31st 2003 was included in the study. There were 327 participants, 46.2% were male and 53.8% were female. The age ranged from 17 years to 74 years with a mean of 39.4 years. Participants stated their own ethnicity as; 71.9% White, 8% Asian, 5.8% Black and 2.8% other ethnicities. There were 38 (11.5%) participants whose ethnicity was either not collected or not stated.

Procedure
The study was discussed with the team and consent was given by the manager for data to be collected. Ethical approval was discussed but not needed because the study was a clinical audit. All referrals made to the team were inputted onto a database by the administrator. A list of all referrals made between 1st January 2003 and 31st December 2003 was printed from the database and the relevant case notes were located from the team base or medical records if the case was closed to the team. At the front of the notes was a referral form which was completed by the professional who initially saw
the service user at the assessment. Each participant was given an identity number, demographic information such as gender, date of birth, ethnicity (as stated by themselves), date of referral, reason for referral and source of referral was collated from these forms and inputted into SPSS Statistical Package, version 11.5. Anonymity of all participants was kept at all times.

Statistics
A chi square test is a non-parametric test. It was used to identify a relationship between the ethnicity of participants and whether they were referred to psychology and or psychiatry. A chi square test was used because the independent variable that is, the ethnicity of participants was categorical data. Unfortunately the sample sizes were too small for some of the analysis so descriptive statistics were also presented.

Results
There were 18 categories participants could choose for their ethnicity, based on a list devised by the trust (Appendix 1). For the sample size to be large enough for a statistical test the categories were collapsed into white and non-white. The category for which service participants were referred to was also collapsed into psychiatry alone and psychiatry and psychology. There was no significant difference between ethnic groups in the proportion of participants referred to psychiatry alone or both psychiatry and psychology ($\chi^2 (1, n = 280) = 0.505, p = 0.477$). See table 1 for the frequencies of which service participants were referred to and their stated ethnicity.

TABLE 1: Frequency Table of Ethnicity and Service Referred to.

<table>
<thead>
<tr>
<th></th>
<th>Psychiatry</th>
<th>Psychology + Psychiatry</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>182 (77%)</td>
<td>53 (23%)</td>
<td>235</td>
</tr>
<tr>
<td>Non-white</td>
<td>37 (82%)</td>
<td>8 (18%)</td>
<td>45</td>
</tr>
<tr>
<td>Total</td>
<td>219</td>
<td>61</td>
<td>280 (85.6%)</td>
</tr>
</tbody>
</table>
A chi square test was conducted to investigate whether participants seen by psychiatry alone or both psychiatry and psychology were of different ages or of different genders and whether they were referred by different sources. There was no significant difference between the proportion of men and women referred to psychiatry alone or both psychiatry and psychology ($\chi^2 (1, n = 327) = 0.001, p = 0.970$) or the proportion of those referred by their GP or from another source ($\chi^2 (1, n = 327) = 0.965, p = 0.432$). See tables 2 and 3 for the respective frequencies. There was a significant difference between the ages of participants referred to psychiatry alone and those referred for both psychiatry and psychology input ($\chi^2 (2, n = 327) = 8.060, p = 0.018$). Follow-up tests showed that the 37-55 age group were significantly more likely to be referred to psychiatry than both psychiatry and psychology compared with the 17-36 age group ($\chi^2 (1, n = 279) = 8.045, p = 0.005$). There was no significant difference between the younger age group and the older age group ($\chi^2 (1, n = 206) = 0.785, p = 0.376$) or between the middle age group and the older age group ($\chi^2 (1, n = 169, p = 0.216$). See table 4 for the frequencies. The highlighted numbers represent the significant difference.

**TABLE 2: Frequency Table of Gender and Service Referred to.**

<table>
<thead>
<tr>
<th></th>
<th>Psychiatry</th>
<th>Psychology + Psychiatry</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>119 (79%)</td>
<td>32 (21%)</td>
<td>151</td>
</tr>
<tr>
<td>Female</td>
<td>139 (79%)</td>
<td>37 (21%)</td>
<td>176</td>
</tr>
<tr>
<td>Total</td>
<td>258</td>
<td>69</td>
<td>327</td>
</tr>
</tbody>
</table>
### TABLE 3: Frequency Table of Source of Referral and Service Referred to.

<table>
<thead>
<tr>
<th>Source of Referral</th>
<th>Psychiatry</th>
<th>Psychology + Psychiatry</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>238 (78%)</td>
<td>66 (22%)</td>
<td>304</td>
</tr>
<tr>
<td>Other referral</td>
<td>20 (87%)</td>
<td>3 (13%)</td>
<td>23</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>258</td>
<td>69</td>
<td>327</td>
</tr>
</tbody>
</table>

### TABLE 4: Frequency Table of Age and Service Referred to.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Psychiatry</th>
<th>Psychology + Psychiatry</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 -36 years</td>
<td>115 (73%)</td>
<td>43 (27%)</td>
<td>158</td>
</tr>
<tr>
<td>37-55 years</td>
<td>105 (87%)</td>
<td>16 (13%)</td>
<td>121</td>
</tr>
<tr>
<td>56-74 years</td>
<td>38 (79%)</td>
<td>10 (21%)</td>
<td>48</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>258</td>
<td>69</td>
<td>327</td>
</tr>
</tbody>
</table>

Chi square tests were also used to compare the gender, age and source of referral across the ethnicity categories. There was no significant difference between the two ethnicity groups in terms of and their gender ($\chi^2$ (1, $n = 280$) = 1.138, $p = 0.286$) their age ($\chi^2$ (2, $n = 280$) = 2.056, $p = 0.358$) or the source of the referral ($\chi^2$ (1, $n = 280$) = 2.221, $p = 0.138$). See tables 5, 6 and 7 for the respective frequencies.

### TABLE 5: Frequency Table of Ethnicity and Gender.

<table>
<thead>
<tr>
<th>Gender</th>
<th>White</th>
<th>Non-white</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>105 (81%)</td>
<td>24 (19%)</td>
<td>129</td>
</tr>
<tr>
<td>Female</td>
<td>130 (86%)</td>
<td>21 (14%)</td>
<td>151</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>235</td>
<td>45</td>
<td>280</td>
</tr>
</tbody>
</table>
TABLE 6: Frequency Table of Ethnicity and Age.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>White</th>
<th>Non-white</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-36 years</td>
<td>110 (83%)</td>
<td>23 (17%)</td>
<td>133</td>
</tr>
<tr>
<td>37-55 years</td>
<td>84 (82%)</td>
<td>18 (18%)</td>
<td>102</td>
</tr>
<tr>
<td>56-74 years</td>
<td>41 (91%)</td>
<td>4 (9%)</td>
<td>45</td>
</tr>
<tr>
<td>Total</td>
<td>235</td>
<td>45</td>
<td>280</td>
</tr>
</tbody>
</table>

TABLE 7: Frequency Table of Ethnicity and Source of Referral.

<table>
<thead>
<tr>
<th>Source of Referral</th>
<th>White</th>
<th>Non-white</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>219 (85%)</td>
<td>39 (15%)</td>
<td>258</td>
</tr>
<tr>
<td>Other</td>
<td>16 (73%)</td>
<td>6 (27%)</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>235</td>
<td>45</td>
<td>280</td>
</tr>
</tbody>
</table>

It was not possible to use a chi square test to compare why participants were referred with their ethnicity and which service they were referred to. This was because all the assumptions of a chi square test were not met; the expected frequencies were less than 5 cases in each cell making the test invalid. There were a total of 31 different reasons why participants were referred (Appendix 2). Four reasons accounted for 66.9% of participants. The most common referral was depression (37.6%), followed by a psychotic episode (12.8), anxiety was next (8.9%) followed by anxiety and depression (7.6%). The other 27 reasons jointly accounted for the remaining 33.1% of referrals. See table 8 for a breakdown of the four main referrals along with the ethnicity of the participants and which service they were referred to.
TABLE 8: Frequency Table of Reason for Referral, Ethnicity and Service Referred to.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Service</th>
<th>Total</th>
<th>Psychiatry</th>
<th>Psychiatry &amp; Psychology</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Non-white</td>
<td></td>
<td>11 (11%)</td>
<td>102 (83%)</td>
<td>21 (17%)</td>
<td>123</td>
</tr>
<tr>
<td>Depression</td>
<td>88 (89%)</td>
<td>99</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td>21 (58%)</td>
<td>15 (42%)</td>
<td>36</td>
<td>38 (90%)</td>
<td>4 (10%)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>25 (93%)</td>
<td>2 (7%)</td>
<td>27</td>
<td>19 (66%)</td>
<td>10 (34%)</td>
</tr>
<tr>
<td>Anxiety &amp; Depression</td>
<td>19 (86%)</td>
<td>3 (14%)</td>
<td>22</td>
<td>20 (80%)</td>
<td>5 (20%)</td>
</tr>
</tbody>
</table>

Discussion

The results show a number of points which are important for the service in which the study took place. Participants' stated ethnicity fell into 13 different groups but a sample of 327 did not allow for them all to be included within the analysis. Collapsing the groups into white and non-white provided a large enough sample for the analysis but reduced the specificity of the results. The hypothesis has not been supported as there was not a significant difference between ethnic groups in the proportion of participants referred to psychiatry alone or both psychiatry and psychology services. Twenty-three percent of white participants were referred to psychiatry and psychology services compared to eighteen percent of the non-white population. This suggests that the white and non-white service users are equally represented in both the psychiatry and psychology services of the community mental health team.

Caution must be taken when interpreting these results. Although there are similar proportions of white and non-white participants referred to both psychiatry and psychology, the results do not tell us anything about whether
this is representative of the local community. Known service users may be equally represented but the results can not be generalised to the community or population as a whole. There may also be individual ethnic minority groups that are either over-represented or under-represented in their referrals to the service however a much larger sample size would be needed to investigate this.

The gender of participants did not influence whether they were referred to psychiatry alone or psychiatry and psychology services. There was no significant difference suggesting that both sexes have equal access to psychiatry and psychology services. The source of referral also did not influence who participants were referred to. The majority of referrals (93%) were from general practitioners (GPs). They referred 78% of participants to psychiatry alone and 22% to psychiatry and psychology. This suggests that they are aware of the services available and use their discretion in deciding where to refer patients. It may useful if GPs and other staff had regular training in how different mental illnesses can present in people of different ethnicities and cultures to ensure that illnesses can be identified early and treated appropriately.

The 37-55 age group were found to be significantly more likely to be referred to psychiatry than both psychiatry and psychology and more likely to be referred to psychiatry than the 17-36 age group. It is difficult to know the reason for these results, there could be confounding variables not controlled for. The 37-55 year olds may not be referred to psychology very often because of the type of their presenting needs. They may have more frequent relapses than the younger group and so are referred to the psychiatrist who saw them previously for continuation of care. To improve the opportunity of these people accessing psychology services there needs to be general training sessions for all possible referrers about psychology services and how they can benefit adults of all ages. The service users themselves also need to be aware of the benefits of psychology. This significant result is based on splitting the ages into 3 equal groups of age ranges. Having equal numbers of
participants in each group may have given rise to different results, however to study this further was not within the remit of this study but would be interesting for future studies.

For all reasons for referral there were more referrals made to psychiatry than both psychiatry and psychology suggesting that psychiatric treatment is the treatment of choice for all problems in this sample. When looking at the relationship between the ethnicity of participants and the reason for their referral, it can be seen that 42% of non-white participants were referred for psychosis. This is an over-representation as only 16% of non-white participants were referred. Although a diagnosis is unknown in this study, these results are similar to that of Bhui et al (1998). Further analysis would be needed to examine who in the non-white group are over-represented.

The results indicate that the hypothesis was not supported; non-white service users are just as likely to be referred for psychology input as the majority white service users. The study can not provide specific information regarding black and other ethnic minority groups because of the small sample size. Nor can these results be generalised to other years or services. There was only one significant result, that being 37-55 year olds were significantly more likely to be referred for psychiatry than both psychiatry and psychology services compared to the 17-36 year olds. The reasons for this difference can be speculated upon but are unclear.

This study is not without its drawbacks. The data is based on information collected from a secondary source which means that there may be inconsistencies and errors not known about or accounted for. There was 11.5% of the ethnicity data missing which may have had changed the results if available. This missing data makes the results more tentative. Initially data was also sought on the social class, religion, occupation and diagnosis of participants to observe any other relationships with the service people were referred to, however this information proved difficult to obtain. To improve future studies of similar intent it would be important for the researcher to
collect all the data from the participants involved rather than case notes. This however would have serious implication for time, resources, consent and ethical issues. A larger sample would also be needed so that various statistical tests can be carried out on all of the data.

Although the results are tentative, this study is positive for the service involved. From the information available it appears that the white and non-white service users equally represent psychiatry and psychology services within the community mental health team. There does not appear to be discrimination in which the non-white participants are less likely to be referred to psychology than their white counterparts. The service can use this study along with the NSF standards (DoH, 1995) and 'Inside Outside' (DoH, 2003) as a benchmark to improve upon. The community mental health team should take the responsibility of providing training for the relevant people regarding the presentations and effects of mental health problems and the appropriate services available for people of all ethnicities and across the lifespan. This training will assist in disseminating information about mental illnesses so that people are more aware, appropriate referrals can be made and people from ethnic minority groups will be less likely to be discriminated against. To assist in these improvements, the findings will be presented to the team (appendix 3) so that they can take things forward and provide the relevant training.
References


Bird, L. (1999). The Fundamental Facts.... All the latest facts and figures on mental illness. The Mental Health Foundation.


APPENDIX 1: Ethnicity categories
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</tr>
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<td>APA</td>
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</tr>
<tr>
<td>BLC</td>
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<td>MIXED WHITE AND BLACK CARIBBEAN</td>
</tr>
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<tr>
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<td>OTHER</td>
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</tr>
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APPENDIX 2: Reasons for Referral Categories
### Reasons for referral

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<tr>
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<td>Anxiety and depression</td>
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<td>Psychotic episode and drug abuse</td>
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<td>Mental illness and personality issues</td>
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<td>Manic episode</td>
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<td>Eating disorder and personality issues</td>
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</tr>
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<td>PTSD, anxiety and substance abuse</td>
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<td>Agoraphobia and psychosis</td>
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<td>Self image issues and depression</td>
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<td>Post-natal depression</td>
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<tr>
<td>Depression and alcohol abuse</td>
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<tr>
<td>Depression and psychosis</td>
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</tr>
<tr>
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<td>0.9</td>
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<tr>
<td>Violent behaviour</td>
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<td>1.2</td>
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<tr>
<td>Depression and drug abuse</td>
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<td>1.8</td>
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<tr>
<td>Stress-management</td>
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<td>0.3</td>
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</tbody>
</table>
APPENDIX 3: Letter Confirming Feedback to the Service
24th August 2004

Danielle Gooblar
19 Inverness Road
Worcester Park
Surrey
KT4 8PT

Dear Danielle

Thank you for coming to feedback the result of the audit you carried out into the ethnicity of referrals to Psychology and Psychiatry services within the CMHT.

I would be grateful if you would send me a copy of the summary of the research by email.

Many thanks,

With best wishes,

Yours sincerely

Dr Tom Barker
Clinical Psychologist
Morden Community Mental Health Team
Major Research Project

Ambivalence and Readiness to Change in Anorexia Nervosa

Year 3

July 2006
I would like to thank all of the participants who participated in my major research project. I am particularly grateful to the Eating Disorder Service at Heatherwood Hospital, Berkshire Healthcare NHS Trust, especially the clinicians who invited participants to participate and to the Eating Disorder Association who very kindly assisted with the recruitment of participants and without them the research would not have been possible. I am most grateful for the support I have received from my supervisor, Dr Martin Carroll during the development and completion of the research project. I thank him for his patience, encouragement and enthusiasm in keeping me interested in the research. I also thank him for his dedication and commitment to the research. I would also like to thank my research tutor, Fiona Warren for all her assistance and support with the research methodology.

Finally, I would like to thank my friends and family for their proof reading, patience and support throughout the research project and for providing me with love and encouragement during stressful times.
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Abstract
People with anorexia nervosa are considered difficult to treat and ambivalent about change (Vitousek et al., 1998).

Objective
The purpose of this study was to examine ambivalence in relation to various aspects of anorexia nervosa and its relationship with the decisional balance (Cockell et al., 2002) and stages of change (Prochaska & DiClemente, 1982).

Method
Sixty-two participants completed a stage of change questionnaire, decisional balance scale, the eating disorder examination-questionnaire and an ambivalence measure, which assessed both ambivalence-conflict (e.g. conflicting thoughts) and ambivalence-distress (e.g. discomfort with the conflicting thoughts). Participants were allocated into the precontemplation (n = 7), contemplation (n = 14), action (n = 17) or maintenance stage group (n = 21) based on responses on the stage of change questionnaire and compared on the other measures.

Results
Ambivalence-conflict did not significantly differ across the groups. Ambivalence-distress showed the same pattern across the stages of change but some of the differences were significant. Interestingly, the pattern of means was identical for ambivalence-conflict, ambivalence-distress and the decisional balance subscales (i.e. burden score and benefit score).

Discussion
There were two main points of discussion. Firstly, the results confirmed the difference found by previous research (Cockell et al., 2003) between participants in the precontemplation stage group and contemplation stage group. Secondly, ambivalence appears to be relevant in all stages of change and it would be beneficial for research to examine ambivalence further in the stages of change.
Introduction

1.1. Overview

It is well documented that people who suffer from anorexia nervosa struggle to change their eating behaviour and restore their weight (Loeb and Wilson, 1998). This resistance to change has resulted in people with anorexia nervosa being characterised as difficult to treat and work with psychologically (Murphy & Manning, 2003). It has also lead to a focus on understanding motivational processes in anorexia nervosa and to the development of motivational treatments to facilitate change. Fundamental to motivational approaches is the movement from a position of not seeing there is a problem to a position of recognising there is a problem, and eventually to making changes. Within eating disorders, the process has been examined with Prochaska and DiClemente’s (1982) stage of change model, where a person moves through different stages related to change (i.e. precontemplation, contemplation, action and maintenance) and with the decisional balance (i.e. burdens and benefits of anorexia).

Explicit in research on motivation is the idea that the experience of ambivalence is necessary for change. Ambivalence is the experience of having conflicting thoughts or feelings about a situation or behaviour, and the discomfort that goes with it. Ambivalence is low when an individual has not perceived there is problem and increases when a problem is recognised. When a person feels ambivalent there is discomfort. The person attempts to alleviate the discomfort by resolving the ambivalence-conflict (no change or change). The purpose of the current research is to examine ambivalence regarding various aspects of anorexia nervosa and how this is related to motivation to change and the burdens and benefits of having an eating disorder.

1.2. Eating Disorders

Anorexia nervosa is an illness in which an individual avoids food and induces weight loss in a response to psychological conflict, which is thought to be resolved by achieving the goal of thinness or avoiding fatness (Russell, 1995).
Anorexia nervosa has the highest mortality rate of any psychiatric disorder (Touyz et al., 2003); between 12% and 20% of sufferers die (Crisp & McClelland, 1996). Predominantly women and those in high social classes are affected (Szmukler & Patton, 1995). In women, eating disorders are among the most common psychiatric disorder (Morgan et al., 1999). The estimated prevalence of eating disorders is 0.03 - 8% (Murphy & Manning, 2003). It is still unclear why individuals develop eating disorders; however it is thought to be a combination of biological, familial, genetic, psychological and sociocultural factors that are involved (Wren & Lask, 1993). The DSM-IV (American Psychiatric Association; APA, 1994) diagnosis for anorexia nervosa is described in table 1:

Table 1: DSM-IV Criteria for Anorexia Nervosa

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

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

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

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

Individuals are described as the Restricting Type (having not regularly engaged in binge-eating or purging behaviour) or the Binge-Eating/Purging Type.

pp.544-545
It has been suggested that symptoms of anorexia nervosa may serve a number of functions including feeling attractive, in control, safe, having increased confidence and they help to avoid negative emotions (Vitousek et al., 1998). These functions are often seen as reinforcers that maintain the disorder and are therefore barriers to change (Garner & Bemis, 1982). Often, anorexia goes untreated during the early stages. This results in the disorder becoming well developed and difficult to treat (Murphy & Manning, 2003). Anorexia nervosa is considered particularly difficult to treat because individuals with the disorder often deny they have a problem and do not volunteer themselves for treatment. They are usually encouraged to attend by worried family and friends (Vitousek et al., 1998). When progress is observed in inpatients, it is often lost at discharge (Villapiano & Goodman, 2001). Geller et al., (2001) proposed that treatment dropout and recidivism may be due to interventions being aimed at reducing symptoms in individuals who are not yet ready for change. It is still unclear what supports a favourable outcome.

1.3. Treatment for Anorexia Nervosa

It has been suggested that early intervention provides the best opportunity for recovery in the long-term (Morgan et al., 1999) however this is often not possible. When treatment becomes an option, clinicians must consider the severity of the disorder, previous attempts at treatment and providing a balance between weight restoration and improving psychological and emotional wellbeing. Crisp (1995) suggests that the best treatment plans involve a combination of weight restoration with psychotherapeutic interventions that explore the development of the eating disorder, and how the individual will manage without the eating disorder.

The National Institute for Clinical Excellence (NICE, 2004) recommend that clinicians should consider using Cognitive Behaviour Therapy (CBT), Cognitive Analytic Therapy (CAT), Interpersonal Psychotherapy (IPT), Psychodynamic Therapy or Family Therapy focusing explicitly on the eating disorder when preparing to treat anorexia nervosa. Within eating disorders,
CBT was originally developed for bulimia nervosa (Fairburn, 1981) and later developed for anorexia nervosa by Garner & Bemis (1982). Although CBT for anorexia nervosa has been described in the literature, there is little empirical evidence supporting its effectiveness. Channon et al., (1989) compared CBT with behaviour therapy and a weight restoration control group. They found improvements but no statistical difference between the groups.

Clinicians have identified a number of difficulties when attempting to treat individuals with anorexia nervosa. One difficulty is that when physical health improves, professionals and significant others often assume that patients are improving psychologically and emotionally as well, which is not always the case. Another difficulty is motivation. Lack of motivation and resistance to treatment are noted in most clinical accounts of eating disorder patients (Feld et al., 2001). It is not surprising that individuals with anorexia nervosa lack motivation to change and are ambivalent about treatment and recovery, given that the anorexia becomes the individual's main coping strategy (Cockell et al., 2004). Recovery involves moving away from a safe way of thinking and behaving, therefore feeling ambivalent is a natural response. Knowing more about ambivalence may help clinicians manage motivation, resistance and ambivalence better.

1.4. Ambivalence

The term ambivalence was first applied to psychological phenomena by Bleuler (1911, as cited in Jonas et al., 2000). He used the term to signify the simultaneous occurrence of incompatible emotions, cognitions or intentions in one person. Originally, Bleuler thought that ambivalence was only present in individuals with schizophrenia, but later considered its presence in 'normal' people. Freud (1912/1943, as cited in Jonas et al., 2000) used the term to describe the inconsistencies between emotions such as love and hate.

The concept of ambivalence has had an important role in various areas of psychology including clinical, developmental and social psychology (Jonas et al., 2000). Consistency theorists view ambivalence as a temporary state that
results in inconsistencies being resolved (Jonas et al., 2000). This fits with cognitive dissonance theory (Festinger, 1957), which is based on the idea that individuals strive towards consistency, whether that is in their opinions and attitudes or between what a person knows and believes and what a person does. There are however times when there is inconsistency, for example between what a person knows and their behaviour such as, knowing smoking is detrimental to their health but continuing to smoke. At these times, an individual tries to resolve these inconsistencies. If the attempt to achieve consistency fails, the inconsistency continues to exist and this results in psychological discomfort. Festinger (1957) used the word 'dissonance' for inconsistency and 'consonance' for consistency. He hypothesised that the existence of dissonance means the individual is experiencing psychological discomfort, which motivates them to try to reduce the dissonance to achieve consonance. An alternative resolution to reducing the dissonance is to avoid situations and information that may create dissonance.

Dissonance may occur when the individual becomes aware of new events or information, which creates dissonance with existing knowledge, attitudes or cognitions regarding particular behaviours. For example, for an individual with anorexia nervosa, learning that being too thin can cause heart failure would create dissonance with the view that being thin improves one's life. Dissonance is almost unavoidable when individuals have cognitions veering them in two directions. Individuals feel ambivalent and attempt to reduce the dissonance to reduce the distress.

Ambivalence has also been viewed as consistent with a social cognitive approach. Social cognitive researchers do not assume that cognitive elements are always consistent. Researchers have specifically focused on how people deal with information that is inconsistent with existing cognitions or schemas (Sherman & Hamilton, 1994). One explanation is that not all relevant cognitive elements are accessible at the same time. This could be due to our memory being selective toward certain pieces of information, such as the pros of change or the cons of change. Within attitude research,
attitudinal ambivalence refers to 'evaluative inconsistency' within the basis of an attitude. The inconsistency can be present within a particular evaluative response (cognitive, affective) or between cognitions and affect, however the individual is not constantly aware of the inconsistency (Conner & Sparks, 2002).

Sparks et al. (2004) suggested that ambivalence incorporates the notion that attitudes towards an 'attitude object' can be both positive and negative. Jonas et al. (2000) define attitudinal ambivalence as

'The simultaneous existence of positive and negative beliefs or emotions with regard to the same object in an individual's attitude basis' (p.41).

Within attitude research, there are thought to be three types of ambivalence: cognitive ambivalence (mixed beliefs/thoughts) which is associated with inconsistent evaluations; affective ambivalence (mixed feelings) which is associated with positive and negative emotions at the same time; and affective-cognitive ambivalence, where positive affect is combined with negative cognitions or vice versa (Thompson et al., 1995). Thompson et al. (1995) suggested that to create more reliable measures of overall ambivalence, affective ambivalence and cognitive ambivalence should be included and assessed.

There are two approaches to assess and measure attitude ambivalence (Priester & Petty, 1996). One is to measure positive and negative views separately and then use a formula to combine them into an ambivalence index (objective ambivalence) and the second approach is to assess the subjective perception of ambivalence by directly asking individuals whether their attitudes are one-sided or mixed. Objective ambivalence should increase with increasing similarity as well as increasing extremity of the two evaluative ratings (Thompson et al., 1995). However, no consensus has been reached about the ideal ambivalence formula. The most widely applied equation was devised by Griffin and presented by Thompson et al. (1995): ambivalence = (P+N)/2-(P-N) (where P = positive views and N = negative views). Few
Major Research Project

studies have compared the two types of measures. Thompson et al. (1995) found a significant correlation of .40. Lipkus et al. (2001) found a correlation of just .19, suggesting little convergent validity between the types of measures. Priester and Petty (1996) also found only a moderate relationship between experienced ambivalence and the formula based indexes, suggesting that the two cannot be regarded as interchangeable.

Jonas et al. (2000) suggest that subjective ambivalence assumes that the individual is consciously aware of their ambivalent state. They do not consider this to be always true and suggest that assessing positive and negative evaluations separately allows accessible aspects to be elicited as well as those that are less salient. However, subjective ambivalence measures are usually considered the 'gold standard' to which formula-based measures are validated against (Thompson et al., 1995), especially as reliability data can be computed. Formula-based measures are less reactive to extraneous factors and they assume that positive and negative evaluations are weighted equally; this may not be the case as individuals can consider the positive aspects to be much more important than the negative aspects. It could be that other factors determine experienced ambivalence in addition to inconsistency between positive and negative views, such as one's own views differing from significant others (Priester & Petty, 1996). At present Conner and Sparks (2002) suggest that it is difficult to give advice about which measure to use.

1.5. Stages of change

Ambivalence has been extensively studied within the context of the transtheoretical model of change. Prochaska and DiClemente (1982) developed this model in the context of smoking cessation. The model was a framework to help conceptualise motivation and readiness to change and help understand ambivalence about change. Prochaska and DiClemente's (1982) original model described four stages of change: precontemplation, contemplation, action and maintenance. Those in the precontemplation stage are unaware of the problem or do not want to accept there is a problem so are unwilling to change. Individuals in the contemplation stage accept there is a
problem and are thinking about change, although they are not ready to change. This stage is characterised by a period of ambivalence about change. In the action stage individuals become actively involved in making changes. In the maintenance stage individuals work to maintain the changes. Prochaska et al. (1992) described a fifth stage that falls between the contemplation and action stage and involves planning for change, the preparation stage. This stage has only been identified as a separate stage in some studies. Prochaska et al. (1992) described how the model of change was originally thought as a linear progression but later changed to a spiral pattern as they included relapse in the model. Individuals may progress through the stages, however relapse can occur in the action or maintenance stage resulting in re-entry into an earlier stage. Individuals can go through the cycle several times before changing their behaviour permanently and reaching termination, when the individual has mastered change.

One way of assessing stages of change is to use a simple algorithm, which asks individuals if they want to change their problem behaviour. Prochaska et al. (1994) used this approach with twelve health-related problem behaviours and successfully allocated participants to the five stages of change. Etter and Perneger (1999) also used this approach to compare two algorithm measures for smoking cessation. One was the measure used by Prochaska et al. (1994) and the other asked one question for each stage. They found that only 62% of participants were allocated into the same stage by the two measures. The alternative measure allocated half the number of participants to the precontemplation stage and double the number of participants to the contemplation stage compared with the measure used by Prochaska et al., (1994). Both measures were unable to allocate occasional smokers and allocated a number of participants who had attempted to stop smoking in the last year to the precontemplation and contemplation stages. There were also discrepancies between groups, they were highly heterogeneous and some participants were allocated to inappropriate stages based on their attempts to stop smoking. Etter and Perneger (1999) found that neither measure provided a satisfactory and homogenous classification of smokers or former smokers.
An algorithm measure does not appear to be able to address behaviours that are not simply defined (Sullivan & Terris, 2002).

McConnaughy et al. (1983) developed an alternative scale to measure the stages of change of counselling patients. Although the stages are not considered discrete and movement unidirectional, for the purposes of measurement the stages were viewed in this way. From the original 165 items suggested, over a three-stage process, the researchers created a 32-item measure based on four stages of change: precontemplation, contemplation, action and maintenance, with eight items for each stage. Using principle component analysis, they found that the four components explained 58% of the variance. They calculated alpha coefficients on the eight items of each scale. These were .88 for precontemplation, contemplation and maintenance and .89 for action. McConnaughy et al. (1983) proposed that the measure is brief yet highly reliable for measuring stages of change. The measure is adequate for research purposes but not considered suitable for clinical application, as norms have not yet been developed.

Many studies have shown support for the transtheoretical model and have provided further reliability and validity for the stages. (For example, McConnaughy et al., 1983; McConnaughy et al., 1989; Prochaska et al., 1988). There has also been support for the model in terms of modifying addictive behaviours (Prochaska et al., 1992).

1.6. Stages of change in eating disorders
A number of reports have supported the usefulness of the transtheoretical model of change in eating disorders (e.g. Rieger et al.; 2000; Treasure & Ward, 1997). Blake et al. (1997) and Stanton et al. (1986) adapted the scale by McConnaughy et al., (1983) to use with individuals with eating disorders. Treasure et al. (1999) found that participants with bulimia classified in the action stage at the beginning of treatment showed greater improvements in bingeing than those in the contemplation stage. Rieger et al. (2000) found
that their measure of readiness to change was able to predict weight gain. Hasler et al. (2004) found that engagement in continuing treatment was negatively correlated to the precontemplation stage and positively correlated to the contemplation stage. These results support the notion that the stage of change model is relevant to the treatment of people with eating disorders.

Ward et al. (1996) examined the transtheoretical model in patients who required inpatient care for their anorexia. They used a short version of the stage of change questionnaire by McConnaughy et al. (1983) (without the maintenance questions as they were all in pre-maintenance stages by their inpatient status). From a total of 35 participants, 3 were in the precontemplation stage, 14 in the contemplation stage, and 18 in the action stage. However, the majority of participants had some features of all three stages. Clinical presentations of the majority of participants in the action stage were considered contradictory to participants being in the action stage. Most of these participants appeared highly ambivalent about change, which was reflected in the tied scores across the stages. This raises the question of how accurate it is to assign an individual to a single stage. Also, ambivalence can be overlooked, as it often assumed by clinicians that the behaviour is negative and must be changed, rather than seeing the individual as having made an informed decision not to change (Sullivan & Terris, 2001). Sullivan and Terris (2001) argued that ambivalence is unlikely to be captured by asking about behaviours consistent with each stage of change. Rather, there is a need to address the patients' experienced ambivalence in its own right.

A number of other problems have also been identified with assessing stages of change with a questionnaire. It is difficult to know which symptom an individual is considering when answering the questionnaire (Treasure et al., 1999). Treasure et al. (1999) found that matching treatment to stages did not appear to contribute to the outcome and suggested that this was because the stage of change measure did not ask about specific behaviours. Individuals could have a desire to put on weight but not want to give up the compensatory strategies that helps them remain thin. Although helpful, Treasure et al.
(1999) proposed that it may be over simplistic to measure the stage of change a person is in just once before treatment matching, especially if it is unclear which symptoms patients are considering changing.

Geller and Drab (1999) have attempted to address some of these concerns by developing the Readiness and Motivation Interview (RMI) which explores an individual’s motivation for changing specific behaviours. Geller et al. (2001) found that readiness differed across symptom domains. Dunn et al. (2003) and Jordan et al. (2003) have also attempted to address the concerns of measuring different symptoms. Dunn et al. (2003) gave participants three stages of change measures, a general one referring to eating behaviours, one referring to bingeing behaviour and one referring to compensatory behaviours in relation to bulimia. They found that the individual measures accounted for greater variance than the general measure, suggesting that particularly in bulimia, assessments of readiness to change should be more specific to symptoms. Jordan et al. (2003) developed stage of change measures to assess different behaviours and cognitions associated with anorexia. They found that the readiness to stop restricting/bingeing/purging was the best overall measure.

In assessing the psychometric properties of the RMI, Geller et al. (2001) explored the relationship of the RMI with the brief symptom inventory (BSI, Derogatis & Spencer, 1992, as cited in Geller et al., 2001). This is an inventory of psychiatric symptoms where participants indicate the extent to which they are distressed by various problems. They found that the RMI action score was negatively correlated to the BSI score suggesting that taking action is associated with decreased distress regarding psychiatric problems. They hypothesised that higher levels of distress promoted a decision to change, but this distress needed to reduce for change to occur. This result is different to the clinical view reported by Treasure et al. (1995) who suggested that patients feel panicky about weight gain as they are giving up their coping strategy and source of pleasure. They suggested that in the short term,
change leads to an increase in distress, and anxiety and despair are common while patients struggle with accepting gains in weight.

1.7. Motivation to change
Despite the critiques, the transtheoretical model of change has led to treatment approaches focusing on motivation to change. When considering readiness to change, there are thought to be two components: firstly, the problem must be recognised as important which leads to a willingness to change and secondly the individual must believe in their ability to change (Rollnick, 1998). Treasure and Schmidt (2001) suggested that individuals need both to be able to change. In addition, to wanting to change, one must also be motivated. Motivational interviewing (Miller & Rollnick, 1991) is a counselling technique developed in addiction work. The aim is to help clients make a decision to change by increasing motivation. Clients are encouraged to see their behaviour in the context of broader goals and values, and identify the discrepancy. Motivational interviewing is helpful with individuals who are ambivalent about change because the idea of change comes from the individual rather than someone else. Miller (1994) views motivational interviewing as different from other counselling techniques because it focuses on resolving the ambivalence in the direction of behaviour change. Within this approach, ambivalence is considered understandable and justifiable (Killick & Allen, 1997). The interaction between clinician and client is considered vital in providing the opportunity for change to occur. The therapeutic relationship can help build and strengthen the commitment to change. If change does not occur, it is usually thought to be due to denial or resistance. Both of which are common in individuals with eating disorders (Vitousek et al., 1998).

Miller (1995, as cited in Treasure et al., 1999) combined motivational interviewing with the transtheoretical model to create a short manualised form of therapy called motivational enhancement therapy (MET). The goal is to determine the stage of change an individual is in, then assist in helping them move through the stages until change has been achieved. Motivational enhancement strategies presume that the motivation necessary for change is
not present so this needs to be nurtured during the treatment process. Therefore, to improve treatment outcomes, clinicians have focused on these motivational deficits (Shaffer & Simoneau, 2001). Project MATCH Research Group (1997) used MET with substance misuse problems and found that four sessions were as effective as twelve sessions of CBT.

1.8. Motivation to change in eating disorders
Killick and Allen (1997) found strategies of motivational interviewing useful in treating bulimia nervosa by helping them move through the stages of change. In treating anorexia nervosa, Treasure and Ward (1997) suggested that treatment in the precontemplation stage and contemplation stage should involve a cognitive/affective re-evaluation of the anorexia, which can be achieved through motivational interviewing techniques. Treasure et al. (2003) have attempted to introduce motivational interviewing strategies into the family home, by teaching families some of the strategies so that home life is less confrontational. Treasure et al. (1999) conducted the first study applying MET to individuals with eating disorders. They studied 125 female participants with bulimia nervosa in a randomised control trial of manualised therapy. Participants were assigned to 4 weeks of MET followed by 8 weeks of group CBT; 4 weeks of individual CBT followed by 8 weeks of group CBT; or 4 weeks of MET followed by 8 weeks of individual CBT. Prior to treatment 90% of participants were in the contemplation stage and 10% of participants were in the action stage. Participants in the action stage showed greatest improvement in binge eating and overall significant reductions in vomiting and laxative use. Overall, they found that MET was as effective in the short-term as CBT at reducing symptoms in binge eating, vomiting and using laxatives.

Feld et al. (2001) extended a pre-intervention MET group to individuals with anorexia nervosa as well as bulimia nervosa. Nineteen participants completed the study, 62% of whom suffered from anorexia nervosa. They found a significant increase across the sessions on the motivation scales and found that MET positively influenced participant's motivation to change. They also found a decrease in depressive symptomology, an increase in self-
esteem and a decrease in interpersonal distrust, suggesting additional benefits beyond the influence on motivation. Touyz et al. (2003) also introduced readiness to change principles to three day programmes, which are currently in the process of evaluation. The programmes use MET, cognitive, and behavioural ideas, to match stages of change with treatment. Individuals in the contemplation stage or preparation stage were assessed for a five-day intensive programme where the focus is on reasons for change before learning skills to help change. After approximately six weeks individuals move to a three-day programme, aimed at those in the late contemplation or action stages. Here the focus is on understanding the triggers to eating disorder urges followed by CBT for relapse prevention. The other programme Touyz et al. (2003) have developed is a long-term day programme for individuals who have had an eating disorder for a minimum of seven years. This is for those who refuse to attend the 'action' programme but will consider exploring barriers to change.

Geller (2002) describes being 'motivational' as an approach towards treatment. This includes a belief system about the relationship clinicians hope to have with their clients and what they aim to achieve with their clients, including their role in the process of change. Geller (2002) considered this motivational approach as necessary throughout treatment and alone, is not sufficient for behaviour change. She proposed that in addition, therapy techniques are needed appropriate for the clients' readiness. A motivational approach can help clients understand their eating disorder so they have the options to work out the best course of action. It also allows a safe place to consider all the environmental and cultural factors that might be interplaying with the eating disorder.

1.9. Decisional balance
The balance of the pros and cons of being unwell or changing are considered by Prochaska (1994) as strongly associated with motivation and the stages of change. This is known as the decisional balance and can be viewed as an objective measure of ambivalence. Transition between the stages occurs
partly through weighing up the pros and cons. The decisional balance is based on the decision making model of Janis and Mann (1977) which is conceptualised as a conflict model. Good decision-making involves considering all relevant information and weighing up the gains and losses on a decisional balance sheet. They described four consequences of decision-making (eight factors), which were gains and losses for the self, gains and losses for significant others, self-approval or disapproval, and approval or disapproval from significant others. Prochaska et al. (1994) found that a two factor decisional balance, i.e. pros and cons was sufficient, rather than the eight factors originally described by Janis and Mann (1977).

Velicer et al. (1985) constructed a 24-item decisional balance measure to study decision making processes across the stages of change for smoking cessation. Items based on Janis and Mann's (1977) categories, were inputted into principle component analysis. Two components were created, pros of smoking and cons of smoking. These were compared across the stages of change, which were identified as immotive, contemplators, relapsers, recent quitters and long-term quitters. They found that the first three groups scored significantly higher on the pros of smoking than the recent quitters, equivalent to the action stage and that recent quitters scored significantly higher than long-term quitters, equivalent to the maintenance stage. In terms of the cons of smoking, immotives (precontemplation) and long-term quitters (maintenance) were not significantly different from one another, however both scored significantly lower than the contemplators and relapsers. The recent quitters were not significantly different from any other group. These results suggested that Velicer et al. (1985) were able to differentiate the pros and cons of smoking across the four stages of change. They concluded that the decisional balance construct could be used together with the stages of change model in studying cognitive and motivational shifts across the stages.

Prochaska et al., (1994) conducted a study to support the relationship between the stages of change model and decisional balance. They used twelve health-related behaviours, which included reducing negative
behaviours, and increasing positive behaviours. They found that for all
behaviours the pros of change were higher in the contemplation stage than
the precontemplation stage, however there were inconsistent patterns across
the other stages. For some behaviours the pros increased from the
contemplation stage to the action stage and for others the pros decreased.
There was an inconsistent pattern found from the precontemplation stage to
the contemplation stage for the cons of change. For seven behaviours, cons
of change were higher in the contemplation stage and for five behaviours,
cons of change were higher in the precontemplation stage. There was a
consistent pattern found between the contemplation stage and action stage.
For all 12 behaviours, the cons of changing were significantly lower for
participants in the action stage than those in the contemplation stage. From
these results, Prochaska et al. (1994) argued that the study shows strong
support for the generalisation of the three basic constructs of the
transtheoretical model: the stages of change; the pros and cons; and the
integration between the stages and decisional balance variables. This study
also supports the generalisation of the model across a variety of populations.
Prochaska (1994) created two principles based on the changes in pros and
cons. The strong principle is based on a one standard deviation increase in
the pros of change between the precontemplation and action stage and the
weak principle represents the half standard deviation decrease in the cons of
change between the precontemplation stage and action stage.

Share et al. (2004) investigated the relationship between the stages of change
and decisional balance in 119 women with alcohol problems. Participants
scored between -2 and 2 on a five-point readiness to change scale. Higher
scores on the contemplation and action scales and lower scores on the
precontemplation scale indicated greater readiness to change. They found
that high scores on the precontemplation stage were positively correlated with
costs of change and these outweighed the benefits of change in this stage.
No relationships were found in the contemplation stage, but by the action
stage, high scores were negatively correlated with the costs of change,
suggesting that a decrease in costs of changing is associated with taking
action. There was no relationship in the action stage with the benefits of changing. When participants were allocated to stages, 77% were allocated to the contemplation stage and 23% were allocated to the action stage. Although precontemplation scores were correlated with costs of change and benefits of change, participants also scored high in the other stages resulting in allocation to them and not the precontemplation stage. Share et al. (2004) found no significant difference in either the costs or benefits of change across the stages, although the costs of change were higher in the contemplation stage and the benefits of change were higher in the action stage. They compared the difference score (benefits - costs) and found a significant difference between the two groups; there were more benefits of change than costs of change in the action stage than in the contemplation stage. This suggests that those in the action stage saw more advantages to stop drinking than to continue drinking compared to those in the contemplation stage. Share et al. (2004) argued that this finding is consistent with the decisional balance model, a choice is made based on both the costs and benefits.

### 1.10. Decisional balance and anorexia nervosa

Blake et al. (1997) applied the decisional balance construct to anorexia nervosa. They extended the study of Ward et al. (1996) to include outpatient and well as inpatient participants. There were 109 participants; 53 percent with anorexia and the remaining had bulimia. They adapted the decisional balance scale on weight loss by Rossi et al., (1995). They found no participants in the maintenance stage. The majority of those with bulimia were in the action stage whereas 12 participants with anorexia were in the precontemplation stage, 14 were in the contemplation stage and 25 were in the action stage. Collating the data together, Blake et al. (1997) found that the pros of change increased from the precontemplation stage to action stage and were significantly higher in the contemplation stage and action stage than in the precontemplation stage. There was no significant difference found in the cons of change across the stages, however, they decreased from the precontemplation stage to the contemplation stage and slightly increased in the action stage. This study supports Prochaska (1994) in finding that there is
a shift in the balance of pros and cons between the precontemplation and contemplation stage in individuals with eating disorders. Support for the strong principle (Prochaska, 1994) was also found by the increase in over 1 standard deviation between the precontemplation stage and action stage. The weak principle was not supported.

Cockell et al. (2002) developed a reliable and valid decisional balance measure for anorexia. Their scale had three factors: burdens (cons), benefits (pros) and functional avoidance, describing ways anorexia is used to avoid situations or negative emotions. The scale needed further exploration, therefore Cockell et al. (2003) conducted a study using the decisional balance scale to increase the understanding of movement through the stages of change, particularly from precontemplation to contemplation. The study was also to establish psychometric properties for the decisional balance scale. Studying eighty participants, Cockell et al. (2003) found that the decisional balance measure showed that those in the precontemplation stage identified less costs (burdens) than those in the contemplation and action stages. The benefits or positive consequences of anorexia did not change across the stages. They also found that insight into the function of anorexia was associated with higher psychiatric distress, however burden and benefit scores were not correlated with psychiatric distress.

The decisional balance results in the eating disorder field appear to be both consistent and inconsistent with other research. One consistent result is that there is an increase in the pros of change or burdens of the eating disorder from the precontemplation stage to the contemplation stage (Blake et al., 1997; Cockell et al., 2003; Prochaska et al., 1994; Velicer et al., 1985). Changes in the pros of change from the contemplation stage to action stage are less consistent. Cockell et al. (2003) found no significant difference in burdens between the contemplation stage and action stage, supporting Blake et al. (1997). Whereas Prochaska et al. (1994) found that for some behaviours there was an increase in the pros of change and for other behaviours there was a decrease in the pros of change. Although non-
significant, Velicer et al. (1985) found a decrease in the cons of smoking (burdens) between the contemplation stage and the action stage.

In the eating disorder literature, there is no significant difference in the benefits of the eating disorder (equivalent to the cons of change) across the stages of change. Although, non-significant trends show a decrease in benefits from the precontemplation stage to the contemplation stage. Blake et al. (1997) then found a slight increase between the contemplation stage and action stage whereas Cockell et al. (2003) found a continuing decrease. In comparison, Velicer et al. (1985) found a slight increase in the benefits of smoking and Prochaska et al. (1994) found mixed findings across the twelve behaviours. For seven behaviours, there was an increase in the cons of change and for five behaviours, there was a decrease from the precontemplation stage to contemplation stage. Velicer et al. (1985) found that the benefits of smoking were significantly lower in the action stage than the precontemplation stage and the contemplation stage. Prochaska et al. (1994) also found that the cons of changing were significantly lower in the action stage than the contemplation stage for all twelve behaviours.

1.11. Current study
Ambivalence has been central to understanding the change process in anorexia nervosa and in research on the transtheoretical model of change and the decisional balance. However, the experience of reported ambivalence has not been specifically examined. Therefore, the overall aim of this study is to examine subjective ambivalence in anorexia nervosa and how it relates to the decisional balance and the transtheoretical model of change.

1.11.1. Aim: To measure subjective ambivalence regarding anorexia nervosa
The first aim is to assess subjective ambivalence. A questionnaire was devised that asked about twelve issues related to anorexia nervosa. The measure included three questions about the conflict inherent in ambivalence: one asked about cognitive ambivalence (conflicting thoughts), another about
affective ambivalence (mixed feelings) and the last question asked about cognitive/affective ambivalence (conflicting thoughts with feelings). Thompson et al. (1995) found for a number of social issues they were studying, affective and cognitive ambivalence were significantly related and evaluative ambivalence was related to both torn feelings and mixed beliefs but not to affective/cognitive ambivalence. All three types were included in the current study. The measurement included a question about ambivalence-distress. Conflicting thoughts are inherent in everyday life but individuals do not always feel distressed about them. Festinger (1957) hypothesised that when an individual experiences dissonance they experience psychological distress, they therefore attempt to resolve the dissonance to reduce the distress. This theory suggests that the more dissonance felt, the greater the distress. Therefore, participants who feel ambivalent will also feel distressed about the ambivalence. It is therefore expected that ambivalence and ambivalence-distress will be correlated, but it is unclear to the extent of the correlation as an individual may feel greatly distressed due to feeling a little ambivalent or they may feel very ambivalent but are not that concerned about it.

1.11.1.1. Hypothesis 1:
It is predicted that there will be a positive correlation between ambivalence-conflict and ambivalence-distress.

1.11.2. Aim: To examine the relationship between subjective ambivalence and the stages of change
The second aim is to examine the relationship between subjective ambivalence and the stages of change. The transtheoretical model of change suggests that ambivalence is greatest in the contemplation stage. Based on cognitive dissonance theory (Festinger, 1957) it is expected that ambivalence-conflict would be higher in the contemplation stage than the precontemplation stage. This is due to individuals in the contemplation stage recognising the positive and negative aspects of the anorexia. These aspects of anorexia are promoting behaviours that veer in opposite directions and causes dissonance, as the person is contemplating whether to change or not. It has been
proposed that once in the action stage, ambivalence has been worked through and change is occurring (Cockell et al., 2003). Thus from this perspective ambivalence-conflict should be lower in the action stage than the contemplation stage. However, Ward et al. (1996) found that participants in the action stage were highly ambivalent, which contradicted with their expectations. It is unclear what will happen to ambivalence-conflict in the maintenance stage. If participants are progressing well with change and are about to terminate from the cycle, perhaps ambivalence-conflict will remain stable or decrease. However, if relapse is imminent, ambivalence-conflict may increase.

The relationship between ambivalence-distress and the stages of change will also be examined. The same pattern expected for ambivalence-conflict is expected for ambivalence-distress. Within cognitive dissonance theory (Festinger, 1957), distress or discomfort is the motivating factor which results in a reduction in dissonance. Therefore it is expected that the group with the greatest dissonance or ambivalence (contemplation stage group) will be associated with the greatest ambivalence-distress. In research assessing distress more generally, Treasure et al. (1995) suggested that distress could be a hindrance to change, however Geller et al. (2001) hypothesised that high levels of psychiatric distress promoted a decision to change and that the distress needed to lower for change to occur. This combined with cognitive dissonance theory suggests that ambivalence-distress may be lower in the action stage than the contemplation stage. It is unclear what will happen to ambivalence-distress in the maintenance stage of change.

1.11.2.1. **Hypothesis 1:**

It is predicted that participants in the contemplation stage group will report greater ambivalence-conflict than participants in the precontemplation stage group and action stage group.
1.11.2.2. Hypothesis 2:
It is predicted that participants in the contemplation stage group will report
greater ambivalence-distress than participants in the precontemplation stage
group and action stage group.

1.11.3. Aim: To replicate and extend the study conducted by
Cockell et al. (2003)
Another aim of this study is to replicate the study conducted by Cockell et al. (2003) and then extend it to include the maintenance stage of change.
Learning about this stage of change is critical as relapse rates range from
33%-63% (Field et al., 1997, Herzog et al., 1999). By replicating the study of
Cockell et al. (2003), the current research expects to find the burden score will
be greater in the contemplation stage group and action stage group than the
precontemplation stage group but will be no different in the contemplation
stage group and action stage group. There is not expected to be a difference
found in the benefit score between the precontemplation, contemplation and
action stage groups. It is unclear whether the maintenance stage group will
differ in the burden score from the contemplation stage group and action stage
group. However, it is expected that the burden score in the maintenance
stage group will be greater than in the precontemplation stage group given
that those in the precontemplation stage are less likely to identify negative
aspects of their anorexia nervosa than those who are maintaining changes, as
they may not consider themselves to have anorexia. It is unclear whether the
addition of the maintenance stage group will produce a difference in the
benefit score. However, given that Cockell et al. (2003) did not find a
difference in benefit scores between any of the other stages it is expected that
there will be no difference in benefit score in the maintenance stage group and
the other three stage groups.

1.11.3.1. Hypothesis 1:
It is predicted that the burden score will be greater in the contemplation stage
group than in the precontemplation stage group.
1.11.3.2. **Hypothesis 2:**
It is predicted that the burden score in the action stage group will be greater than in the precontemplation stage group but no different to the contemplation stage group.

1.11.3.3. **Hypothesis 3:**
It is predicted that the burden score will be greater in the maintenance stage group than in the precontemplation stage group.

1.11.3.4. **Hypothesis 4:**
It is predicted that the benefit score will be no different in the precontemplation stage group, contemplation stage group and action stage group.

1.11.3.5. **Hypothesis 5:**
It is predicted that the benefit score will be no different in the maintenance stage group to the other three stage groups.

1.11.4. **Aim: To compare subjective ambivalence with objective ambivalence**
The final aim is to examine the relationship between subjective ambivalence and the decisional balance. The decisional balance scale asks about burdens and benefits of anorexia separately, and can be considered an objective measure of ambivalence if created into a formula. Whereas the subjective ambivalence measure will specifically ask about the ambivalence experienced. Therefore, the two types of measures can be compared to examine the relationship between subjective ambivalence and objective ambivalence. Based on attitudinal research (Thompson et al., 1995) it is expected that there will be a low correlation between subjective ambivalence and objective ambivalence. It is therefore also predicted that ambivalence-distress will be weakly correlated with objective ambivalence given the expected relationship with ambivalence.
1.11.4.1. **Hypothesis 1:**
It is predicted that subjective ambivalence will be weakly correlated with objective ambivalence.

1.11.4.2. **Hypothesis 2:**
It is predicted that ambivalence-distress will be weakly correlated with objective ambivalence.
**Method**

### 2.1 Design

A cross-sectional, quasi-experimental, non-equivalent group design was used. These types of design are typically used to investigate relationships when the researcher cannot control all of the factors that may affect the outcome. It is called quasi-experimental because the researcher does not manipulate an independent variable. These designs are also used when there are multiple groups or measures.

### 2.2 Recruitment and participants

Participants were recruited from two sources. One source was the Eating Disorder Service at Heatherwood Hospital, Berkshire Healthcare NHS Trust where all participants were in treatment for their eating disorder. During appointments at the service, clinicians invited potential participants to volunteer to participate in the research. They distributed the questionnaire packs and asked clients to decide whether they would like to participate. Potential participants were informed that completing the questionnaires was confidential, anonymous, and their choice and they should return the questionnaire pack to the administrator whether they decided to participate or not. Of the 20 participants approached, 90 percent (n = 18) returned their questionnaires. Demographics for these participants are described in table 2. The second source was the Eating Disorder Association (EDA), UK who, agreed to assist with the recruitment of participants after they read the research proposal, a sample of the invitation letter, information sheet, consent forms and questionnaire pack. The EDA sent out the questionnaire packs to all suitable individuals attached to their research pool who had given permission to be contacted for research purposes via the EDA. These were females over the age of eighteen with anorexia nervosa or those who described themselves as having recovered from anorexia nervosa. Within the questionnaire pack was a memo from the EDA supporting the research and a stamped addressed envelope for participants to return the completed questionnaires to the researcher. Two hundred and twenty-six individuals were potential participants attached to the research pool of the EDA. There
was a 22.6 percent response rate, 51 questionnaires were returned, 44 of which were included in the study. Five potential participants had moved away, one individual was deceased and one individual had bulimia nervosa. Demographics for the participants are described in table 2. Overall, 61.3 percent (n = 38) of participants described themselves as a person with an eating disorder and 32.3 percent (n = 19) described themselves as a person recovered from an eating disorder. A further 3.2 percent (n = 2) described themselves as neither (previously had a formal diagnosis) and 3.2 percent (n = 2) described themselves in recovery.

All participants were females and over eighteen years old. The age range was 18-57 with a mean age of 30.84 (SD = 9.52). Of the total sample, 96.8 percent gave details on their ethnicity. One described herself as Caucasian; the remaining 59 used a mixture of white, English, British or a combination. All participants had English as a first language as practical constraints prevented the use of interpreters or the translation of the questionnaires. All participants either suffered from Anorexia Nervosa of the restrictive type or had recovered from Anorexia Nervosa (92 percent had been given a formal diagnosis; n = 57). The mean length of illness was 12.6 years (SD = 9.22) and 64.5 percent (n = 40) of the sample were receiving treatment. Men and individuals under the age of eighteen were excluded from the research as this study aimed to replicate and further developed previous research, which did not include men or individuals under the age of eighteen.

Table 2: Demographic details of the sample

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2.3 Research ethics and consent

Approval for the research was obtained from Berkshire Research Ethics Committee (Appendix A), Berkshire Healthcare NHS Trust Research and Development Department (Appendix B) and the University of Surrey Ethics Committee (Appendix C) after they inspected a sample invitation letter, information sheet, consent form and the questionnaire pack (see materials section). Attached to the questionnaire pack were two consent forms. One was returned with the questionnaires, indicating that participants had given informed consent for the information gathered to be used for research purposes. Once received by the researcher, the consent form was separated from the questionnaires and stored in a confidential file. The data entered onto the SPSS database was non-identifiable.

2.4 Materials

Within each questionnaire pack was: a covering letter inviting participants to participate (Appendix D); an information sheet (Appendix E) explaining the purpose of the study and how one can participate; two consent forms (Appendix F), one returned to the researcher and the other kept by participants; a background information sheet (Appendix G) which was completed and returned; and four questionnaires (see below) (Appendix H) which participants were asked to complete.

2.4.1 Stage of change questionnaire

The University of Rhode Island Change Assessment Scale (URICA) adapted by Rossi et al. (1995) was used. This consists of 32 items used to measure four stage of change; precontemplation, contemplation, action and maintenance. Each subscale contains eight items (see table 3 for an example of items), each with a five-point likert-type scale ranging from strongly disagree (1) to strongly agree (5). The scale produces a score for each of the four stages of change, which reflects the possibility that participants may be in more than one stage at any given time. The scale can also be used to identify which stage of change an individual is in; the subscale with the highest summed score. If two subscales have the same summed score the furthest
one in the cycle of change is used (Rollnick et al., 1992). The internal consistency has not been reported for a weight control sample but has been proved adequate for other problem behaviours. McConnaughy et al. (1983) reported internal consistency coefficients of .88, .88, .89 and .88 for the four stages; precontemplation, contemplation, action and maintenance, respectively.

Table 3: Example of items from URICA

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Example of item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>As far as I am concerned, I do not have any weight problems that need changing</td>
</tr>
<tr>
<td>Contemplation</td>
<td>It might be worthwhile for me to work on my weight</td>
</tr>
<tr>
<td>Action</td>
<td>I am finally doing some work on my weight problem</td>
</tr>
<tr>
<td>Maintenance</td>
<td>I am working to prevent myself from having a relapse of my weight problem</td>
</tr>
</tbody>
</table>

2.4.2 Decisional balance scale

The Decisional Balance Scale developed by Cockell et al. (2002) is a 30 item self-report scale, which assesses positive and negative consequences of anorexia nervosa. It was designed to measure of readiness to change and motivation in anorexia nervosa. The Decisional Balance Scale has three subscales: Burdens; Benefits and Functional Avoidance. The Burdens subscale (cons) consists of fifteen items, assessing the negative consequences of anorexia nervosa such as the impact on health, negative affect, social isolation, intrapersonal difficulties and interpersonal difficulties. The Benefits subscale (pros) consists of eight items, identifying anorexia nervosa as positive and valuable for the individual such as creating self-control, enhancing self-esteem and providing a way of being perfect. The Functional Avoidance subscale is an addition to other decisional balance measures. This consists of seven items that assess how anorexia nervosa is used to avoid negative emotions, anticipated responsibilities and challenges in life. Participants respond to the statements on a five-point likert-type scale.
ranging from not at all true (1) to completely true (5). The Decisional Balance Scale has been found to have good psychometric validity (Cockell et al., 2003) and internal consistency is good with coefficient alphas of .88 for each of the three subscales. Test-retest reliability was also good ranging from .64 to .70 indicating reasonable support for the stability of the measure. The seven items forming the Functional Avoidance subscale were not included in this research, as they were not considered necessary for the purpose of the current study. Examples of items used in this study are displayed in table 4.

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Example of items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burdens</td>
<td>1. It bothers me that anorexia leaves me with no energy</td>
</tr>
<tr>
<td></td>
<td>2. I hate the fact that anorexia controls my life</td>
</tr>
<tr>
<td>Benefits</td>
<td>1. Being a very low weight makes me feel confident</td>
</tr>
<tr>
<td></td>
<td>2. Anorexia is my way of being perfect</td>
</tr>
</tbody>
</table>

2.4.3 Ambivalence measure
A 48-item self-report ambivalence measure was developed by the researcher. The measure asks participants to respond to four questions regarding twelve areas in which they may experience ambivalence with respect to their anorexia nervosa. The twelve areas include: having an eating disorder, using weight control strategies, following a healthy eating pattern, the impact of the eating disorder on physical appearance, being a normal weight, gaining weight, the impact of the eating disorder on physical health, the impact of the eating disorder on sense of security, the impact of the eating disorder on relationships, the impact of the eating disorder on confidence, the eating disorder and self-esteem, and the eating disorder helping to deal with difficulties in life. The four questions ask participants about: conflicting thoughts; mixed feelings; conflicting thoughts with feelings; and distress related to the conflicting thoughts and/or feelings (ambivalence-distress). Participants were asked to respond on a likert-type scale. For the first three questions they comment on how much they agree or disagree with the statements, ranging from strongly agree (1) to strongly disagree (6). For the
fourth question participants comment on how distressed they feel about the conflict/mixed thoughts and/or feelings. The responses range from no distress (1) to a lot of distress (4). Participants can score a total ambivalence score of 216 and a total ambivalence-distress score of 48. In addition, there are three subscale score. Participants can score 72 on the conflicting thoughts subscale, 72 on the mixed feelings subscale and 72 on the conflicting thoughts with feelings subscale.

2.4.4 Symptom measure
The Eating Disorder Examination – Questionnaire (EDE-Q; Fairburn & Beglin, 1994) was used to assess current symptoms of the participants. This is a 36-item self-report questionnaire, based on the Eating Disorder Examination interview. The questionnaire focuses on the behavioural features of eating disorders by asking about the frequency of different symptoms over the past 28 days. It also creates four subscales based on the severity of eating pathology as well as a Global Score. The subscales include Restraint, Eating Concerns, Shape Concerns and Weight Concerns. Participants obtain a mean score on each of the subscales and an overall score. This has been found to have good psychometric properties (Mond et al., 2004).

2.5 Data analysis
Missing data was managed by using mean score replacements for items in scales where less than 20% of the items were missing. If more than 20% of the items were missing, the participant’s data was excluded from the relevant analysis.

2.5.1 Power analysis
A priori power analysis calculation was calculated on G*Power, (Faul & Erdfelder, 1992) based on the research by Cockell et al. (2003). The burden score was used for the analysis because it was considered a key dependent variable in both the current study and the research by Cockell et al. (2003). Their study had an effect size of .359, indicating a medium effect size. Using the same effect size, G*Power showed that 92 participants were needed for
statistical significance with an alpha = 0.05 and a power value = .82. The effect size of the current study was computed as partial eta squared ($\eta^2$). Partial $\eta^2$ was .309, described as a large effect size by Green and Salkind (2003). Observed power using an alpha = 0.05 was .93.

2.5.2 Statistical analysis
Data was analysed using SPSS for Windows (version 13). In addition to exploring descriptive statistics and correlations, it was anticipated that a variety of parametric tests would be used including multivariate analysis of variance (MANOVA), analysis of variance (ANOVA) and t-tests providing that the assumptions underlying the tests were not violated.
Results

3.1. Managing the data set
Descriptive statistics were performed on the data, producing mean scores and standard deviations. Standardised scores (z scores) were calculated to identify possible outliers. No univariate outliers were found. Skewness and kurtosis coefficients were computed; all values fell between -1.96 and +1.96 suggesting the distribution is not significantly different from a normal distribution. Kolmogrov-Smirnov (Lilliefors) tests on all variables were non-significant confirming that the distribution of the data was not significantly different from a normal distribution. For analyses where applicable, tests of homogeneity of variance (Levene Statistic) were conducted and all were non-significant. Therefore, parametric tests were used for the analyses.

3.2. Preliminary analysis
Participants were sorted into groups based on their highest stage of change score. Fifty-nine participants (95%) fully completed the stage of change questionnaire. Seven participants (11.9%) scored highest within the precontemplation stage; fourteen (23.7%) participants scored highest within the contemplation stage; seventeen (28.8%) participants scored highest within the action stage; and twenty-one (35.6%) participants scored highest within the maintenance stage of change.

Analyses were conducted to compare symptom severity across the stage of change groups. A MANOVA showed there was no significant difference on the EDE-Q subscales across the four stage of change groups (Wilks' Lambda; F (12, 129.9) = 0.315, p = .986). Means and standard deviations are presented in table 5. An ANOVA showed there was no significant difference on BMI scores across the four stage of change groups (F (3, 49) = 0.950, p = .424). Means and standard deviations are presented in table 6.
Table 5: Mean scores and standard deviations for EDE-Q scores across the four stage of change groups

<table>
<thead>
<tr>
<th></th>
<th>Restraint Concerns</th>
<th>Weight Concerns</th>
<th>Shape Concerns</th>
<th>Eating Concerns</th>
<th>Global Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M  SD</td>
<td>M  SD</td>
<td>M  SD</td>
<td>M  SD</td>
<td>M  SD</td>
</tr>
<tr>
<td>Precontemplation</td>
<td>3.10 2.12</td>
<td>3.50 1.79</td>
<td>4.00 1.58</td>
<td>3.13 1.87</td>
<td>3.43 1.80</td>
</tr>
<tr>
<td>Contemplation</td>
<td>3.77 1.88</td>
<td>3.81 1.61</td>
<td>4.25 1.77</td>
<td>3.44 1.68</td>
<td>3.82 1.55</td>
</tr>
<tr>
<td>Action</td>
<td>3.20 1.99</td>
<td>3.39 1.82</td>
<td>3.87 1.80</td>
<td>3.13 1.74</td>
<td>3.39 1.60</td>
</tr>
<tr>
<td>Maintenance</td>
<td>3.21 1.65</td>
<td>3.89 1.82</td>
<td>4.32 1.68</td>
<td>3.14 1.75</td>
<td>3.64 1.59</td>
</tr>
</tbody>
</table>

Table 6: Mean scores and standard deviations for BMI scores across the four stage of change groups

<table>
<thead>
<tr>
<th></th>
<th>BMI Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
</tr>
<tr>
<td>Precontemplation</td>
<td>18.32</td>
</tr>
<tr>
<td>Contemplation</td>
<td>16.74</td>
</tr>
<tr>
<td>Action</td>
<td>17.38</td>
</tr>
<tr>
<td>Maintenance</td>
<td>17.84</td>
</tr>
</tbody>
</table>

3.3. Aim: To measure subjective ambivalence regarding anorexia nervosa

The twelve questions that asked about conflicting thoughts were combined to create a conflicting thoughts subscale, the twelve questions that asked about mixed feelings were combined to create a mixed feelings subscale and the twelve questions that asked about thoughts conflicting with feelings were combined to create a conflicting thoughts with feelings subscale. Table 7 presents the descriptive statistics for the measure. The three types of ambivalence-conflict (conflicting thoughts, mixed feelings and conflicting thoughts with feelings) were highly correlated (ranging from .85 to .98; p ≤ .01, 2-tailed test) (see Table 8 for the correlations of the three ambivalence-conflict subscales and the total ambivalence-conflict score, across the twelve aspects of anorexia) and there was high internal consistency (.967). Therefore, their
combined score was used for all analysis. The overall mean ambivalence score was 158.38 (SD = 33.02) indicating relatively high ambivalence. Participants rated their ambivalence-conflict in relation to twelve aspects of their anorexia nervosa. Mean scores and standard deviations were compared (table 9). Participants reported higher ambivalence-conflict regarding some issues relating to their anorexia compared to other issues. Participants reported highest ambivalence-conflict for gaining weight followed by eating a healthy 2000 calorie diet. They reported lowest ambivalence-conflict regarding the impact of the eating disorder on their physical health (this was still relatively high ambivalence, mean of 11.76 out of a total of 18).

The items relating to the physical aspects of anorexia (i.e. eating healthily, physical appearance, stable weight, gaining weight and impact on physical health) and the items relating to the psychological aspects of anorexia (i.e. impact on sense of security, impact on relationships, impact on confidence, self-esteem and coping with difficulties) were combined respectively to create a mean physical score and a mean psychological score (out of 6 on the likert-scale). Means and standard deviations are presented in Table 10. The physical aspects and psychological aspects were compared for ambivalence-conflict and ambivalence-distress. The paired sample t-tests were significant (t (61) = 4.79, p ≤ .01 and t (61) = 3.22, p < .01 respectively), participants reported greater ambivalence-conflict and ambivalence-distress for physical aspects of anorexia than psychological aspects of anorexia.

Table 7: Descriptive statistics for the ambivalence measure

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
<th>Alpha Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflicting Thoughts</td>
<td>53.14</td>
<td>11.03</td>
<td>13 – 72</td>
<td></td>
</tr>
<tr>
<td>Mixed Feelings</td>
<td>53.66</td>
<td>11.15</td>
<td>13 - 72</td>
<td></td>
</tr>
<tr>
<td>Conflicting Thoughts</td>
<td>51.58</td>
<td>11.89</td>
<td>13 - 72</td>
<td></td>
</tr>
<tr>
<td>with Feelings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Ambivalence-</td>
<td>158.38</td>
<td>33.021</td>
<td>38 - 216</td>
<td>0.967</td>
</tr>
<tr>
<td>conflict</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 8: Correlations for the ambivalence-conflict measure

<table>
<thead>
<tr>
<th></th>
<th>Total Ambivalence-conflict</th>
<th>Conflicting Thoughts Subscale</th>
<th>Mixed Feelings Subscale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflicting Thoughts Subscale</td>
<td>.96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed Feelings Subscale</td>
<td>.97     .93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflicting Thoughts with Feelings Subscale</td>
<td>.95     .85       .89</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All significant at .01 level (2-tailed)

Table 9: Means and standard deviations for ambivalence-conflict and ambivalence-distress for 12 aspects of anorexia

<table>
<thead>
<tr>
<th></th>
<th>Ambivalence-conflict</th>
<th>Ambivalence-distress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M        SD</td>
<td>M        SD</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>14.05    3.50</td>
<td>2.92    0.98</td>
</tr>
<tr>
<td>Weight Control Strategies</td>
<td>13.52    3.26</td>
<td>2.79    0.99</td>
</tr>
<tr>
<td>Eating Healthily</td>
<td>14.71    3.09</td>
<td>2.87    1.03</td>
</tr>
<tr>
<td>Physical Appearance</td>
<td>13.24    3.63</td>
<td>2.69    0.97</td>
</tr>
<tr>
<td>Stable Weight</td>
<td>14.13    3.90</td>
<td>2.69    0.99</td>
</tr>
<tr>
<td>Gaining weight</td>
<td>14.97    3.50</td>
<td>3.10    1.02</td>
</tr>
<tr>
<td>Impact-Physical Health</td>
<td>11.76    3.98</td>
<td>2.31    0.95</td>
</tr>
<tr>
<td>Impact-Sense of Security</td>
<td>12.10    4.43</td>
<td>2.26    1.07</td>
</tr>
<tr>
<td>Impact-Relationships</td>
<td>13.00    3.89</td>
<td>2.79    0.96</td>
</tr>
<tr>
<td>Impact-Confidence</td>
<td>11.89    3.89</td>
<td>2.50    0.98</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>12.47    3.94</td>
<td>2.53    0.98</td>
</tr>
<tr>
<td>Coping with Difficulties</td>
<td>12.55    3.90</td>
<td>2.58    0.98</td>
</tr>
</tbody>
</table>
Table 10: Means and standard deviations for physical and psychological aspects of anorexia nervosa (AN)

<table>
<thead>
<tr>
<th></th>
<th>Mean Ambivalence-conflict Score</th>
<th>Mean Ambivalence-distress Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Physical aspects of AN</td>
<td>4.57</td>
<td>0.90</td>
</tr>
<tr>
<td>Psychological aspects of AN</td>
<td>4.13</td>
<td>1.10</td>
</tr>
</tbody>
</table>

3.3.1. Hypothesis 1: It is predicted that there will be a positive correlation between ambivalence-conflict and ambivalence-distress.

As predicted ambivalence-distress was positively correlated with the combined ambivalence-conflict score (r (62) = .27, p = .031, 2-tailed test). Interestingly, the correlation was quite small suggesting that ambivalence-conflict and ambivalence-distress are not equivalent. Participants rated their ambivalence-distress in relation to twelve aspects of their anorexia (table 9), participants reported most ambivalence-distress regarding gaining weight followed by having an eating disorder, and they reported least ambivalence-distress regarding the impact of the eating disorder on their sense of security.

3.4. Aim: To examine the relationship between subjective ambivalence and the stages of change

3.4.1. Hypothesis 1: It is predicted that participants in the contemplation stage group will report greater ambivalence-conflict than participants in the precontemplation stage group and action stage group.

An ANOVA showed there was no significant difference between ambivalence-conflict scores across the four stage of change groups (F (3, 55) = 0.41, p = .747, partial \( \eta^2 = .022 \)). Means and standard deviations are presented in table 11. The hypothesis was not supported, however the pattern of means was

---

1 The mean score of the overall ambivalence-conflict scale was used as all 12 aspects of anorexia were included.
as predicted. Participants in the contemplation stage group reported greater ambivalence-conflict scores than participants in the precontemplation stage group and the action stage group. Participants in the maintenance stage group reported greater ambivalence-conflict scores than participants in the action stage group (graph 1). The descriptive statistics of the ambivalence-conflict scores across the stage of change groups showed that mean scores (for each question) in all four groups were somewhere between slightly agree (a score of 4) and agree (a score of 5) on the likert-scale, suggesting that even those in the precontemplation stage group reported ambivalence-conflict to some degree (table 12).

Table 11: Mean scores and standard deviations for the ambivalence-conflict score across the four stages of change groups

<table>
<thead>
<tr>
<th>Ambivalence-conflict Score</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>152.89</td>
<td>34.09</td>
</tr>
<tr>
<td>Contemplation</td>
<td>167.03</td>
<td>23.53</td>
</tr>
<tr>
<td>Action</td>
<td>159.69</td>
<td>32.06</td>
</tr>
<tr>
<td>Maintenance</td>
<td>165.41</td>
<td>24.79</td>
</tr>
</tbody>
</table>

Table 12: Mean ambivalence-conflict scores and their appropriate description from the ambivalence measure

<table>
<thead>
<tr>
<th>Mean Ambivalence-conflict Score</th>
<th>Description on the Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Precontemplation</td>
<td>4.25</td>
</tr>
<tr>
<td>Contemplation</td>
<td>4.64</td>
</tr>
<tr>
<td>Action</td>
<td>4.44</td>
</tr>
<tr>
<td>Maintenance</td>
<td>4.59</td>
</tr>
</tbody>
</table>
Graph 1: Mean ambivalence-conflict score across the four stage of change groups
3.4.2. **Hypothesis 2:** It is predicted that participants in the contemplation stage group will report greater ambivalence-distress than participants in the precontemplation stage group and action stage group.

An ANOVA showed there was a significant difference on ambivalence-distress across the four stage of change groups with a large effect size (F (3, 55) = 2.75, p = .05, partial $\eta^2 = .131$). A conservative post hoc test such as Turkey HDS did not find a significant difference between groups. However, LSD comparisons which is a more liberal test found significant differences between the precontemplation stage group and contemplation stage group ($p = .033$) and the precontemplation stage group and maintenance stage group ($p = .025$). Means and standard deviations are presented in table 13. The hypothesis was supported in finding greater ambivalence-distress in the contemplation stage group than the precontemplation stage group, however was unsupported by not finding a significant difference between ambivalence-distress scores in the contemplation stage group and the action stage group. The pattern of means was however as expected with ambivalence-distress lower in the action stage group. Interestingly, ambivalence-distress was significantly greater in the maintenance stage group than the precontemplation stage group but not different to the contemplation stage group or action stage group suggesting that ambivalence-distress remains high once individuals start contemplating change (graph 2).

**Table 13:** Mean scores and standard deviations for distress score across the four stages of change

<table>
<thead>
<tr>
<th>Ambivalence-distress Score</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>25.86$^a$</td>
<td>10.06</td>
</tr>
<tr>
<td>Contemplation</td>
<td>35.00$^b$</td>
<td>6.75</td>
</tr>
<tr>
<td>Action</td>
<td>29.47$^{ab}$</td>
<td>9.55</td>
</tr>
<tr>
<td>Maintenance</td>
<td>34.90$^b$</td>
<td>9.51</td>
</tr>
</tbody>
</table>

$^a$ $^b$ identify a significant difference between precontemplation and contemplation and precontemplation and maintenance
Graph 2: Mean ambivalence-distress score across the four stage of change groups
3.5. Aim: To replicate and extend the study conducted by Cockell et al. (2003)

3.5.1. Replication of the study conducted by Cockell et al. (2003)

3.5.1.1. Hypothesis 1: It is predicted that the burden score will be greater in the contemplation stage group than the precontemplation stage group.

Hypothesis 2: It is predicted that the burden score in the action stage group will be greater than in the precontemplation stage group but no different to contemplation stage group.

The ANOVA conducted to replicate the findings of Cockell et al. (2003) was significant with a large effect size (F (2, 35) = 7.82, p = .002; partial $\eta^2$ = .309). Turkey HSD comparisons found a significant difference in burden score between the contemplation stage group and precontemplation stage group (p = .004) and the contemplation stage group and action stage group (p = .007). Means and standard deviations are presented in table 14. Supporting hypothesis 1, the mean burden score for the contemplation stage group was significantly greater than the mean burden score for the precontemplation stage group. Hypothesis 2 was not supported; mean burden scores did not differ between the precontemplation stage group and action stage group. The mean burden score was however significantly greater for the contemplation stage group than the action stage group. Although this finding is inconsistent with the results of Cockell et al. (2003) and was not predicted, a similar finding was found in five health-related behaviours studied by Prochaska et al. (1994), where the pros of change decreased between the contemplation stage and action stage.

3.5.1.2. Hypothesis 3: It is predicted that the benefit score will be no different in the precontemplation stage group, contemplation stage group and action stage group.

An ANOVA showed there was no significant difference in mean benefit score between the precontemplation stage group, the contemplation stage group and the action stage group (F (2, 35) = 1.85, p = .173; partial $\eta^2$ = .095). This
finding is consistent with Cockell et al. (2003) and supports the hypothesis. Interestingly, although the difference was non-significant, the pattern of means was the same as that found for the burden score. The benefit score was lowest in the precontemplation stage group, highest in the contemplation stage group and lowered in the action stage group. Mean scores and standard deviations are presented in table 14.

Table 14: Mean scores and standard deviations for burden and benefit subscales across the first three stages of change

<table>
<thead>
<tr>
<th></th>
<th>Burdens</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Precontemplation</td>
<td>2.25&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.10</td>
</tr>
<tr>
<td>Contemplation</td>
<td>3.68&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.78</td>
</tr>
<tr>
<td>Action</td>
<td>2.64&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.93</td>
</tr>
</tbody>
</table>

<sup>a</sup> <sup>b</sup> indicates a significant difference between contemplation and precontemplation; and contemplation and action

Cockell et al. (2003) conducted exploratory analysis using symptom severity scores and BMI scores. They found that the benefit score was significantly correlated with eating disorder severity, but not with the BMI score, and the burden score was not correlated with either. The pattern of correlations was different in this study. Consistent with the findings of Cockell et al. (2003), the benefit score was significantly positively correlated with all four subscales of the EDE-Q, and the global EDE-Q score, ranging from .59 to .74 (p ≤ .01, 2-tailed test), and was not significantly correlated to the BMI score (r (56) = -.14, p = .32, 2-tailed test). However, inconsistent with the findings of Cockell et al. (2003), the burden score was significantly positively correlated to all subscales of the EDE-Q (.41 - .51 p ≤ .01, 2-tailed test) and significantly negatively correlated to the BMI score (r (56) = -.54, p ≤ .01, 2-tailed test) (table 15 for correlations).
Table 15: Correlations for symptom severity and burden and benefit scores

<table>
<thead>
<tr>
<th></th>
<th>Burdens</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDE-Q Restraint</td>
<td>.41*</td>
<td>.59*</td>
</tr>
<tr>
<td>EDE-Q Weight Concerns</td>
<td>.53*</td>
<td>.74*</td>
</tr>
<tr>
<td>EDE-Q Shape Concerns</td>
<td>.51*</td>
<td>.64*</td>
</tr>
<tr>
<td>EDE-Q Eating Concerns</td>
<td>.51*</td>
<td>.64*</td>
</tr>
<tr>
<td>EDE-Q Global score</td>
<td>.51*</td>
<td>.70*</td>
</tr>
<tr>
<td>BMI</td>
<td>-.54*</td>
<td>-.14</td>
</tr>
</tbody>
</table>

* denotes significance at .01 level (2-tailed test)

3.5.2. Extension of the study conducted by Cockell et al. (2003)

Cockell et al. (2003) used the pre-maintenance stages for their analysis because participants did not score in the maintenance stage on the stage of change questionnaire. The maintenance stage was included in this analysis because 35.6% of participants scored highest in the maintenance stage.

3.5.2.1. Hypothesis 1: It is predicted that the burden score will be greater in the maintenance stage group than the precontemplation stage group.

An ANOVA including the maintenance stage group in the analysis showed there was a significant difference between the groups for the mean burden score (F (3, 55) = 5.17, p = .003; partial η² = .220). LSD comparisons found a significant difference in burden score between the maintenance stage group and precontemplation stage group (p = .013) and the maintenance stage group and action stage group (p = .030). Means and standard deviations are presented in table 16. The hypothesis was supported; the mean burden score for the maintenance stage group was significantly greater than the mean burden score for the precontemplation stage group. Interestingly, the mean burden score for the maintenance stage group was significantly greater than the mean burden score for the action stage group suggesting that some burdens of anorexia may not be acknowledged until the maintenance stage; even those taking action to change may not have identified all of the burdens of their anorexia.
3.5.2.2. **Hypothesis 2:** It is predicted that the benefit score will be no different in the maintenance stage to the other three stages.

An ANOVA including the maintenance stage group in the analysis showed there was no significant difference between the groups for the mean benefit score (F (3, 55) = 1.59, p = .203; partial $\eta^2 = .080$). Means and standard deviations are presented in table 16. The hypothesis was supported; the maintenance stage group did not differ significantly from the precontemplation stage group, contemplation stage group or action stage group for mean benefit scores. Although the result was non-significant, the pattern of means is consistent with the pattern of means for the burden score. The mean benefit score is greater in the maintenance stage group than the action stage group suggesting that once individuals are maintaining the changes they have made regarding their anorexia, they become more 'bothered' about the burdens of anorexia, however at the same time see the benefits. Interestingly, the pattern of means for both the burden score and benefit score are consistent with the pattern of means for the ambivalence-conflict score and ambivalence-distress (graph 3).

Table 16: Mean scores and standard deviations for Burdens and Benefits subscales across the four stages of change

<table>
<thead>
<tr>
<th></th>
<th>Burdens</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Precontemplation</td>
<td>2.25(^a)</td>
<td>1.10</td>
</tr>
<tr>
<td>Contemplation</td>
<td>3.68(^b)</td>
<td>0.78</td>
</tr>
<tr>
<td>Action</td>
<td>2.64(^a)</td>
<td>0.93</td>
</tr>
<tr>
<td>Maintenance</td>
<td>3.26(^b)</td>
<td>1.06</td>
</tr>
</tbody>
</table>

\(^a\) and \(^b\) indicate a significant difference between maintenance and precontemplation and maintenance and action.
Graph 3: Mean scores for burdens and benefits across the stage of change groups
3.6. Aim: To compare subjective ambivalence with objective ambivalence

3.6.1. Correlations
Cockell et al. (2003) proposed that an increase in burdens shows how individuals work through ambivalence. Therefore, based on the results above, finding that the burden score is highest in the contemplation stage and decrease in the action stage is in line with what happens to subjective ambivalence. There was a weak correlation between the burden score and ambivalence-conflict score ($r (62) = .29, p \leq .05$, 2-tailed test). There was no significant correlation found between the benefit score and ambivalence-conflict score ($r (62) = .17, p = .18$, 2-tailed test). Interestingly there was a strong correlation between ambivalence-distress and the burden scores ($r (62) = .77, p \leq .01$, 2-tailed test) and ambivalence-distress and the benefit scores ($r (62) = .58, p \leq .01$, 2-tailed test).

3.7.2. Subjective ambivalence and objective ambivalence
The decisional balance scale was combined to create an objective measure of ambivalence to compare against the subjective measure. The formula used was developed by Griffin and presented by Thompson et al. (1995):

\[
\text{Ambivalence} = \frac{(\text{benefits} + \text{burdens})}{2} - (\text{benefits} - \text{burdens})
\]

An ANOVA showed there was a significant difference in objective ambivalence scores across the four stage of change groups ($F 3(54) = 4.59, p = .006$, partial $\eta^2 = .203$). Means and standard deviations are presented in table 17. Turkey HSD comparisons found that objective ambivalence was significantly greater in the contemplation stage group than the precontemplation stage group ($p = .25$) and the action stage group ($p = .013$). These significant differences are the same as those found in the burden analysis and supports the proposal by Cockell et al. (2003) that burdens show how individuals work through ambivalence (graph 4).
3.7.2.1. **Hypothesis 1**: It is predicted that subjective ambivalence will be weakly correlated with objective ambivalence.

A low positive correlation was found between subjective ambivalence and objective ambivalence ($r (61) = .25$, $p = .05$, 2-tailed test) supporting the hypothesis that subjective ambivalence and objective ambivalence are weakly correlated.

3.7.2.2. **Hypothesis 2**: It is predicted that ambivalence-distress will be weakly correlated with objective ambivalence.

A medium to high positive correlation was found between ambivalence-distress and objective ambivalence ($r (61) = .62$, $p < .01$, 2-tailed test). This was not predicted and does not support the hypothesis that there will be a weak correlation between ambivalence-distress and objective ambivalence, instead ambivalence-distress appears to have a strong correlation with objective ambivalence.

Table 17: Mean scores and standard deviations for objective ambivalence across the four stage of change groups

<table>
<thead>
<tr>
<th>Objective ambivalence</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>2.34&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.53</td>
</tr>
<tr>
<td>Contemplation</td>
<td>4.15&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1.28</td>
</tr>
<tr>
<td>Action</td>
<td>2.61&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.27</td>
</tr>
<tr>
<td>Maintenance</td>
<td>3.44&lt;sup&gt;ab&lt;/sup&gt;</td>
<td>1.32</td>
</tr>
</tbody>
</table>

<sup>a  b</sup> indicates a significant difference between contemplation and precontemplation and contemplation and action

Finally, exploratory analyses were conducted to examine the relationship between symptom severity and subjective ambivalence and symptom severity and objective ambivalence. There was a weak correlation between the combined
ambivalence-conflict score and the shape concerns subscale ($r (60) = .26, p \leq .05$, 2-tailed test) and a weak negative correlation with the BMI score ($r (56) = -.27, p \leq .05$, 2-tailed test). Objective ambivalence had a weak correlation with the weight concerns subscale ($r (59) = .30, p = .023$, 2-tailed test) shape concerns subscale ($r (59) = .31, p = .017$, 2-tailed test) and eating concerns subscale ($r (60) = .33, p = .011$, 2-tailed test). There was also a weak correlation between objective ambivalence and the global EDE-Q score ($r (58) = .29, p = .028$, 2-tailed test), however there was a stronger negative correlation with the BMI score ($r (55) = -.58, p \leq .001$, 2-tailed test). Interestingly ambivalence-distress had stronger correlations with all of the EDE-Q (.48 - .66, $p \leq .01$, 2-tailed test) and a weaker negative correlation with the BMI score compared to objective ambivalence ($r (56) = -.46, p \leq .01$, 2-tailed test) (table 18 for correlations).

Table 18: Correlations for symptom severity, ambivalence-conflict, ambivalence-distress and objective ambivalence

<table>
<thead>
<tr>
<th></th>
<th>Ambivalence-conflict</th>
<th>Ambivalence-distress</th>
<th>Objective ambivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BMI Score</strong></td>
<td>-.27*</td>
<td>-.46**</td>
<td>-.58**</td>
</tr>
<tr>
<td><strong>EDE-Q Restraint</strong></td>
<td>.07</td>
<td>.44**</td>
<td>.23</td>
</tr>
<tr>
<td><strong>EDE-Q Weight</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns</td>
<td>.17</td>
<td>.66**</td>
<td>.30*</td>
</tr>
<tr>
<td><strong>EDE-Q Shape</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns</td>
<td>.26*</td>
<td>.61**</td>
<td>.31*</td>
</tr>
<tr>
<td><strong>EDE-Q Eating</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns</td>
<td>.17</td>
<td>.64**</td>
<td>.33*</td>
</tr>
<tr>
<td><strong>EDE-Q Global Score</strong></td>
<td>.24</td>
<td>.62**</td>
<td>.29*</td>
</tr>
</tbody>
</table>

* denotes significance at .05 level and ** denotes significance at .01 level (2-tailed test)
Graph 4: Mean objective ambivalence score across the four stage of change groups
4.1. Measuring subjective ambivalence

A measure was developed to assess cognitive ambivalence, affective ambivalence and cognitive/affective ambivalence within anorexia nervosa. All three subscales were highly correlated with one another and the combined ambivalence-conflict score. This suggests that they were all measuring the same concept. Although cognitive ambivalence and affective ambivalence were significantly related in the study by Thompson et al. (1995), the relationship was not as strong. The strong correlation in the current study suggests that it is not necessary to ask about different types of ambivalence-conflict, instead future research could focus on only one type of ambivalence-conflict (e.g. do you have conflicting thoughts/feelings?). As predicted, ambivalence-distress was significantly correlated with ambivalence-conflict. However, as the correlation was small, it highlighted the importance of asking about ambivalence-distress, and it appears that ambivalence-conflict and ambivalence-distress are measuring different constructs. It is unclear how ambivalence-conflict and ambivalence-distress are related and suggests that further research would be useful in this area, for example for whom or when might ambivalence-conflict and ambivalence-distress be the same and for whom and when might they be different and to what extent do either of them relate to change.

Participants were asked to rate their ambivalence and ambivalence-distress about twelve aspects of their anorexia. The twelve aspects were chosen to include physical, psychological and social aspects of anorexia. This measure showed that participants were ambivalent about all aspects of their anorexia and were distressed to some degree about their ambivalence. The mean scores showed that participants were more ambivalent about some aspects and less ambivalent about others. Ambivalence-distress also varied for the different aspects of anorexia. Participants were particularly ambivalent and reported most ambivalence-distress about gaining weight. This is not surprising given that individuals with anorexia wish to remain slim. Participants were least ambivalent about the impact of their anorexia on their
physical health which may have been because all participants were worried about their physical health.

The aspects of anorexia were separated into physical aspects and psychological aspects to compare whether participants' ambivalence-conflict and ambivalence-distress varied between them. Participants reported significantly greater ambivalence-conflict and ambivalence-distress for the physical aspects of anorexia compared to the psychological aspects. This suggests that participants had more conflicting thoughts about the impact of anorexia on them physically than psychologically. This is not surprising given that physical improvements are often the initial focus of treatment, therefore are likely to be more in mind than psychological changes. This provides support for Treasure et al. (1999), and Sullivan and Terris (2001) in suggesting that asking about one symptom, that is weight control on the stage of change questionnaire, is not sufficient in understanding ambivalence, as ambivalence-conflict and ambivalence-distress appears to vary for different aspects of anorexia. It would be particularly helpful for clinicians to know what aspects of anorexia clients are ambivalent about, as it could help with the engagement process.

4.2. Stages of change

4.2.1 Precontemplation and contemplation stages

A key finding in this research was the confirmation of the difference between the precontemplation stage group and the contemplation stage group. Consistent with research in other fields (Prochaska et al., 1994) and eating disorders (Cockell et al., 2003); the burden score was significantly greater for participants in the contemplation stage group than for participants in the precontemplation stage group. This was supported by objective ambivalence and ambivalence-distress being significantly greater in the contemplation stage group than the precontemplation stage group. Although non-significant, ambivalence-conflict and the benefit score were also greater in the contemplation stage group than the precontemplation stage group. These results suggest that participants in the contemplation stage are quite different
from those in the precontemplation stage, they are weighing up the pros and cons of their anorexia (benefits and burdens), they are ambivalent about various aspects of their anorexia and they report greater distress regarding their ambivalence. High ambivalence-distress suggests that participants may want to resolve the ambivalence-conflict to reduce the discomfort (Festinger, 1957). This may explain why participants are in the contemplation stage group; they are considering change as their option to reduce the distress.

4.2.2. Action stage
Ambivalence-conflict and ambivalence-distress were predicted to be lower in the action stage group than the contemplation stage group whereas the burden score and benefit score were predicted to be no different in the action stage group and contemplation stage group. The results found that neither ambivalence-conflict nor ambivalence-distress was significantly lower in the action stage group than the contemplation stage group. However objective ambivalence and the burden score were significantly lower in the action stage group than the contemplation stage group. A lower burden score in the action stage group than the contemplation stage group is inconsistent with the findings of Cockell et al. (2003) but is not a completely new finding. Prochaska et al. (1994) found the pros of change decreased between the contemplation stage and action stage for five health-related behaviours. They did not suggest a reason for this finding, however it could be that once individuals have made a decision to make changes, although the burdens regarding their anorexia do not disappear, the burdens may bother them less which is reflected by a lower burden score. For example, when asked to comment on the statement 'it bothers me that my weight controls my mood', those in the action stage do not necessarily think that their weight does not control their mood, instead, because they are doing something about it, they are less concerned about it. Cockell et al. (2003) suggested that burdens show how individuals work through ambivalence. Finding a lower burden score in the action stage group than the contemplation stage group supports this suggestion, especially as objective ambivalence was also significantly lower in the action stage group. The pattern of mean scores for ambivalence-
conflict and ambivalence-distress were also slightly lower for participants in the action stage group than for participants in the contemplation stage group. This suggests that the mean scores for all variables were lower for participants in the action stage group than for participants in the contemplation stage group. Further research would be necessary to replicate this finding.

4.2.3. Maintenance stage
As predicted participants in the maintenance stage group reported greater burden scores than those in the precontemplation stage group and did not differ from the other stage groups on benefit scores. Participants in the maintenance stage group also reported significantly greater ambivalence-distress than participants in the precontemplation stage. This is not surprising given that participants in the precontemplation stage group have less ambivalence-conflict to feel distressed about. In addition, participants in the maintenance stage group reported greater burden scores than participants in the action stage group suggesting that those who are maintaining their changes are more bothered by the burdens than those who are making changes. Burden scores of participants in the maintenance stage group were no different to burden scores of those in the contemplation stage group. Similar scores for participants in the contemplation stage group and maintenance stage group were also found for ambivalence-conflict, ambivalence-distress, objective ambivalence and benefit score. This raises the question of what is different about participants in the action stage group. The only significant difference between participants in the action stage group and maintenance stage group was for burden scores. However, the other variables produced patterns of mean scores in the same direction. Mean scores for participants in the maintenance stage group were slightly greater than mean scores for participants in the action stage group for ambivalence-conflict, ambivalence-distress, objective ambivalence and the benefit score, suggesting that further investigation into this pattern would be beneficial.
4.3. Ambivalence-conflict

Ambivalence-conflict was reported in all four groups. It was identified that participants in the precontemplation stage group were ambivalent to some extent. These participants do not consider themselves to have a problem, however at the same time they reported feeling ambivalent. This may have been because the stages of change are not discrete stages (Wilson & Schlam, 2004), which means that participants were also scoring in the contemplation stage, action stage and maintenance stage where they were more ambivalent, however their highest score was in the precontemplation stage resulting in allocation to that group.

Finding high ambivalence-conflict reported by participants in the maintenance stage group is important to consider. It suggests that these participants may be unsure of the changes they have made and may potentially relapse. It is important to discover why participants are ambivalent in the maintenance stage as it may have implications for the length of treatment, particularly post change. Cockell et al. (2004) identified that there has been a lack of research on maintaining changes once gained. Gaining a greater understanding of ambivalence-conflict in the maintenance stage could have a beneficial outcome for the success of treatment.

4.4. Ambivalence-distress

The results showed that ambivalence-distress was an important variable to study. It appears to be measuring something different to ambivalence-conflict and significant results were found across the stage of change groups. Ambivalence-distress is an interesting concept because the distress will depend on how connected the person feels to the ambivalence-conflict. Perhaps, a person could be highly ambivalent but not feel emotionally connected to the ambivalence-conflict therefore not feel distressed about it. Alternatively, a person could be less ambivalent but have a great emotional connection with the ambivalence-conflict resulting in greater distress. Participants may have reported ambivalence-distress for the issues that were personally relevant to them. Further research could look qualitatively at
individuals' perceptions of the aspects of anorexia that are relevant to them and any associated distress.

Ambivalence-distress as a variable had a large effect size (partial $\eta^2 = .131$) and there was reasonable power to detect a significant difference (power = .64). Given the large effect size, increasing the number of participants may have increased the power to detect a significant difference between participants in the action stage group and participants in the maintenance stage group. Future research would be able to test for this result.

4.5. Decisional balance
The burden score was a key variable in this study. The effect size was large (partial $\eta^2 = .220$), the four stage of change groups accounted for 22% of the variance of the burden score. The burden score also had a large power value (.91) to detect significant differences. Given that finding a significant difference between participants in the contemplation stage group and action stage group is inconsistent with the findings of Cockell et al. (2003), it would be useful to conduct further research as an attempt to replicate this finding and gain a greater understanding of people in the action stage of change.

Although the pattern of means for the benefit score followed the same pattern as the other variables, the results supported previous research (Cockell at al., 2003) by remaining stable for participants in all four stages of change groups. Even once changes have been made, individuals are continuously aware of the positive aspects of anorexia. This may explain the difficulties faced in treating anorexia (Murphy & Manning, 2003). Individuals may always be battling with themselves. The burdens or negative aspects of the anorexia may increase, but the benefits of anorexia do not appear to decrease. Interventions that focus on highlighting and encouraging thinking about the burdens may not be sufficient; it seems that individuals also need to become less connected to the advantages of the anorexia.
4.6. Objective ambivalence
The formula for objective ambivalence used the burden score and the benefit score. Thompson et al. (1995) suggested that objective ambivalence increases with an increase in similarity of ratings as well as extremity of ratings. The burden score appears to be the key variable in objective ambivalence, the benefits do not change but as burdens increase they become more equally weighted with the benefits thus greater ambivalence is reported. Therefore the stage group that reported greatest burden scores (contemplation stage group) also reported greatest objective ambivalence.

As hypothesised objective ambivalence and subjective ambivalence were only weakly correlated suggesting that they are measuring different constructs. The weak relationship between objective ambivalence and subjective ambivalence may account for the weak relationship between the burden score and subjective ambivalence. This suggests that subjective ambivalence is tapping into something different and is therefore important to measure separately.

Objective ambivalence had a strong correlation with ambivalence-distress, thus the hypothesis was not supported. This correlation may have been explained by the strong correlation between ambivalence-distress and the burden score. Questions on the burden subscale of the decisional balance measure ask about whether the burdens of anorexia 'bother' the participant. If a person feels 'bothered' by something they are likely to feel discomfort and distress, resulting in a strong correlation. Ambivalence-distress appears to be related to all the variables studied, highlighting the importance of measuring it as separate to ambivalence-conflict.

4.7. Eating disorder severity
Additional analysis involved investigating eating disorder severity and BMI scores in relation to the decisional balance and ambivalence. Replicating Cockell et al. (2003), this study found the EDE-Q scores were positively correlated to the benefit score, indicating that higher benefit scores were
associated with eating disorder severity, however this was not supported by the BMI scores which were not correlated with the benefit scores. The current study was inconsistent with the findings of Cockell et al. (2003), in that the burden score was positively correlated with the EDE-Q scores and negatively correlated with the BMI scores. This indicates that higher burden scores are associated with eating disorder severity and lower BMI scores. This is a surprise result, as it is expected that those who are improving, that is individuals with higher BMI scores and less severe symptomology would be identifying more negative aspects of their anorexia rather than those with more severe anorexia. However, this result combined with the correlation between benefit scores and symptom severity suggests that participants with the most severe symptoms are weighing up the pros and cons of their eating disorder so could be potentially contemplating change. Murphy and Manning (2003) commented on anorexia being difficult to treat because it goes untreated in the early stages. The current result however suggests that maybe more severe symptoms are needed for individuals to be able to think about the negative aspects (burdens) as well as the positive aspects (benefits) and therefore contemplate change.

Both objective and subjective ambivalence were only weakly correlated with only some of the EDE-Q subscales and objective ambivalence was moderately negatively correlated with the BMI score. Ambivalence-distress had a stronger correlation with all of the EDE-Q and was moderately negatively correlated with the BMI score. These results suggest that participants with greater symptom severity are reporting greater ambivalence-distress again supporting the importance of ambivalence-distress as a factor.

4.8. Limitations
4.8.1. Sample
Firstly, the sample must be questioned. Only sixty-two participants were included in this study. This was only 25% of individuals invited to participate. As participants were allocated to four groups many more participants would have been needed to add to the power of the study. It is unknown why so few
volunteered to participate from the eating disorder association, given that 226 people with anorexia or who had recovered from anorexia were attached to the research pool. The questionnaire pack was quite long which may have deterred some individuals from completing it. Also due to the timing of the research, questionnaires were sent out before Christmas when people may have felt too busy and then forgot to complete the questionnaire at a later date. Given that participants were anonymous to the researcher, it was not possible to follow-up any questionnaires that had not been returned.

Participants who returned the questionnaires may have been biased in some way. Only seven participants were allocated to the precontemplation stage group. This suggests that the majority of participants in this study recognised that they had a problem and were either contemplating change or were already engaged in the change process. This is not a surprise given that participants were either those already in treatment or those who had signed up to the EDA, presumably because they considered themselves to have a problem. However, this questions the view that people with anorexia often deny they have a problem and are reluctant to change (Vitousek et al., 1998). Of the eighteen participants who were currently in treatment at Heatherwood Hospital, only one participant was allocated to the precontemplation stage. Finding few participants in the precontemplation stage group is a challenge for this research, however is consistent with Ward et al. (1996) and Share et al. (2004) struggling to find participants in the precontemplation stage. Individuals who do not consider themselves to have a problem are possibly less inclined to participate in research. Given the small number of participants in this stage, the results must be interpreted with caution.

Those who did participate in the study, were all volunteers therefore they may have over-represented the action and maintenance stage groups. This is a particular concern given that the largest group was the maintenance stage group. However, there were not significantly less participants in the contemplation stage group than the action stage group. In addition, convenience samples have often been used in previous research. Cockell et
al. (2003) recruited from the United States, Canada and England to represent the different stages of change. They also used a sub-diagnosis of anorexia and only 38% of their sample had anorexia nervosa of the restrictive type. The current sample was a random sample and 92% reported to have a diagnosis of anorexia nervosa.

4.8.2. Ambivalence measure
Ambivalence-conflict as a variable had a very small effect size (partial $\eta^2 = .022$). This suggests that finding a significant difference across the stage of change groups would be very difficult. The questionnaire would need to be adapted for future research to be able to identify any significant differences. One way to adapt the measure could be to reduce the likert-scale from a 6-point scale to a 4-point scale. Asking about ambivalence-distress on a 4-point scale appeared suitable to identify differences; however using a 6-point scale may have produced too much variance. For future research, using a 4-point scale combined with asking only one question about ambivalence-conflict may be sufficient to increase the effect size.

The ambivalence measure was completed after completion of the decisional balance measure. Conner & Sparks (2002) suggested that individuals are not always aware of their inconsistencies in evaluations. This study may have primed participants to think about ambivalence-conflict and ambivalence-distress by completing the decisional balance measure first. This may have resulted in participants being aware of pros and cons of their anorexia that they otherwise may not have identified without a prompt. To investigate whether the decisional balance measure influenced the ambivalence measure, future research could randomly allocate participants to complete either the decisional balance measure followed by the ambivalence measure or the ambivalence measure followed by the decisional balance measure.

4.8.3. Transtheoretical model of change
The transtheoretical model of change has been criticised by several researchers (e.g. Littell & Girvin, 2002; Wilson, & Schlam, 2004) particularly
with reference to measurement of the stages. The stage of change questionnaire used in this research has been suggested to be a reliable measure (McConnaughy et al., 1983; McConnaughy et al., 1989). However, participants allocated to the precontemplation stage group because they did not consider themselves to have a problem on the stage of change questionnaire, at the same time reported ambivalence. This may have been due to scoring on the other stages as well, however, some researchers have criticised the measure for not identifying discrete stages of change (Wilson & Schlam, 2004).

Rieger et al. (2000) suggested that the measure over-estimates readiness to change. This is a concern in this research given that the majority of participants were in either the action stage or maintenance stage of change groups. This is possibly a particular issue for participants who were receiving treatment given that often, the clinical presentation is that even once individuals are accessing treatment, they are reluctant to change their eating disorder behaviour (Feld et al., 2004). This is contradictory to the current study finding the majority of participants in treatment in the action stage group and the maintenance stage group. If the stages of change are not truly representative of where participants are at, it questions the validity of the results. There is also a concern that within this study, the maintenance stage of change group is in fact the relapse stage given that ambivalence-conflict, ambivalence-distress, burdens and benefits are all higher in this stage. Only further research with other measures of change will be able to determine whether the maintenance stage and relapse stage are overlapping.

Previous research has used the stage of change measure used in the current study so comparisons can still be made, however, for future research a more valid measure would be useful. Geller and Drab (1999) have attempted to do this by developing the RMI, however for the purposes of this research and the time restraints, interviewing participants was not possible. It would however be interesting to investigate subjective ambivalence in relation to the RMI.
In addition, preliminary analysis involved assessing symptom severity across the stage of change groups. There were no significant differences found for the EDE-Q subscales or BMI scores. This suggests that the stage of change questionnaire is not identifying participants in terms of their symptoms. It is expected that BMI scores would increase as participants move through the stages of change and make improvements. This may not have been identified if the sample was biased in some way and all participants had the same BMI scores and severity of symptoms, however, this was not true, thus further casts doubt on the usefulness of the stage of change measure. Conducting a longitudinal study could resolve these issues.

4.9. Future directions
4.9.1. Clinical directions

This study suggests that a motivational approach (Geller, 2002) would be beneficial in all stages of change given that all participants were ambivalent. Cockell et al. (2004) suggested that there is a lack of research on individuals who are maintaining changes. The findings from this study also suggest that further attention must be paid to individuals in the maintenance stage of change. Thinking about clients' ambivalence-distress may be particularly useful as this may be overlooked at a stage where individuals appear to be doing well physically. The suggestions by Cockell et al. (2004) regarding social support, empowering patients, providing information and teaching effective coping strategies must be put into practice for these individuals in the maintenance stage who are ambivalent and distressed.

The findings from this study support what clinicians are already doing in their clinical practice, in terms of asking clients about aspects of anorexia that are important to them and whether they wish to change their behaviour. Clinicians sense what aspects of anorexia individuals wish to change and which aspects they are ambivalent about. Continually talking through the ambivalence and particularly the distress associated with the ambivalence may help individuals work through their ambivalence. The current findings highlight that this is important to do, as ambivalence-conflict and ambivalence-distress do not
seem to disappear once change is initiated. This also highlights the importance of relapse prevention work for individuals in the maintenance stage of change.

4.9.2. Research directions

Following on from the current study, there are a number of directions in which the research can proceed.

1. The pattern of mean scores found in this study was repeated for all variables. The decrease from the contemplation stage to the action stage and then the increase in the maintenance stage could be examined further to ascertain whether it was specific to this sample or a replicable finding. To do this a measure would be needed that can reliably and validly allocate participants into the appropriate stage of change. The ambivalence measure would also need to be adapted to increase the effect size.

2. The current study found that participants in the precontemplation stage group were ambivalent. A future study could investigate what mechanisms these individuals are using to minimise their ambivalence and resolve their conflict without changing and what moves them on to the contemplation stage.

3. To gain a greater understanding of individuals across the stages of change it would be helpful to conduct a longitudinal study so that individuals can be followed through their change process. Although, following individuals from the precontemplation stage may prove difficult as those who do not consider themselves to have a problem might be reluctant to participate in research that is conducted over a number of years. Longitudinal research may also help answer the question about whether individuals actually go through each stage and what happens at each progression or re-entry at an earlier stage.

4. Participants may have been primed to report ambivalence through the initial completion of the decisional balance measure. Participants may experience difficulties verbalising ambivalence without prompts. This could be investigated through a priming task of providing information
about anorexia and assessing ambivalence in relation to the information provided.

5. Priester and Petty (1996) suggested that subjective ambivalence could be due to factors such as a difference in one's opinion with significant others. Further research could explore others' influence on subjective ambivalence, by including questions about others' views of the problem, to investigate whether there is a relationship between subjective ambivalence and others' views of the anorexia and the impact on ambivalence-distress.

6. The decisional balance scale developed by Cockell et al. (2002) had three subscales. The functional avoidance subscale was not included in this study, as it was not considered relevant to ambivalence. Cockell et al. (2003) found that insight into the function of anorexia was associated with greater psychiatric distress. Therefore there could be a relationship between functional avoidance and ambivalence-distress. Further research could explore this relationship.

4.10. Summary

Cockell et al. (2002) created the decisional balance scale to assist in the understanding of change between the precontemplation stage and contemplation stage. This study has reconfirmed the difference between participants in the precontemplation stage group and participants in the contemplation stage group. Participants in the contemplation stage group reported greater burden scores than participants in the precontemplation stage group. This was also supported by greater objective ambivalence and greater ambivalence-distress reported by participants in the contemplation stage group compared to participants in the precontemplation stage group.

The current study has moved on to examine ambivalence and change between the contemplation stage, action stage and maintenance stage. Ambivalence-conflict and ambivalence-distress are relevant constructs and appear to be measuring something different to one another and to the decisional balance scale, they both warrant further attention. Both
ambivalence-conflict and ambivalence-distress were present in all four stage of change groups suggesting that individuals are not either, ambivalent or not, instead participants in the precontemplation stage group were ambivalent but to a lesser degree than participants in the other groups.

Inconsistent with the findings of Cockell et al. (2003), the burden score was significantly lower for participants in the action stage group than participants in the contemplation stage group. This suggests that once participants were making changes, they became less bothered by the burdens of their anorexia. This was supported by objective ambivalence also being less for these participants. Interestingly, the pattern of mean scores was repeated in all analyses. For participants in the action stage group, all variables were lower than for participants in the contemplation stage group and the maintenance stage group. This suggests that something is different about participants in the action stage group. Further research into this pattern of means would be beneficial to the understanding of ambivalence and the process of change in individuals with anorexia nervosa.
References


Appendices
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix D: Covering Letter - Inviting Participants to Participate
Dear participant,

My name is Danielle Gooblar and I am a trainee clinical psychologist studying at the University of Surrey. As part of my doctoral training and in conjunction with Dr. Carroll, Clinical Psychologist at the Berkshire Eating Disorder Service, I am conducting a research study looking at the process of change in recovery from anorexia nervosa.

We are particularly interested in people’s attitudes towards change and the mixed thoughts and feelings that arise when considering change. We are interested in hearing from people that are not considering change, people that are planning on making changes, and people that have achieved changes.

The attached questionnaires ask about how you might feel about your eating disorder in general, how you might feel about controlling your weight and about specific mixed thoughts or feelings you may or may not have about aspects of your eating disorder.

Completion of the questionnaires should take approximately 40 minutes. If you would like to participate please read the attached information sheet, which contains more information about the study. If you return the questionnaire and consent form we will assume that you have read, understood and agreed to the statements outlined in the information sheet.

If you have any further questions please do not hesitate to contact me.

Thank you for your time.

Danielle Gooblar

Attached: Information Sheet; Consent Forms; Background Information Sheet; Questionnaires
### Information Sheet – August 2005

**Study title**

**Readiness to Change and Ambivalence in Anorexia Nervosa**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

This study has been reviewed by the Berkshire Research Ethics Committee who raised no objections on ethical grounds.

Thank you for reading this.

**Who is conducting the study?**

The study is being conducted by Danielle Gooblar, a trainee clinical psychologist on the Surrey Doctorate in Clinical Psychology.

**What is the purpose of the study?**

Individuals with anorexia nervosa often experience difficulties getting better and making use of services. Previous research has attempted to understand these difficulties by exploring whether people are ready to change their behaviour. It has been suggested that people often feel ambivalent about changing. They want to feel better but they also do not want to put on weight. The purpose of this study is to explore mixed thoughts and feelings that individuals have about their eating disorder to gain a greater understanding of the process of change and to inform models of treatment for people with eating disorders.
• **Why have I been chosen?**

You have been approached because you have been seen by a professional for your anorexia nervosa or because you have joined the Eating Disorder Association research pool. Permission has been sought and received from a Research and Development committee, a NHS ethics committee and the Eating Disorder Association. I am hoping that a number of other individuals like yourself will also be participating in the study.

• **Do I have to take part?**

The decision to take part is entirely up to you. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Even if you decide to take part now you are still free to withdraw at any time and without giving a reason. Withdrawing or not taking part will not affect your current or future treatment. However because the information you provide is anonymous once you have sent the information it cannot be withdrawn.

• **What do I have to do?**

Simply complete the attached questionnaire pack and return them to the administrator’s office or to me in the stamped addressed envelope provided. This should take about 35-45 minutes. If you have any questions about the questionnaires you can contact me.

• **What are the possible disadvantages and risks of taking part?**

Thinking about and answering questions about your eating disorder is likely to be a sensitive issue. In the unlikely event of you feeling upset while taking part in this study or immediately after you should contact someone in your support system or someone from the resources available to you. You are reminded that you are free to withdraw from the research at anytime without reason.

• **What are the possible benefits of taking part?**

There are no immediate benefits of taking part in the study. However you may find answering the questionnaires interesting and beneficial for personal reasons. It is hoped that the research will provide a greater understanding of people with or who have had an eating disorder and also help inform services in the future. Therefore you may feel that you would like to be part of this process.

• **Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential. The questionnaires are anonymous and will be kept separately from the consent form. All data will be kept confidential; no-one will be informed that you have participated in the research study.
• **What will happen to the results of the research study?**

The results of the study will be analysed and written up as my major research project for the Surrey Doctorate in Clinical Psychology. I will also seek to have the research published in a relevant journal. If you would like a copy of the published results you can send your details to me. It is reminded that you will not be identified in any report/publication.

• **What do I do if I wish to make a complaint?**

If you have a complaint about the conduct or the content of this research then you should contact Dr. Mary John, Course Director, Surrey Doctorate in Clinical Psychology by telephoning 01483 686887 or by e-mailing M.John@surrey.ac.uk, alternatively you can contact Trevor Lyalle at the Patient Advice and Liaison Service (PALS) of Berkshire Healthcare NHS Trust on 01189 605027.

• **Contact for Further Information.**

Dr Martin Carroll (01344 877 197) Eating Disorder Service, Heatherwood Hospital, London Road, Ascot, SL5 8AA.
Or
Danielle Gooblar
C/o Surrey Doctorate in Clinical Psychology. University of Surrey, Guildford, Surrey, GU2 7XH

Participation in this study assumes the following:

• You have read and understood the information sheet about the above study.
• You understand that if you have any questions about the research you have the opportunity to address these to the researcher before, during or after taking part in the research.
• You understand that participation is voluntary and that you are free to withdraw at any time, without giving any reason.
• You have signed the attached consent forms and kept a copy for yourself.

Thank you very much for your time in reading this information sheet and participating in the study.
Title of Project: Readiness to Change and Ambivalence in Anorexia Nervosa

Name of Researcher: Danielle Gooblar

Please initial box

1. I confirm that I have read and understand the attached information sheet dated .................

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that withdrawal will not affect current or future treatment.

3. I agree to take part in the above study.

4. I understand that by agreeing to take part, the questionnaires I complete will be analysed and included within a major research project for a doctorate in Clinical Psychology and will be published within a relevant journal. I understand that I will not be identified within any report/publication.

5. I understand that because the information I provide is anonymous, once I have sent the information it cannot be withdrawn.

Name _____________________________ Signature _____________________________ Date ________________

Copy 1: To be sent back with the questionnaires
CONSENT FORM

Title of Project:

Readiness to Change and Ambivalence in Anorexia Nervosa

Name of Researcher: Danielle Gooblar

Please initial box

1. I confirm that I have read and understand the attached information sheet dated ..................

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that withdrawal will not affect current or future treatment.

3. I agree to take part in the above study.

4. I understand that by agreeing to take part, the questionnaires I complete will be analysed and included within a major research project for a doctorate in Clinical Psychology and will be published within a relevant journal. I understand that I will not be identified within any report/publication.

5. I understand that because the information I provide is anonymous, once I have sent the information it cannot be withdrawn.

Name ___________________________ Signature ___________________________ Date ________________

Copy 2: For you to keep
Appendix G: Background Information Sheet
Background Information

Before completing the questionnaires please complete the following questions.

1. What is your gender? .....................

2. How old are you? ..........................

3. How would you describe your ethnicity? ...........................................

4. What is your relationship status?
   single / married / co-habiting / separated / divorced / widowed

5. What is your current occupation? .............................................

6. What is your weight? ..........................

7. What is your height? ............................

8. Do you describe yourself as?
   A person with an eating disorder / a person recovered from an eating disorder

9. Have you ever received a diagnosis of anorexia nervosa?   Yes/ No

10. How old were you when your eating disorder began? .....................

11. Are you currently receiving treatment for your eating disorder? Yes/ No

12. If yes to Q10 what treatment are you receiving?

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

13. What is your current status?
   In-patient / Out-patient / Neither

Thank you for your time in completing this information.
Appendix H: Questionnaires including:
1: Stage of Change Questionnaire
2: Decisional Balance Scale
3: Ambivalence Measure
4: Eating Disorder Examination – Questionnaire
**Stage of Change Questionnaire**

Each statement describes how a person might feel about controlling his or her weight. Please indicate the extent to which you tend to AGREE or DISAGREE with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. There are FIVE possible responses to each of the questionnaire items. Please circle the number that best describes how much you agree or disagree with each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>As far as I am concerned, I do not have any weight problems that need changing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I think I might be ready for some self-improvements in my weight</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am doing something about my weight that has been bothering me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It might be worthwhile for me to work on my weight</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am not the problem one. It doesn’t make much sense for me to be here</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It worries me that I might slip back on a weight problem I have already changed, so I am ready to work on my problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am finally doing some work on my weight problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have been thinking that I might want to change my weight</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have been successful in working on my weight but I am not sure I can keep up the effort on my own</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>At times my weight is a difficult problem, but I am working on it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Working on my weight is pretty much a waste of time for me because it does not have anything to do with me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
I am working on my weight in order to better understand myself.

I guess I have weight difficulties, but there is nothing that I really need to change.

I am really working hard to change my weight.

I have a weight problem and I really think I should work on it.

I am not following through with the changes I have already made as well as I had hoped, and I am working to prevent a relapse of my weight problem.

Even though I am not always successful in changing, I am at least working on my weight problem.

I thought once I had resolved my weight problem, I would be free of it, but sometimes I still find myself struggling with it.

I wish I had more ideas on how to solve my weight problem.

I have started working on my weight but I would like some help.

Maybe someone will be able to help me with my weight.

I may need a boost right now to help me maintain the changes I have already made in my weight.

I may be a part of my weight problem, but I do not really think I am.

I hope that someone will have some good advice for me about weight control.
<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anyone can talk about changing their weight; I am actually doing something about it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>All this talk about psychology is boring. Why can’t people just forget about their weight?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am working to prevent myself from having a relapse of my weight problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It is frustrating, but I feel I might be having a recurrence of the weight problem I thought I had resolved</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have worries about my weight, but so does the next person. Why spend time thinking about it?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am actively working on my weight problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I would rather cope with my weight than try to change it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>After all I have done to try to change my weight, every now and then it comes back to haunt me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
### Decisional Balance Scale

Each statement describes how a person might feel about their eating disorder. Please indicate how TRUTHFUL the statements are for you. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. There are FIVE possible responses to each of the questionnaire items. Please circle the number that best describes how true each statement is for you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all true</th>
<th>Somewhat true</th>
<th>True</th>
<th>Very true</th>
<th>Completely true</th>
</tr>
</thead>
<tbody>
<tr>
<td>It bothers me that anorexia keeps me from socialising</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It bothers me that anorexia prevents me from sharing my feelings with others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I don’t like it that anorexia keeps me from eating out with others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I spend too much time thinking about food, eating and calories</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It bothers me that because of anorexia I can’t prepare a meal by myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Because of anorexia, I fell guilty a lot of the time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am fed up with thinking about my weight and/or shape</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It bothers me that my weight controls my mood</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I worry about the effect anorexia is having on my health</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am tired of being sick with anorexia</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It bothers me that anorexia leave me with no energy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I worry that because of anorexia I will not be able to have children</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Anorexia makes me moody</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Statement</td>
<td>Not at all True</td>
<td>Somewhat true</td>
<td>True</td>
<td>Very true</td>
<td>Completely true</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>------</td>
<td>-----------</td>
<td>-----------------</td>
</tr>
<tr>
<td>I hate the fact that anorexia controls my life</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have lost my freedom to anorexia</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Anorexia gives me self-control</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Being a very low weight makes me feel confident</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Being a very low weight makes me feel good about myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Fitting into small sized clothes makes me feel good about myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Being thinner than others makes me feel good about myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Anorexia helps me obtain an immediate goal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Anorexia is my way of being perfect</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Anorexia makes me feel accomplished</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Ambivalence Scale

Each statement asks you to consider different thoughts and feelings you may have about your eating disorder and how these thoughts or feelings may be conflicting or mixed. For example, you may have conflicting thoughts about eating a new type of food in that you want to eat a normal diet but don’t want to gain weight. Similarly, you may have mixed feelings about eating a new type of food such as feeling both excited and scared. Furthermore, your thoughts may conflict with your feelings. You want to eat normally but this terrifies you. Please indicate the extent to which you AGREE or DISAGREE with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. Please circle the number that best describes how much you agree or disagree with each statement.

1. I have conflicting thoughts about having an eating disorder

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

2. I have mixed feelings about having an eating disorder

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

3. My thoughts about having an eating disorder are conflicting with my feelings about having an eating disorder

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
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</table>

4. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No distress</th>
<th>Not much distress</th>
<th>Some distress</th>
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</tr>
</thead>
<tbody>
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...
5. I have conflicting thoughts about using weight control strategies

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
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6. I have mixed feelings about using weight control strategies

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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7. My thoughts about using weight control strategies are conflicting with my feelings about using weight control strategies

<table>
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<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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8. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No distress</th>
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<tbody>
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</table>

9. I have conflicting thoughts about following a healthy eating pattern (i.e. 3 meals a day & snacks equaling at least 2000 calories per day)

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
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</tbody>
</table>
10. I have mixed feelings about following a healthy eating pattern (i.e. 3 meals a day & snacks equaling at least 2000 calories per day)

<table>
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<th>Strongly agree</th>
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<td>6</td>
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</tbody>
</table>

11. My thoughts about following a healthy eating pattern are conflicting with my feelings about following a healthy eating pattern

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
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<td>6</td>
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</table>

12. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No distress</th>
<th>Not much distress</th>
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<tbody>
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</tbody>
</table>

13. I have conflicting thoughts about the impact of the eating disorder on my physical appearance

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
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</table>

14. I have mixed feelings about the impact of the eating disorder on my physical appearance

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
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</tbody>
</table>
15. My thoughts about the impact of the eating disorder on my physical appearance are conflicting with my feelings about the impact of the eating disorder on my physical appearance

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
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</table>

16. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No distress</th>
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<tbody>
<tr>
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</tbody>
</table>

17. I have conflicting thoughts about being what is considered medically to be a normal weight (e.g. BMI; 20-25)

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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</tbody>
</table>

18. I have mixed feelings about being what is considered medically to be a normal weight (e.g. BMI; 20-25)

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
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<th>Disagree</th>
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</tbody>
</table>

19. My thoughts about being what is considered medically to be a normal weight (e.g. BMI; 20-25) are conflicting with my feelings about being what is considered medically to be a normal weight (e.g. BMI; 20-25)

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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<td>6</td>
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</tbody>
</table>
20. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No</th>
<th>Not much</th>
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<tbody>
<tr>
<td>1</td>
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<td>4</td>
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</tbody>
</table>

21. I have conflicting thoughts about gaining weight

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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22. I have mixed feelings about gaining weight

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
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<th>Slightly disagree</th>
<th>Disagree</th>
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<td>6</td>
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</tbody>
</table>

23. My thoughts about gaining weight are conflicting with my feelings about gaining weight

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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</table>

24. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No</th>
<th>Not much</th>
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<tbody>
<tr>
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<td>4</td>
</tr>
</tbody>
</table>
### 25. I have conflicting thoughts about the impact of the eating disorder on my physical health

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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<td>5</td>
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### 26. I have mixed feelings about the impact of the eating disorder on my physical health

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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<td>4</td>
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<td>6</td>
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</tbody>
</table>

### 27. My thoughts about the impact of the eating disorder on my physical health are conflicting with my feelings about the impact of the eating disorder on my physical health

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
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### 28. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No distress</th>
<th>Not much distress</th>
<th>Some distress</th>
<th>A lot of distress</th>
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<tbody>
<tr>
<td>1</td>
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<td>4</td>
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</tbody>
</table>

### 29. I have conflicting thoughts about the impact of the eating disorder on my sense of security

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
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<td>4</td>
<td>5</td>
<td>6</td>
</tr>
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</table>
30. I have mixed feelings about the impact of the eating disorder on my sense of security

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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<td>6</td>
</tr>
</tbody>
</table>

31. My thoughts about the impact of the eating disorder on my sense of security are conflicting with my feelings about the impact of the eating disorder on my sense of security

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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32. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No distress</th>
<th>Not much distress</th>
<th>Some distress</th>
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<tbody>
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</tbody>
</table>

33. I have conflicting thoughts about the impact of the eating disorder on my relationships

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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<td>6</td>
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</tbody>
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34. I have mixed feelings about the impact of the eating disorder on my relationships

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
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<td>4</td>
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<td>6</td>
</tr>
</tbody>
</table>
35. My thoughts about the impact of the eating disorder on my relationships are conflicting with my feelings about the impact of the eating disorder on my relationships

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
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36. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No distress</th>
<th>Not much distress</th>
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<tbody>
<tr>
<td>1</td>
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<td>4</td>
</tr>
</tbody>
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37. I have conflicting thoughts about the impact of the eating disorder on my confidence

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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<td>4</td>
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</table>

38. I have mixed feelings about the impact of the eating disorder on my confidence

<table>
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<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
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</tbody>
</table>

39. My thoughts about the impact of the eating disorder on my confidence are conflicting with my feelings about the impact of the eating disorder on my confidence

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
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</table>
40. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No</th>
<th>Not much</th>
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</tr>
</tbody>
</table>

41. I have conflicting thoughts about whether the eating disorder makes me feel good about myself

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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</table>

42. I have mixed feelings about whether the eating disorder makes me feel good about myself

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
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</table>

43. My thoughts about whether the eating disorder makes me feel good about myself are conflicting with my feelings about whether my eating disorder makes me feel good about myself

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
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44. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No</th>
<th>Not much</th>
<th>Some</th>
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<td>1</td>
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<td>4</td>
</tr>
</tbody>
</table>
45. I have conflicting thoughts about whether the eating disorder helps me to deal with the difficulties in life

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
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46. I have mixed feelings about whether the eating disorder helps me to deal with the difficulties in life

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
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</table>

47. My thoughts about whether the eating disorder helps me to deal with the difficulties in life are conflicting with my feelings about whether my eating disorder helps me deal with the difficulties in life

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
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<td>6</td>
</tr>
</tbody>
</table>

48. How distressed are you about these conflicting/mixed thoughts and/or feelings?

<table>
<thead>
<tr>
<th>No distress</th>
<th>Not much distress</th>
<th>Some distress</th>
<th>A lot of distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Major Research Project

**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 or more) without eating anything 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>3. Have you tried to avoid eating any foods which you like in order to influence your shape or weight?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4. Have you tried to follow definite rules regarding your eating in order to influence your shape or weight; for example, a calorie limit, a set amount of food, or rules about what or when you should eat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5. Have you wanted your stomach to be empty?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6. Has thinking about food or its calorie content made it much more difficult to concentrate on things you are interested in, for example read, watch TV, or follow a conversation?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7. Have you been afraid of losing control over eating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>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? (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>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>
Major Research Project

On how many days out of the past 28 days...

<table>
<thead>
<tr>
<th>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>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>Times</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 time</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 the effect on your shape or weight? (Do not count binges).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

16. Over the past four weeks (28 days), have there been any times when you have felt that you have eaten what other people would regard as an unusually large amount of food given the circumstances?

17. How many such episodes have you had over the past four weeks?

18. During how many of these episodes of overeating did you have a sense of having lost control over your eating?

19. Have you had other episodes of eating in which you have had a sense of having lost control and eaten too much, but have not eaten an unusually large amount of food given the circumstances?

20. How many such episodes have you had over the past four weeks?

21. Over the past four weeks have you made yourself sick (vomit) as a means of controlling your shape or weight?

22. How many times have you done this over the past four weeks?

23. Have you taken laxatives as a means of controlling your shape or weight?

24. How many times have you done this over the past four weeks?
25. Have you taken diuretics (water tablets) as a means of controlling your shape or weight?  
No (0) Yes (1)

26. How many times have you had 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 had over the 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>
</tr>
</thead>
<tbody>
<tr>
<td>29. Has your weight influenced how you think about (judge) yourself as a person?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Has your shape influenced how you think about (judge) yourself as a person?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. How much would it upset you if you had to weigh yourself once a week for the next four weeks?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. How dissatisfied have you felt about your weight?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. How dissatisfied have you felt about your shape?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. How concerned have you been about other people seeing you eat?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. How uncomfortable have you felt seeing your body; for example, in the mirror, in shop window reflections, while undressing or taking a bath or shower?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. How uncomfortable have you felt about others seeing your body; for example, in communal changing room, when swimming or wearing tight clothes?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please check you have answered all the questions.

Thank you for taking the time to fill in these questions.
Research Log Checklist
## Research Log Checklist

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
<td>✓</td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
<td>✓</td>
</tr>
<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
<td>✓</td>
</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
<td>✓</td>
</tr>
<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
<td>✓</td>
</tr>
<tr>
<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
<td>✓</td>
</tr>
<tr>
<td>11</td>
<td>Collecting data from research participants</td>
<td>✓</td>
</tr>
<tr>
<td>12</td>
<td>Choosing appropriate design for research questions</td>
<td>✓</td>
</tr>
<tr>
<td>13</td>
<td>Writing patient information and consent forms</td>
<td>✓</td>
</tr>
<tr>
<td>14</td>
<td>Devising and administering questionnaires</td>
<td>✓</td>
</tr>
<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
<td>✓</td>
</tr>
<tr>
<td>16</td>
<td>Setting up a data file</td>
<td>✓</td>
</tr>
<tr>
<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
<td>✓</td>
</tr>
<tr>
<td>18</td>
<td>Choosing appropriate statistical analyses</td>
<td>✓</td>
</tr>
<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
<td>✓</td>
</tr>
<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
<td>✓</td>
</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
<td>✓</td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
<td>✓</td>
</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
<td>✓</td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
<td>✓</td>
</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
<td>✓</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
<td>✓</td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
<td>✓</td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
<td>✓</td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
<td>✗</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
<td>✓</td>
</tr>
</tbody>
</table>