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Motivation to change in adolescents with eating disorders

By

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Thesis submitted in fulfilment of the DPsych in Counselling Psychology

City University, London

Department of Psychology

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2. Declaration

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3. Section A - Preface

3.1 PREFACE

Overview

The central theme of this thesis is motivation to change in young people with eating disorders. It links different areas of my work as a Chartered Counselling Psychologist working with and researching clients with eating disorders. I currently work in private practice specialising in this area.

One model of change has stood as the standard bearer for conceptualising the stages of change in therapy for over 20 years. Prochaska and DiClemente developed this predominant framework that focused on the notion of an individual's readiness to change in the 1980's. It is described as the Transtheoretical Model of Change (TTM) (Prochaska et al, 1992). This model initially dominated the substance abuse field but has since become popular in the understanding and treatment of many fields of work, including that of eating disorders.

I initially became interested in motivation to change in young people with eating disorders a number of years ago; as it's theoretical application began to be introduced in to the field. At the time I worked directly with this client group and had first hand experience of managing difficulties related to an individuals motivation to change their eating disordered behaviour. Since training as a counselling psychologist, the theoretical aspects of models of motivation to change have been applied within different areas of my client work, yet it seems to remain a more complex issue within the field of adolescent eating disorders.

After conducting a review of the relevant literature it became apparent there was very little written on motivation to change in adolescent eating disorders. In the wider field of adolescent eating disorders the research contributions from counselling psychologists were somewhat scant. The main body of literature is comprised of contributions from nurses, medical practitioners and clinical psychologists working in the field. My primary motivation to undertake this degree

was to provide an initial understanding of a relatively under researched area and secondly, to make a difference and raise the profile of Counselling Psychology within the field of adolescent eating disorders.

The thesis focuses on three different areas related to the general field of eating disorders and are all linked to the practice of Counselling Psychology with this client group. Firstly there is an exploratory piece of research. It focuses on reviewing the current application of the stages of change model within the specific area of adolescent eating disorders and providing a different clinical application of the model. Secondly there is a case study. This is reflexive exploration that focuses on the progress and some of the challenging issues that I encountered in my clinical work with a client with an eating disorder. Finally there is critical review of the literature that explores the importance of the family in understanding and treating adolescent eating disorders and provides a link from the main project to current modes of treatment. An overview of each section is now provided.

Section B - Research

The research section is comprised of two parts. The first study was conducted in response to the majority of the relevant literature being focused on adults and the resulting need to assess the applicability of the stage of change model to adolescents with eating disorders. The study focused, in particular, on validating a measure of change, the University of Rhode Island Change Questionnaire, for use with this sample group. Prior to conducting this research, alternative measures of motivation were being developed for this sample group without thorough investigation of the properties of the original measure. The aim was to explore, in a sample of adolescents with eating disorders, the psychometric properties of the URICA that had been adapted to measure motivation to change eating behaviour. It also aimed to ascertain whether the sample group would fall into predicted subgroups as previously found in other studies.

As assessment is an integral part of the role of a counselling psychologist, it is important to ensure that the measures we use are evidence based and fit the client group for which they are intended.

Part 2 was conducted in response to findings from Part 1. The results displayed some difficulties in applying the stages of change model both to young people and the eating disorders field and raised a need to review this model. From this it seemed important to conduct a qualitative study to understand more fully motivation to change within this sample population. Much of the completed research has focused on the individual and their attitudes, whereas with this particular client group there is a definite need to examine environmental influences on an individual's motivation such as family, peers and other role models. From the first study, responses received from parents suggest that understanding motivation to change in adolescents requires an understanding of the views of the parents and the impact of the eating disorder on the family as a whole.

The study aimed to develop a model to understand the contextual and relationship factors influencing motivation to change/recover in adolescents with eating disorders. A secondary aim will be to compare the experiences of both parent/carer and child and use the differences and similarities to inform services about what family interventions could be clinically useful.

The aim of the two studies was to: -

- Review the current theory and gain a broader understanding of motivation to change in this client group.
- Set the current theoretical application of models of change and new findings within a systemic context.
- Generate findings that can inform the development and delivery of appropriate psychological treatments for this population.

Section C – Professional Practice

In this section I have presented a case study that focuses on working with a client with an eating disorder, specifically Bulimia Nervosa. I chose to present this particular case because I found it a key learning experience from both a personal and a professional perspective. Moreover the case highlights the challenges of recovering from an eating disorder and the positive changes that the support of a counselling relationship can bring. The client was a 33 year old, single female who had been suffering from an eating disorder since she was seventeen. Although she had dramatically reduced her symptoms over the years, she continued to repeat negative patterns of behaviour, which she wanted to understand and revise. This case was my third client within private practice and I undertook a steep learning experience as an independent counselling psychologist.

Section D – Critical Review of the Literature

The aim of the review was to explore the importance of the family's role in understanding and treating adolescent eating disorders. Having worked extensively with families throughout the treatment process of eating disorders I have been able to experience the significant impact that working systemically can have on an individual's progress. The review covers a number of theoretical perspectives and aims to critically appraise the current approaches to the therapeutic use of the family in treatment programmes for this sample group.

Conclusion

I have found the process of conducting research, reviewing the literature and reflecting on my client work hugely beneficial in terms of my personal and professional development.

When struggling with the complexities and enormity of the research process, the use of supervision and consultation with other professionals became invaluable. Meeting with professionals who specialised in the area of young people with eating

disorders allowed me to triangulate my findings and substantiate areas in which there was some doubt.

The process has provided me with insight and understanding into this topic and client group in numerous ways. My perspective is now much broader as a direct result of this thesis. I feel that this has impacted positively on my clinical practice.

4. Section B – Research

Motivation to change in adolescents with eating disorders

Part 1 - A questionnaire validation study

Part 2 - A systemic perspective

4.1 Abstract

Motivation is a complex issue, thought to influence engagement as well as response to treatment in a number of mental health disorders. Little attention has been paid to the motivation of adolescents who are/have been treated for an eating disorder, in whom motivation to change is complicated by developmental factors and dependence on others.

The present study has been conducted in two parts. Part 1 investigates the validity of the stages of change model in adolescents through use of a questionnaire based on Prochaska and DiClemente's model. Part 2 is a qualitative study assessing motivation to change in young people with eating disorders within a systemic context. Index participants for both parts of the study were aged between 12-16 years and were recruited from three specialist eating disorder services.

The aims of Part 1 were a) to explore the psychometric properties of an adapted version of the University of Rhode Island Change Assessment Questionnaire (URICA) with a sample of young people with eating disorders, and b) determine if this version of the URICA could be made more developmentally appropriate for use with this sample whilst retaining its psychometric properties. Part 2 aimed to develop a model to understand the contextual and relationship factors influencing motivation to change/recover in adolescents with eating disorders.

Results from Part 1 (n=39) indicate that the stages of change model has limited validity in adolescents with eating disorders, but can be used to distinguish those with no motivation to change from those with some degree of contemplation. Qualitative findings (n=11) identified three main groups of factors influencing motivation: illness factors, treatment factors and 'normal life'. Findings suggest that inpatient treatment makes it difficult for young people to think about their eating disorder because they are preoccupied by 'going home'. Issues around control and responsibility emerged as central themes influencing motivation; and young people and their families' value different components of treatment in the recovery process.

5. Section B - Part 1 – A questionnaire validation study

5.1 - Introduction and Review of the Literature

The current climate in the media is alive in relation to the area of young people with eating disorders. This is as a result of hypotheses that prevalence rates are on the increase (and, at an earlier age) and due to the release of new guidelines, aimed at improving the care of people with eating disorders, particularly among young people, at the beginning of 2004. The National Institute for Clinical Excellence (NICE, 2004) has set out treatment plans for anorexia, bulimia and binge eating, making specific recommendations for children and adolescents because of the suggested rising numbers who have eating disorders.

NICE, which decides which health treatments and technologies should be available in England and Wales, called for eating disorder services to be tailored to the needs of young people and involve other family members and stressed the importance of psychological therapies in tackling eating disorders. As the work of Counselling Psychologist's is increasing within the healthcare service, over and above Primary Care, it is important that the relevant knowledge and skills are adopted to be able to treat such severe conditions as eating disorders.

To contextualise the study, it is firstly important to provide the diagnostic criteria, according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM IV) (American Psychiatric Association, 1994), of the main three eating disorder types that will be referred to in this study. It is important to note however that there is some controversy about the use of such diagnostic criteria, particularly with younger patients.

Diagnostic criteria for 307.1 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. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specify type:

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

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

Diagnostic criteria for 307.51 Bulimia Nervosa

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

(1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

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

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

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

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

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

Specify type:

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

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

Diagnostic Criteria for Eating Disorders Not Otherwise Specified (EDNOS) 307.50

EDNOS is described in the DSM IV (American Psychiatric Association, 1994) as a category [of] disorders of eating that do not meet the criteria for any specific eating disorder. This category is frequently used for people who meet some, but not all, of the diagnostic criteria for anorexia nervosa or bulimia nervosa. For example, a person who shows almost all of the symptoms of anorexia nervosa, but who still has a normal menstrual cycle and/or body mass index, can be diagnosed with EDNOS. A sufferer may experience episodes of bingeing and purging, but may not do so frequently enough to warrant a diagnosis of bulimia nervosa. A person may also engage in bingeing episodes without the use of inappropriate compensatory behaviors; this is referred to as binge eating disorder.

People diagnosed with EDNOS may frequently switch between different eating disorders, or may with time fit all diagnostic criteria for anorexia or bulimia.

It has been suggested that eating disorders, particularly, Anorexia Nervosa, are the most worrying conditions presented to adolescent mental health services (Gowers et al, 2000). As a result, young people are often hospitalized due to ill health, family and professional concern and their resistance to intervention. Supporting this view of the severity of the eating disorders, Vitousek et al (1998) state that:

“By clinical reputation, anorexia nervosa is one of the most frustrating and recalcitrant forms of psychopathology.” (p391)

Anorexia Nervosa is often described as an ‘egosyntonic’ disorder, which means that the thoughts and feelings related to the disorder are in harmony with the ego. Consequently, any attempts directed at resolving Anorexia are experienced as unwanted intrusions but for the majority there is a resulting degree of ambivalence. Inevitably, when treating these individuals, there are a number of barriers encountered when working towards reduction of symptoms. When meeting this ambivalence, it is often found that as a result of implementing treatment programmes that aim to bring about change, resistance is encountered (Geller & Drab, 1999).

As people with eating disorders differ in their readiness to change and willingness to engage in treatment as a result, there stands a need for a means of identifying level of readiness to be able to tailor treatments to the individuals needs. Working with this ambivalence in a counselling relationship can be a difficult task, often leading the therapy to become ‘stuck’ at times. It is important then to understand individual’s thoughts and feelings related to changing their behaviour and adjust the therapeutic techniques used accordingly.

In the treatment of eating disorders such as Anorexia Nervosa, it has now become essential that ‘motivation’ is considered when exploring a person’s attitude towards their recovery. ‘Motivation’ can be described as what provides the impetus for the focus, effort and energy needed to move through the entire process of change (Rollnick et al., 1999). It is only in recent years that hypotheses regarding motivation and readiness to change have emerged in relation to the eating disorders (Herzog, Keller & Lavori, 1988; Treasure & Ward, 1997). With particular reference to working with young people, the concept of motivation is particularly

significant as it is rarely their decision to enter the treatment process; usually they are coerced by significant adults in their life, leaving them angry and resentful (Miller & Rollnick, 2002). The life stage of adolescence can also be associated with a self-perception of invulnerability, which may contribute to an unwillingness or inability to recognise the seriousness of their disorder and also their ambivalence about changing (Elkind, 1984; Geller & Drab, 1999).

Why people change and why they do not change is a question that therapists have asked for many years. For almost two decades, one model of change has stood as the standard bearer for conceptualising the stages of change in therapy. Prochaska and DiClemente developed this predominant framework that focused on the notion of an individual's readiness to change in the 1980's. It is described as the Transtheoretical Model of Change (TTM) (Prochaska et al, 1992). The model identifies different stages of motivational change that a person goes through, when receiving psychotherapeutic care. Stages of change represent a collection of intentions and behaviours through which individuals pass as they move from having a problem to doing something to resolve it (Prochaska & Norcross, 1994). The five stages originally described were Precontemplation (being unaware of or unwilling to change symptoms), Contemplation (thinking about change but not ready to make commitment), Preparation (intending to change in the near future) (now omitted), Action (actively involved in the process of change), and Maintenance (working to maintain changes made). In line with TTM, techniques have been developed to enhance an individual's change process, e.g. motivational interviewing. Within their approach of Motivational Interviewing, Miller and Rollnick (2002) described how the behaviour of the therapist had a marked effect on compliance with treatment. A confrontational style led to resistance and non-compliance, whereas a supportive empathic response improved compliance. They therefore developed a style of interaction, which aimed to maximise the clients' motivation to change and theoretically fitted the Transtheoretical Model of Change. Similarly, in the practice of Counselling Psychology the emphasis is on 'being' with the client in a manner that will facilitate growth and potential, adopting a stance that is in line with and directed by the clients position. Throughout this study the focus

will be on whether it is clinically useful to apply this overarching theory of change to young people with eating disorders within a counselling relationship and whether it can be measured using the tool developed to fit alongside this model of change.

At the outset the model was mainly applied and found to be clinically relevant to problem/addictive behaviours such as smoking, alcohol, and drug abuse. In the early studies (based initially on smokers) results showed that stage of change determined was found to be predictive of smoking cessation at 6 month follow up (DiClemente et al, 1991). For example, after 6 months, those initially assessed to be at the stage of Precontemplation indicated significantly less attempts to quit or that they were not smoking at all (26% and 8% respectively), than those in the Contemplation stage (80% and 21% respectively).

The instrument developed to assess the stages of change as described, was the University of Rhode Island Change Assessment Questionnaire (URICA) (McConaughy, Prochaska and Velicer, 1983). It consisted of 32 items measured on a Likert scale and yielded continuous data for each of the four scales. The URICA item generation was based on behavioural criteria for the five stages of change (Precontemplation, Contemplation, Preparation, Action and Maintenance). Reliability and factor analyses generated four scales (Precontemplation, Contemplation, Action and Maintenance) with eight separate items loading on each of the scales (McConaughy et al., 1983).

With regard to the psychometric properties of the URICA, the results from the original research and its replication both supported its use and found it to be reliable for adult psychotherapy participants (McConaughy et al., 1983, McConaughy, DiClemente, Prochaska and Velicer, 1989). Greenstein, Franklin, and McGuffin (1999) have examined the URICA in relation to an adolescent sample and found their participants responded similarly to adults and clustered into clinically meaningful groups, concordant with the model of change. They found the questionnaire to be psychometrically sound and to reflect the results of the original

research on the URICA and its replication (McConaughy et al. 1989). They concluded that their results provide evidence that the URICA can be used to measure stage of change in adolescents with emotional, behavioural, and/or psychiatric problems. Overall the URICA has been proven to provide reliable results on three replications (2 with adults, 1 with adolescents).

In the field of eating disorders, studies on the adult clinical population have also found the transtheoretical model of change to have some clinical relevance. Findings have shown that individuals with eating disorders report varying degrees of ambivalence about working towards changing and employ different strategies at different stages of change (Ward, Troop, Todd & Treasure, 1996). The early results therefore suggested it might be useful in assessing ambivalence about change in this particular field.

More specifically, when the URICA was applied to adults with eating disorders, it was initially found to have some significance.

Treasure et al. (1999) in a study of bulimic outpatients, found that those classified as being in the action stage at the start of treatment showed greater improvement in bingeing than those in contemplation, although there was no reduction of compensatory behaviours, e.g. excessive exercise. R. Levy (1997) also applied the model to bulimic patients and found that the stages and processes progressed through were consistent with the transtheoretical model. Precontemplators used the change processes, markedly less than those in the other stages and at the opposite end of the spectrum those in the action stage avoided situations that elicited binge-purge behaviour more frequently than did subjects in any other stage. Franko (1997) also suggested that readiness for change is an important variable to consider in predicting group therapy outcome for bulimic patients, in that the bulimic women who were most ready to make changes, indicated in their high Action scores, were those with the greatest clinical improvement in binge frequency.

However, some authors suggest that the measure is not applicable to eating disorders (Geller et al, 2001). The URICA has been termed too generic and uni-dimensional to measure the complex nature of eating disorder symptoms, e.g. bulimics motivated to reduce binges may be reluctant to change weight control behaviour (Treasure et al., 1999). As a result of the URICA's narrow focus it is also thought that it could overestimate a patient's readiness to change (Rieger et al, 2000).

Ward et al (1996) questioned the accuracy of the results from the URICA in that it classified the majority of patients into the action stage, which they indicated was not supported by their clinical presentation. On a broader scale, Sullivan and Terris (2001) have asked whether a questionnaire can provide useful information on readiness to change for complex behaviours, such as eating disorders and whether a more in-depth form of investigation is needed. In response to these findings it seems necessary to question whether the URICA is able to highlight the ambivalence characteristic within eating disorders. Within Counselling Psychology practice, the use of the therapeutic relationship is at the core and any quantitative measure would best be balanced with a more in depth exploration of the qualitative experience as described by the sufferer. This approach is reflected in the use of clinician led semi-structured interviews such as the Readiness and Motivation Interview (Geller and Drab, 1999) developed (for use with adults) to fit the more complex patterns of eating disorders based on the Eating Disorders Evaluation (EDE) (Fairburn and Cooper, 1993). This measure provides symptom specific information about readiness to change and motivation in eating disorder patients. It was developed to assist in setting stages for treatment planning. Rieger et al. (2000) also developed a self-report measure (ANSOCQ) assessing a range of eating disorder symptomatology, which is then rated according to statements related to the stages of change.

With regards to the applicability and reliability of the URICA, it is important to mention that there have only been a small number of studies conducted. From these studies it is not entirely certain whether the stages of change model is clinically relevant to the field of eating disorders and there is an overall lack of

clarity in the definition of motivation to change in relation to the eating disorders. It is also important to note that a questionnaire used as part of an assessment process may only ever provide a snapshot of a person's attitude towards their disorder, which is forever changing. Supporting this idea, Treasure and Schmidt (2001) have noted that readiness to change is not a linear progression and it can vary from session to session. Thus, spending a great deal of time measuring something so fluid may not be practical from a clinical point of view.

Despite the limitations indicated, it is evident that the URICA is a quick and easy to administer tool, which is widely used and the benefits of determining stages of change are evident in the literature on motivational interviewing.

Rollnick et al. (1999) found that when there was a mismatch between motivational stage and treatment intervention, they encountered resistance from patients. An example of this would be giving advice to an anorexic patient on increasing calorie intake when they are still actively trying to lose weight. It is thus still an area that a) generates a lot of interest and b) needs further work, particularly as most of the studies have been carried out on inpatients, whereas a study exploring the broad spectrum of stages and assessing patients at different stages of the treatment process, may be more beneficial.

In the context of further work, there is currently scant information on the applicability of the stages of change model to young people with eating disorders and whether a questionnaire such as the URICA could begin to help us explore this area in more detail. There is also, as evidenced, a lack of assessment tools available to measure a young person's readiness to change eating disordered symptoms.

Motivation to change has been found to be important during the developmental stage of adolescence (Alonso, 1996) and it is the lack of motivation to change that can present professionals with major challenges when working with young people. Due to life stage, it is often that young people present with a lower level of

motivation to change their symptoms, than adults, making it an essential area to concentrate on.

In relation to assessment, it is important to note that although Counselling Psychology as a discipline is not commonly associated with quantitative measurement of behaviour or outcomes, change is occurring. The need to develop the role of scientist-practitioner as well as reflective-practitioner has become inherent in the growth of Counselling Psychology. Barkham (1990) argues that the importance of the 'scientist-professional' approach is 'central to the emerging discipline....the empirical and research basis of Counselling Psychology....is of crucial importance to the credibility of Counselling Psychology'.

The primary aim of this study is to explore the psychometric properties of an adapted version of the URICA for use with young people with eating disorders. The terminology used in the questionnaire has been changed and now states more specifically, the term 'eating problems' rather than 'problems'. The general language used has also been changed to suit the age group of the participants (12-16 years). It will also ascertain if the sample fall into predicted subgroups as previously found in other studies (McConaughy et al, 1983; McConaughy et al, 1989; Greenstein et al, 1999). The first two studies listed were conducted with a clinical sample of adults referred for psychotherapy and the third with a sample of adolescents admitted to an inpatient substance abuse treatment programme. In addition to a validation of the questionnaire, this study will also aim to identify key constructs in the URICA, so that it can be abbreviated for ease of use with younger patients.

Gusella et al. (2003) have also recognised the need for a measure to assess readiness to change and have developed The Motivational Stages of Change for Adolescents Recovering from an Eating Disorder (MSCARED). This is a short, transparent, algorithm method of identifying stage of change, which they tested on adolescents involved in group therapy. The results were promising in that on average, girls 'moved up' by one stage of change, from the beginning to the end of the group treatment. However, caution needs to be taken when generalising from

this study due to the small sample size (n=34). It could also be proposed that to have a fully transparent assessment of motivation for use with young people may lead to skewed results as there may be a desire to please the assessor by saying the right thing or a reluctance to admit to 'getting better'. Rivalry can often become an issue with young people with eating disorders (especially in an inpatient setting) and the desire to present as the most unwell/thinnest and in need of the most attention overrides any other (Magagna, 2000, Garfinkel et al. 1985).

In relation to this point, the URICA offers a more opaque assessment, possibly leading to a more accurate reflection of stage of change in some cases, as it is less explicit.

When considering the use of more complex tools such as the RMI with young people, it may be that a lengthy assessment tool may not be best suited to the assessment of younger patients, however its fit with the EDE is an advantage that must be acknowledged. There are also existing studies exploring young peoples attitudes to their eating disorder, such as the Pros and Cons of Anorexia (P-Can) Scale, which has examined the pros and cons of Anorexia Nervosa in children and adolescents (Serpell et al. 2003).

This exploratory approach focuses on the young person defining their problem and uses this as a way of determining how ready they are to change.

As a Counselling Psychologist, emphasis is placed on working as a collaborator with the client in seeking to understand the client's inner reality and construal of life experiences (Woolfe, 1996). With this in mind, there is clear clinical value in examining the meaning of the young person's eating disorder from their own point of view so as to establish a good therapeutic alliance and to be able to enable the treatment to be tailored to the individuals. This would be further enhanced by a psychometric measure and there still remains a need for a reliable measure of motivation to change eating behaviour that is suitable for use with adolescents suffering from eating disorders. Increasingly clinical management is based on the young person's motivation to address their eating difficulties, making the need for development of such an instrument a pressing issue.

This study uses a measure of motivation to change that has been previously validated in an adolescent sample. To enable a comparison between the results of previous validation studies of the URICA, the original has been replicated as closely as possible.

A validation of this adapted version of the URICA will contribute to our understanding of the stages of change model as applied to this particular sample.

In its original form, the URICA is quite long and of a repetitive nature in parts. One of the main aims of this study is to shorten the questionnaire by determining which of the items best reflect the key constructs, thus producing a briefer, less repetitive but validated version.

The hypotheses to be tested are as follows:

Hypothesis 1:

The sample's mean raw scores and standard deviations from the URICA will be similar to those reported in the three previous validation studies.

Hypothesis 2:

The URICA scales/stages will be internally consistent.

Hypothesis 3:

The adjacent stages of change on the URICA (e.g. Contemplation and Action) will be highly correlated except for Precontemplation and Contemplation which will not be correlated.

5.2 - Methodology

5.2.1 Design:

Before we can construct grand psychological theories and laws, it is generally assumed when taking a 'positivist' approach to psychology that we must first be able to measure and describe things with reasonable accuracy (Cattell, 1981).

A great deal of effort has been invested in establishing the reliability and validity of psychological measures over the last century (Breakwell et al., 2000). As a result, there are a huge variety of well-validated tests for a wide range of psychological phenomena, which can be used effectively when provided with appropriate instruction. While many established tests exist, researchers are often faced with the need to create new measures to deal with specific and emerging problems, with the goal being to measure something as well as possible.

Quantitative methods of research (generally those, which use numbers), such as the use of questionnaires, enable greater precision in measurement. There are well-developed theories of reliability and validity to assess measurement errors; thus enabling researchers to know how much confidence to place in their measurement (Barker et al., 2002).

To determine the value of a measure, we must consider both its validity and reliability. The classical definition of validity is "whether the measure measures what it is supposed to measure." For example does this questionnaire actually measure motivation to change in young people with eating disorders or does it not fit with this sample group. Reliability is an estimate of the accuracy of a questionnaire and has been defined as the extent to which the test is effectively measuring anything at all (Rust & Golombok, 2000).

The current study employed tests of both validity and reliability to determine whether the questionnaire used can be seen to be psychometrically sound. To ascertain the true validity and reliability of the URICA it would be important to use

the questionnaire at the beginning and end of treatment as an outcome measure to see if it reflected how a clinical sample presented and whether it reflected their thoughts and behaviours related to their motivation to change. It would also be important to obtain reliability amongst different raters to ascertain whether the questionnaire results are the same each time. Due to both the time and resource limitations of this study, an outcome study is not possible to undertake.

5.2.2 Participants:

The sampling criteria for selecting participants for this study were that they were aged between 12-16 years of age and were currently involved in or recently (within past year) discharged from the clinical treatment process for an eating disorder at specialist eating disorder services.

For the purpose of this research the term eating disorders includes; Anorexia Nervosa, Bulimia Nervosa and Eating Disorder Not Otherwise Specified (EDNOS). The sample in terms of diagnoses was kept broad at this stage to ensure a large enough response for validity purposes. On two of these sites the diagnoses was made using a clinical interview and the Eating Disorders Examination (Fairburn & Cooper, 1993) and the other just using clinical interview. For all cases I took clinician diagnoses, which were based on DSM IV criteria.

Participants were recruited via the institution from which they are/were receiving treatment. These places included an Eating Disorders Service within a large children's hospital and two private in-patient units set up solely for young people with eating disorders. The first point of contact was the Consultant Psychiatrist in charge of the institutions, from which consent had to be given for the study to be conducted. To enable the collaboration to be effective, Hardy (1993) suggests that it is necessary to align the goals of research with the goals of the setting and this was very much done through initial discussions on where research is needed and what could be clinically useful.

5.2.3 Sample size:

Size – In order to estimate an appropriate sample size, in particular to perform a principle components analysis, a method of statistical power analysis was employed to ensure that the study would detect an effect that is actually present (Cohen, 1988). Many studies in Counselling Psychology have simply not been powerful enough and thus may have overlooked the presence of important effects (Cohen, 1992). The power analysis was calculated in consultation with a statistician, Professor Tim Cole, Institute of Child Health, London.

This study is designed to estimate a mean T-score with a precision (standard error) of 1 or less. This requires a minimum sample size of 100 (see calculation below).

$$\frac{(R - \text{mean})}{\text{sd}} \times 10 + 50 = \text{T-score}$$

$$\text{SD (T-score)} = 10 \text{ by definition}$$

$$\text{SE (T-score)} = \frac{10}{\sqrt{n}} \text{ where } n = \text{sample size}$$

150 questionnaires were sent out to allow for a percentage of non-respondents.

5.2.4 Measure

The University of Rhode Island Change Assessment Questionnaire (URICA) – Amended version

Psychometric properties.

The URICA consists of 32 items answered on a Likert scale ranging from disagree (1) to agree (5). The URICA item generation was based on behavioural criteria for the five stages of change (Precontemplation, Contemplation, Preparation, Action

and Maintenance). Reliability and factor analyses generated four scales (Precontemplation, Contemplation, Action and Maintenance) with eight separate items loading on each of the scales (Prochaska & Diclemente, 1986). The original URICA was used in 1983 to evaluate the use of the questionnaire in a sample of adults referred for brief psychotherapy (McConaughy et al., 1983), this study was then replicated by the same authors in 1989 and results from both of the studies of the URICA support its use as an acceptable measure of the stages of change in psychotherapy patients (McConaughy et al., 1989). In relation to young people, Greenstein et al. (1999) repeated the original studies but amended the questions to suit the age group of their sample of adolescent substance abusers admitted for inpatient treatment (12-16 years). Participants responded similarly to the URICA as did previous adult samples and indicated that the URICA could be used to increase understanding and facilitate empirical investigation of motivation to change in adolescents.

The current study also amended the original URICA (see Appendix 1.) to suit the sample group. The amended version by Greenstein et al (1999) was not used as they had not directed it towards an eating disorder population and it used American language. The original version was thus revisited and adapted according to age, diagnoses and geographical area. All items were rephrased using language appropriate for 12-16 year olds, without changing the meaning. The word 'problem' was also changed to 'eating problem' to be more specific to the sample group. The questions were then discussed with four in-patients at one of the institutions, to ensure that the questionnaire was comprehensible to children of their age. It was noted that the questionnaire was a bit repetitive and confusing at times and this issue will be addressed in the main study, as one of the aims is to abbreviate the questionnaire by collapsing some of the items.

5.2.5 Scoring

Scores on each of the stages were obtained by adding together the responses of the items that load on each particular stage. These individual raw scores can

range from 8-40 and the total score is then divided by 8 to produce the mean raw score. Mean raw scores range from 1-5. Mean raw scores are then converted to T-scores, which have a mean of 50 and a standard deviation of 10 for each stage. T-scores are recommended by McConaughy et al. (1989) to ease interpretation of the scores.

5.2.6 Reliability

To assess the inter-item reliability of the questionnaire, the study calculated the coefficients using Cronbach's alpha for each stage/scale. Cronbach's alpha measures how well a set of items measures a unidimensional latent construct. (Cronbach, 1951). As the average inter-item correlation increases, Cronbach's alpha increases as well. Thus, if the inter-item correlations are high, then there is evidence that the items are measuring the same underlying construct, i.e. the same stage of change.

A Pearson Product-Moment Correlation will be used to calculate the correlation coefficient between the four stages, to measure the level of relatedness between the stages. In line with previous evidence it was predicted that the last 3 stages would be correlated whereas the precontemplation stage is more separate. Previous studies have shown that, consistent with the transtheoretical model, precontemplation was negatively correlated with all other stages, whereas correlations among the contemplation, action, and maintenance stages were all positive (McConaughy et al., 1989; McConaughy et al., 1983). It will also be used to calculate the correlation coefficient between the items within the stages as a way of determining which items could possibly be excluded from the questionnaire, thus making it shorter and more user friendly.

5.2.7 Ethical considerations/procedure:

As the study involved a clinical population, there was a thorough ethical procedure to go through to ensure that the project had addressed all relevant issues regarding consent, confidentiality, data protection and potential harm. After completing an ethics release form (see Appendix 2.) and having it granted by the Department of Psychology, City University, two ethics forms were submitted to two different ethics committees due to the participants involved, being under the care of two different healthcare trusts.

The main considerations/issues were as follows:

1. As the sample consisted of children under 16 it is essential that both parental and child consent be sought. This consent is also informed in that the families have had described to them (in the information sheets):

The purpose of the research

The potential benefits of the research

The name of the researcher whom they can contact with enquiries

The name of the doctor directly responsible for the child

How children can withdraw from the project. (Nicholson, 1986)

2. The emotional impact/risk involved in completing the questionnaire is minimal and the procedure is carried out sensitively. It is therefore safe to send as a postal questionnaire without a follow up provision, aside from that of contacting the researcher if there is a need.
3. The use of the results is purely for the research and will not effect the child's treatment in any way. The results will be anonymously recorded on a database and analysed with no reference to individual cases.
4. The data collected and stored will be anonymous, in that the data prepared from any personal information will not allow identification of an individual by a person using the data. The individual's data will be coded using unique identifiers.

A wider ethical consideration to note is the impact of treatment status, i.e. inpatient, outpatient or discharged, on the individual's participation in the project. Within the limits of the project every effort has been made to reassure the participants that participation will not affect treatment, however their possible views on it's impact on their process of recovery or therapy should be considered.

The study was given ethical approval by both ethics boards (see Appendix 3.) following the completion of minor amendments that had been advised by the boards (see Appendix 4.).

5.2.8 Procedure:

Each parent/carer of the participants received a pack by post or by hand (if in-patient) comprising of the following:

1. An introductory letter (see Appendix 5.) primarily stating the purpose of the study and that the results will only be used for research purposes.
2. Information sheets for parents (see Appendix 6.) detailing how and why the study is being done, potential risks and benefits, issues of data protection and compensation and contact details.
3. Information sheets for young person (see Appendix 7.) detailing same areas as parent sheets but using age appropriate language.
4. Consent forms for both parent and child (participant) (see Appendix 8.) confirming that they understand what is being asked of them and that they have the right to withdraw at any time.
5. Questionnaire (see Appendix 9.) to be completed by young person using instructions stated at top of questionnaire. This should take approximately 30 minutes to fill out and should cause minimum distress.

Once the parent/s and young person have understood the information they then sign the consent forms, the young person completes the questionnaire, and both are then returned to the researcher in a stamped addressed envelope.

To ensure data protection and confidentiality, the researcher had minimum, if no contact with personal details of the young person and the packs were either sent out by the institution themselves or the researcher completed the distribution process on site, not taking any personal details outside of the unit.

For those that had been discharged, a letter was sent to their G.P (see Appendix 10.) to inform them they had been invited to take part in the study, as the care of the child now principally resides with them.

After two weeks, a follow up procedure was then carried out, which either consisted of a phone call or a letter (see Appendix 11.), depending on the institution. This involved checking the participant's understanding, answering any parental queries and offering a final chance for their views to be included in this study, so as to demonstrate the worth of their opinions and personal experiences.

5.3 – Results

Of the 150 questionnaires sent out, 39 were returned (38%). These were made up of 33 females and 6 males.

The raw data for each individual's scores (see Appendix 11.) was collected and entered into a database from which the following analyses were performed.

5.3.1 Hypothesis 1: URICA mean raw scores

The mean raw scores for stages were:

Precontemplation =	2.59 (SD = .85)
Contemplation =	3.04 (SD = 1.21)
Action =	3.11 (SD = .97)
Maintenance =	2.83 (SD = 1.05)

These means and standard deviations (see Table 1 & Appendix 12.) are similar in magnitude over the last three stages to those reported in the two URICA psychometric studies conducted with adult psychotherapy outpatients and the one with adolescent inpatients (Greenstein et al, 1999; McConnaughy et al, 1989; McConnaughy et al, 1983). The mean raw scores from Treasure et al's randomized control trial (1999) with adults with Bulimia Nervosa show a different pattern, with the lowest mean raw scores in Precontemplation and the highest in Contemplation. The pattern of scores seem to reflect that participants were due to begin a phase of treatment thus most likely being in the Contemplation stage, with no participants in the Maintenance stage. There were also significant differences in that the mean scores from the present study displayed the lowest scores of the five studies over the latter three stages and the participants had the highest scores on the Precontemplation stage, highlighting a different pattern from the other studies. This is supported by a research study that also used an adapted version of the URICA to suit patients with anorexia nervosa (Ward et al, 1996), where it was found that the majority of those treated as inpatients were in the Precontemplation or Contemplation stage.

TABLE 1: URICA Raw Scores: Means and Standard Deviations

Stage	Present study	Greenstein et al. (1999)*	McConaughy et al. (1989)**	McConaughy et al. (1983)***	Treasure et al (1999)****
PC	2.59 (SD=.85)	2.25 (SD=.67)	2.02 (SD=.67)	1.95 (SD=.70)	CBT1.8 (SD=.60) MET 1.7 (SD=.60)
C	3.04 (SD=1.21)	3.83 (SD=.74)	4.28 (SD=.52)	4.26 (SD=.51)	CBT & MET 4.4 (SD=.50)
A	3.11 (SD=.97)	3.65 (SD=.70)	3.91 (SD=.62)	3.92 (SD=.64)	CBT 3.6 (SD=.80) MET 3.7 (SD= .90)
M	2.83 (SD=.1.05)	3.28 (SD=.70)	3.66 (SD=.83)	3.34 (SD=.83)	N/A

* Extracted from Greenstein, D. K., Franklin, M. E., & McGuffin, P. (1999) Measuring Motivation to Change: An Examination of the University of Rhode Island Change Assessment Questionnaire (URICA) In An Adolescent Sample. *Psychotherapy*, 36 (1), 47-55.

** Extracted from McConaughy, E. A., DiClemente, C. C., Prochaska, J. O., & Velicer, W.F. (1989) Stages of change in psychotherapy: a follow up report. *Psychotherapy*, 26 (4), 494-503.

***Extracted from McConaughy, E. A., Prochaska, J. O., & Velicer, W. F. (1983) Stages of change in psychotherapy: measurement and sample profiles. *Psychotherapy: Theory, Research and Practice*, 20 (3), 368-375.

****Extracted from Treasure, J., Schmidt, U., Todd, G., Katzman, M., Troop, M., & de Silva, P. (1999). Engagement and outcome in the treatment of bulimia nervosa: first phase of a sequential design combining motivation enhancement therapy and cognitive behavioural therapy. *Behaviour Research and Therapy*, 37, 405-418.

5.3.2 Hypothesis 2: Internal consistency

Internal reliability coefficients were calculated (see Appendix 13.). The scale alphas for the stages were:

Precontemplation = .80
 Contemplation = .90
 Action = .82
 Maintenance = .80

As anticipated, these coefficients are satisfactory and similar to those reported in the previous literature on the URICA (see Table 2).

TABLE 2: Scale Alphas

Stage	Present study	Greenstein et al. (1999)*	McConaughy et al. (1989)**	McConaughy et al. (1983)***
PC	.80	.77	.79	.88
C	.90	.88	.84	.88
A	.82	.86	.84	.89
M	.80	.82	.82	.88

* Extracted from Greenstein, D. K., Franklin, M. E., & McGuffin, P. (1999) Measuring Motivation to Change: An Examination of the University of Rhode Island Change Assessment Questionnaire (URICA) In An Adolescent Sample. *Psychotherapy*, 36 (1), 47-55.

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5.3.3 Hypothesis 3: Pearson Product-Moment Correlations (see Appendix 13.)

The correlations between the scales revealed a similar simplex pattern reported in the three previous studies: adjacent scales tended to be more correlated than nonadjacent scales. The largest negative correlation coefficient (-.72) was between Contemplation and Precontemplation. The largest positive correlation coefficient (.81) was between Contemplation and Action. These results are very similar to the pattern reported in the three previous studies (see Table 3).

Also consistent with the transtheoretical model for change, Precontemplation was negatively correlated with all other stages, whereas correlations among the Contemplation, Action and Maintenance stages were all positive.

TABLE 3: Pearson Product-Moment Correlation Coefficients for the Four Stages.

Present study	PC	C	A	M
PC	-	-	-	-
C	-.72	-	-	-
A	-.51	.81	-	-
M	-.25	.51	.52	-

Greenstein et al. (1999)*	PC	C	A	M
PC	-	-	-	-
C	-.57	-	-	-
A	-.45	.70	-	-
M	-.41	.72	.48	-

McConnaughy et al. (1989)**	PC	C	A	M
PC	-	-	-	-
C	-.52	-	-	-
A	-.23	.50	-	-
M	-.22	.45	.48	-

McConnaughy et al.(1983)***	PC	C	A	M
PC	-	-	-	-
C	-.45	-	-	-
A	-.16	.53	-	-
M	.05	.27	.38	-

* Extracted from Greenstein, D. K., Franklin, M. E., & McGuffin, P. (1999) Measuring Motivation to Change: An Examination of the University of Rhode Island Change Assessment Questionnaire (URICA) In An Adolescent Sample. *Psychotherapy*, 36 (1), 47-55.

** Extracted from McConnaughy, E. A., DiClemente, C. C., Prochaska, J. O., & Velicer, W.F. (1989) Stages of change in psychotherapy: a follow up report. *Psychotherapy*, 26 (4), 494-503.

***Extracted from McConnaughy, E. A., Prochaska, J. O., & Velicer, W. F. (1983) Stages of change in psychotherapy: measurement and sample profiles. *Psychotherapy: Theory, Research and Practice*, 20 (3), 368-375.

5.3.4 Construct Validity

As a way of determining which of the items best reflect the key constructs of each stage, a Pearson's Product-Moment Correlation has been carried out to examine the correlations between the items in each stage (see Appendix 13.). With the aim being to produce a briefer, less repetitive version of the URICA.

TABLE 4: Pearson Product-Moment Correlation Coefficients for the Precontemplation items.

	PC1	PC2	PC3	PC4	PC5	PC6	PC7	PC8
PC1								
PC2	.27							
PC3	.27	.24						
PC4	.27	.33	.43*					
PC5	.32	.64*	.33	.35*				
PC6	.41	.09	.32	.37	.02			
PC7	.25	.10	.15	.12	.06	.26		
PC8	.09	.30	.25	.69**	.12	.39*	.26	

** Correlation is significant at the 0.01 level (2-tailed)

*. Correlation is significant at the 0.05 level (2-tailed)

As you can see from Table 4, all items in the Precontemplation stage are positively correlated. The item with the weakest correlation is PC7 and the item with the most consistent correlation is PC5. The most significant correlation is between PC4 and P8.

TABLE 5: Pearson Product-Moment Correlation Coefficients for the Contemplation items.

	C1	C2	C3	C4	C5	C6	C7	C8
C1								
C2	.27							
C3	.35*	.41*						
C4	.46**	.49**	.70**					
C5	.32	.37*	.90**	.59**				
C6	.31	.54**	.71**	.73**	.68**			
C7	.19	.26	.52**	.68**	.53**	.53**		
C8	.39*	.58**	.61**	.84**	.51**	.55**	.54**	

** Correlation is significant at the 0.01 level (2-tailed)

*. Correlation is significant at the 0.05 level (2-tailed)

All Contemplation items are positively correlated (see Table 5), with many at a high degree of significance. C4 and C3 show the highest levels of significance. The lowest degree of significance is evident in item C1.

TABLE 6: Pearson Product-Moment Correlation Coefficients for the Action items.

	A1	A2	A3	A4	A5	A6	A7	A8
A1								
A2	.35*							
A3	.57**	.45**						
A4	.29	.44**	.45**					
A5	.14	.53**	.51**	.44**				
A6	.36*	.61**	.63**	.29	.34			
A7	.25	.16	.16	.24	.09	.21		
A8	.41*	.51**	.51**	.71**	.46**	.35*	.26	

** Correlation is significant at the 0.01 level (2-tailed)

*. Correlation is significant at the 0.05 level (2-tailed)

Again all items are positively correlated with A3 showing consistently high degrees of significance and A7 showing a low correlation with other items.

TABLE 7: Pearson Product-Moment Correlation Coefficients for the Maintenance items.

	M1	M2	M3	M4	M5	M6	M7	M8
M1								
M2	.61**							
M3	.55**	.64**						
M4	.55**	.62**	.76**					
M5	.69**	.59**	.68**	.49**				
M6	.24	-.01	-.11	.19	.05			
M7	.20	.25	.15	.33	.07	.43*		
M8	.38*	.46**	.66**	.83**	.37*	.18	.32	

** . Correlation is significant at the 0.01 level (2-tailed)

* . Correlation is significant at the 0.05 level (2-tailed)

The maintenance items show both positive and negative correlations with item M6 showing the least correlation with the other items. Items M4, M5, and M8 all show a high degree of significance.

A principle components analysis was not possible with the number of recruited participants. As a result of this sampling issue an alternative statistical test was performed measuring scale alpha with items removed.

5.3.5 Scale alpha with item removed

As there was insufficient sample numbers to conduct a principle components analysis it was important to carry out an alternate test to explore whether any items within each scale are redundant, therefore leading to a reduction of items. This was achieved using a reliability analysis, specifically measuring the scale alphas with items removed. The impact of removing each item from the scale is given and if the value when the item is removed is higher than the overall scale alpha, the item could be removed from the scale.

Table 8: Scale Alpha with Item Deleted for Precontemplation Stage Items

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item- Total Correlation	Cronbach's Alpha if Item Deleted
PC Item 1	17.56	44.36	.49	.78
PC Item 2	16.97	41.45	.50	.78
PC Item 3	17.15	41.61	.54	.77
PC Item 4	16.79	39.75	.60	.76
PC Item 5	16.84	41.87	.49	.78
PC Item 6	16.36	40.18	.51	.78
PC Item 7	16.33	42.39	.39	.79
PC Item 8	16.59	38.83	.58	.77

For the Precontemplation stage, none of the items if deleted result in a Cronbach's Alpha that is higher than the overall stage alpha of .80.

Table 9: Scale Alpha with Item Deleted for Contemplation Stage Items

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item- Total Correlation	Cronbach's Alpha if Item Deleted
C Item 1	22.03	79.82	.45	.90
C Item 2	22.23	76.08	.55	.89
C Item 3	21.92	69.70	.77	.87
C Item 4	22.28	67.68	.86	.86
C Item 5	21.92	71.23	.73	.88
C Item 6	22.59	72.46	.73	.88
C Item 7	22.38	72.56	.59	.89
C Item 8	21.97	71.66	.76	.87

For the Contemplation stage, none of the items if deleted result in a Cronbach's Alpha that is higher than the overall stage alpha of .90.

Table 10: Scale Alpha with Item Deleted for Action Stage Items

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item- Total Correlation	Cronbach's Alpha if Item Deleted
A Item 1	22.54	46.73	.46	.81
A Item 2	23.08	43.70	.65	.78
A Item 3	22.31	42.27	.71	.77
A Item 4	22.48	45.57	.61	.79
A Item 5	22.43	46.62	.52	.80
A Item 6	23.13	43.54	.60	.79
A Item 7	22.62	53.93	.10	.86
A Item 8	22.33	44.02	.71	.77

For the Action stage, Item 7 is highlighted as having a Cronbach's Alpha which is higher than the overall scale alpha of .82.

Table 11: Scale Alpha with Item Deleted for Maintenance Stage Items

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item- Total Correlation	Cronbach's Alpha if Item Deleted
M Item 1	20.89	51.52	.57	.77
M Item 2	19.77	48.50	.61	.76
M Item 3	19.59	49.25	.61	.77
M Item 4	19.54	44.26	.76	.74
M Item 5	20.05	49.68	.53	.78
M Item 6	20.05	58.26	.10	.84
M Item 7	20.56	53.73	.36	.80
M Item 8	19.46	45.47	.66	.76

For the Maintenance stage, Item 6 is highlighted as having a Cronbach's Alpha which is higher than the overall scale alpha of .80.

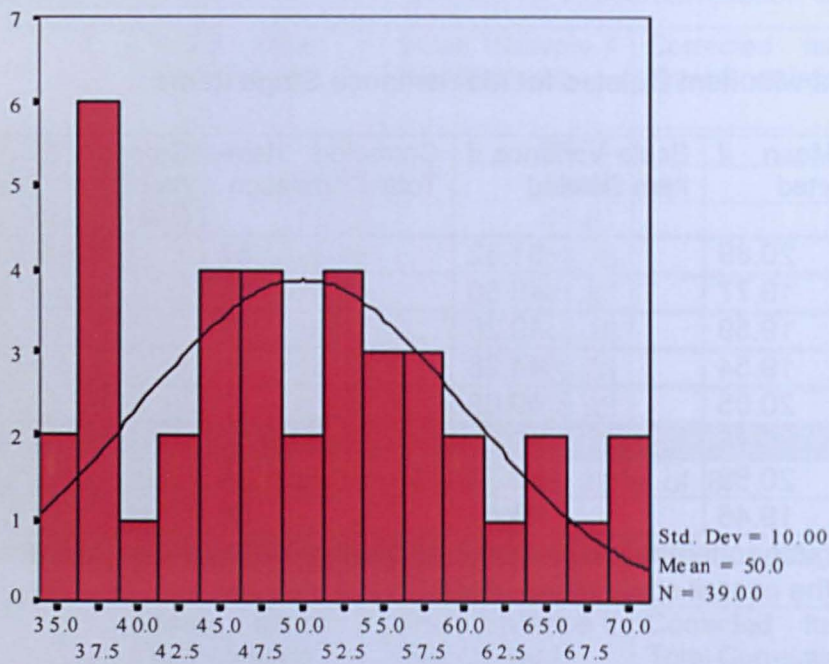
Response Pattern

To illustrate the distribution of the responses over each of the stages I have also included histograms to depict the pattern of the T-scores of each of the four stages.

From the mean scores (see Table 1) we can see that the Contemplation and Action stages were the most highly endorsed, with the Precontemplation stage having the lowest mean score.

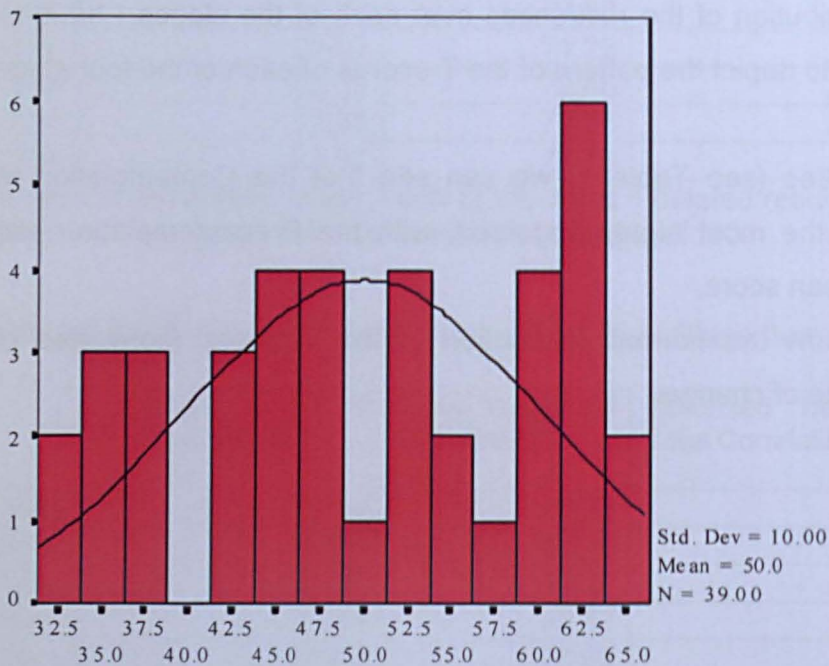
Figures 1-4 also show the normal distribution of the T-scores (converted raw scores) for each stage of change.

Figure 1: Histogram of Precontemplation T-scores



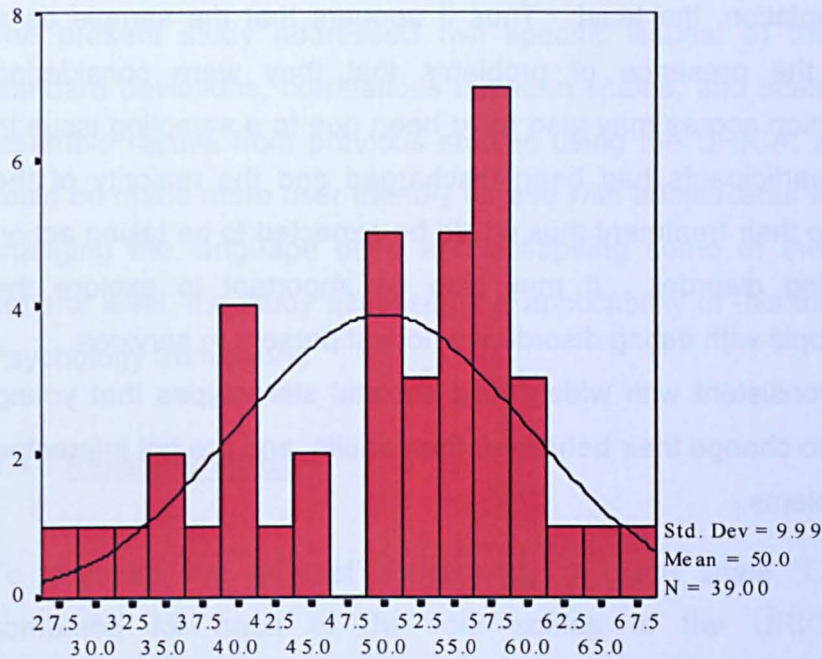
pct

Figure 2: Histogram of Contemplation Scores



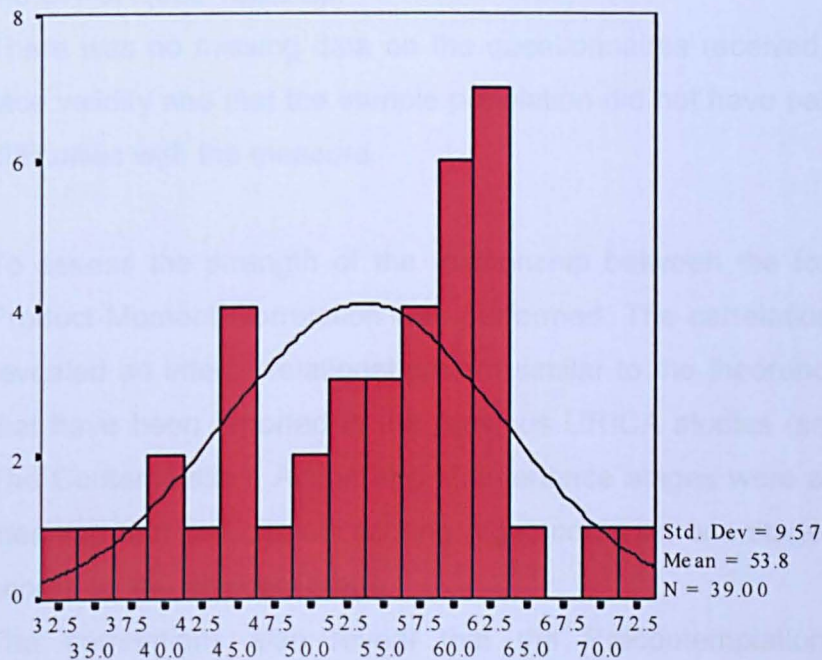
ct

Figure 3: Histogram of Action T-scores



at

Figure 4: Histogram of Maintenance T-scores



mt

Figures 1-4 demonstrate that Action and Maintenance items generated the highest scores and Precontemplation, the least. Thus it appears that the sample as a whole acknowledged the presence of problems that they were considering changing. The high action scores may also have been due to a sampling issue in that 3 out of the 11 participants had been discharged and the majority of the inpatients were well into their treatment thus would be expected to be taking action in changing their eating disorder. It may also be important to explore the motivation of young people with eating disorders who first present to services. These findings are inconsistent with widely held societal stereotypes that young people are less willing to change their behaviour than adults, and are not interested in addressing their problems.

5.4 – Discussion

The present study addressed two specific issues: a) that the URICA means, standard deviations, correlations between scales, and scale alphas would closely resemble results from previous studies using the URICA; and b) that the URICA could be made more user friendly for use with adolescents with eating disorders by changing the language used and collapsing some of the items. On a more general level, the study assessed the applicability of this tool within a Counselling Psychology framework.

5.4.1 Reliability/Validity

To evaluate the internal consistency of each scale, Cronbach's alpha was computed for each of the four scales of the URICA (Precontemplation, Contemplation, Action and Maintenance). The coefficient alphas were all above the acceptable level of 0.7 and revealed that each stage has adequate internal consistency. They are also comparable to those found in the previous studies of the URICA (see Table 2).

There was no missing data on the questionnaires received, which suggests good face validity and that the sample population did not have particular comprehension difficulties with the measure.

To assess the strength of the relationship between the four stages a Pearson's Product-Moment Correlation was performed. The correlations between the stages revealed an intercorrelational pattern similar to the theoretically predicted patterns that have been reported in the previous URICA studies (see Table 3 in Results). The Contemplation, Action and Maintenance stages were all positively correlated, meaning that participants scoring high scores on one stage will tend to have high scores on the adjacent stage.

The correlations also reveal that the Precontemplation stage is negatively correlated with all the other stages, indicating a reverse pattern in which high scores on this stage go with low scores on the others. This makes the position of

not considering change, distinctively different from undertaking a serious consideration towards change.

Previous researchers concluded that because the other adjacent stages tended to be highly correlated, the stages of change could be conceptualised as invariant and additive (McConaughy et al., 1989; McConaughy et al., 1983). However, it could also be viewed that as Contemplation, Action and Maintenance have a high correlation (particularly Contemplation and Action at .81), they could be viewed more as a continuum rather than a series of stages. Thus conceptually, moving towards an adapted version of The Transtheoretical Model of Change.

With particular reference to adolescents, Bauman et al. (2001), also question the model in its entirety. After carrying out a validation of a measure of motivation to change in substance abusers, they began to reconsider the TTM. They only found profiles similar to those of precontemplators and contemplators, with the remaining stage profiles not presenting in this particular sample. Cady et al. (1996), also only identified three groups when researching motivation to change as a predictor of treatment outcome of adolescent substance abusers. They named their groups/stages, Contemplation, Contemplation/Preparation and Preparation. Neither of the above named studies found evidence of the action and maintenance stages represented in their samples as theorised by Prochaska, Norcross and DiClemente (1994). They have not indicated as to why this might be, however it could be suggested that the factor of ambivalence again could be considered to play a part. Adolescents may not fully commit to changing their behaviour and thus remain contemplative, even when in treatment.

In summary, the correlations between stages presented in this study and the findings of Bauman et al. (2001) and Cady et al. (1994) indicate, that for adolescents, a more restricted range of stages has been found and that there is a clear need for a more complete understanding of these stages, in particular the transition from the distinct stage of Precontemplation to a point where elements of all the next three stages can play a part at any one time.

When considering the items within each stage, it was important to reveal that they all measured the same construct and in line with the aims of the study there was a need to reduce the repetitive nature of the questionnaire. The construct validity was assessed using the Pearson's Product-Moment Correlation and Scale Alpha with Item Deleted. The Pearson's Product-Moment Correlation provided some evidence that leads towards a reduction of the total items per stage and over the whole questionnaire, however this was not supported by the Scale Alpha with Items Deleted which only highlighted one possible redundant item on two stages, which could not be removed currently as it would result in an uneven weighting in the stages in the questionnaire. These particular forms of analysis require a larger sample size to then be able to generalise from the findings but in the current study they have been used to provide a guide and some initial thoughts on how the measure could be made more user-friendly.

From the Pearson's correlation tables (Tables 4-7) it is evident that the Precontemplation items are less strongly correlated with each other than the items in the other stages. Although some degree of correlation is required to determine if the items relate to each other, when there is a very high level of correlation it can signify that there is a lot of overlap. This means that the two related items with a strong correlation could then be collapsed to one item. For example, in the Contemplation stage (see Table 5), C3 is very strongly correlated (.90) with C5. It could then be suggested that these items are merged together. Over the Contemplation, Action and Maintenance stages, there is a lot of overlap indicated. However as stated earlier, a clear reduction in items was not supported within the reliability analysis looking at scale alpha if items are deleted. At this stage it is therefore not possible to make a clear indication as to how the questionnaire could be shortened.

5.4.2 Clinical implications

The psychometric properties of this adapted version of the URICA suggest that it could be used to measure motivation to change in young people with eating

disorders. Ideally as part of an assessment process, the adapted version suggested, could be used to determine an individual's stage of change throughout the treatment process. However, for use as a clinical tool, it would need further validation with a larger sample size. It could also be suggested that the adapted URICA would be valid in a wider adolescent population due to its psychometric properties, however this would need more in depth exploration and would be able to be more firmly suggested following an outcome study using the current questionnaire.

Over the course of this research, other studies have also begun to assess the need for a tool to measure motivation to change in young people. These studies have consisted of measures that range from 4 – 35 items (Gowers & Smyth, 2004; Gusella, 2003).

Despite the psychometric value of the questionnaire, perhaps the most important implication from the current study, for practitioners who provide treatment for young people with eating disorders, is that the Contemplation, Action and Maintenance stages seem to display a lot of overlap. In support of what Treasure and Schmidt (2001) found, the findings suggest that when being treated for an eating disorder, it can be that an individual is in the three stages simultaneously, as if thinking about changing, changing and maintaining the changes are part of a cyclical and ongoing process. Therefore, it seems it may be more helpful to think of the latter stages of change on a continuum rather than as separate and treating individuals as if in one particular stage. Treasure and Schmidt (2001) also pointed out that readiness to change can vary from session to session and a questionnaire can only ever provide a snapshot of an individual's attitude. It is therefore also important to add depth to the results of a questionnaire using a qualitative measure. Measuring stage (or state) of change remains important in terms of adjusting therapeutic approach and treatment interventions to suit an individual's attitude towards and motivation to change their eating disorder behaviours. However, as detailed above this should be viewed in the context of something that is fluid and on a continuum to allow a more flexible rather than fixed approach. Within Counselling Psychology, the individual's perspective and experience is continually explored in an attempt to

work towards solutions that are guided by and personal to the individual. As noted, the change process is fluid and dynamic and the therapeutic process within Counselling Psychology lends itself to the fluctuations that occur. Therefore, the limitations of the tool seem to direct towards a more qualitative approach to assessing motivation to change as well as a short quantitative measure.

The ambivalence evident in the distribution of the scores may also be due to the fact that the young people had a range of different thoughts and feelings towards their eating disorder that spanned across the stages, thus making it difficult to respond with a concrete answer. Again, this comes back to the suitability of a single closed form of assessment for this particular sample group. It may be that it is helpful to determine whether they are 'precontemplative' or 'contemplative' and conduct a semi-structured interview according to their position. Another hypothesis regarding the scores distribution that has been addressed within the literature (Geller et al, 1999) is that individuals may be motivated to change different eating disorder symptoms at different times (i.e. bingeing or restricting) and it may therefore be important to measure motivation to change across the varied symptomatology.

These findings are important for Counselling Psychologists as they contribute to our understanding of the change process and its cyclical and fluid nature. With regard to this particular sample, it may be that the young person travels in many directions across the stages before achieving more permanent change. A young persons motivation can also change in different situations, such as if a parent/carer is present. The need to understand the individual as unique and separate is at the heart of Counselling Psychology practice and supports the importance of looking at motivation to change and its unique relationship with developmental stage of adolescence.

Awareness of the change processes and the ambivalence that travels alongside them can inform our approach and thinking about the individual and their family. Therapeutic styles that are respectful, acknowledge choices and ambivalence, and

do not increase resistance seem to be logical choices. The technique that was developed and is practised with these issues in mind is Motivational Interviewing (Miller & Rollnick, 2002). Motivational Interviewing is a directive, client-centered counselling style for eliciting behavior change by helping clients to explore and resolve ambivalence. This approach is focused and goal directed and not only minimises conflict but also uses ambivalence to develop motivation for change.

This approach is based on The Transtheoretical Model of Change, which from this and others studies has been deemed a very useful place to begin exploring issues of motivation but can have it's limitations (Bauman et al., 2001; Cady et al., 1996).

5.4.3 Benefits/difficulties of research using a clinical population

The main advantage of conducting a research project using a clinical population is the range of professionals and disciplines from whose expertise can be drawn. There has also been an element of clinical research related support, which has been very useful throughout.

Due to the limited timeframe of the study, collaboration and involvement required from other professionals was kept to a minimum, to allow the research to take on a pace, which reflected the deadline set. Where some collaboration was stipulated due to data protection issues and internal research procedures, problems arose at times due to restricted availability of staff, further checking of documents, time delays and a difference in priorities.

Planning ahead of schedule allowed the ethical approval to be gained on time, however it was learnt that many of the difficulties arose after ethical approval had been given. Although efforts were made to set up preliminary discussions with each setting prior to the ethical procedure, this was not always possible and would be something to be more aware of in future studies to prevent such difficulties form occurring.

Due to personal links and relationships with professionals within the chosen field of study, access was negotiated to 3 clinics so as to maximise the target population. As suggested in Barker et al. (2002), communication was directed to the 'gatekeeper', which in each case was the Consultant Psychiatrist. The majority of

the time this was extremely beneficial but occasionally, the standards of the Consultant were such that after ethical approval had been granted, further adjustments were requested. Consequently, this had an impact on the timetable of tasks to be completed.

A factor that could be approached differently in future research is the awareness of internal processes within the clinical settings and their impact on the research process. Particular procedures within the clinical settings that are set up for research studies have at times led to tasks taking longer than expected to complete.

Throughout the process, effective use of therapeutic skills such as disclosure, empathy and acceptance (Goodman, 1972), have been invaluable in understanding and responding to doubts and queries from other professionals about the research. A commitment to regular contact and updates on the research process has enabled a flow of communication to develop and has enabled positive and effective relationships to develop.

5.4.4 Response rate/Sampling issues

It is important to discuss the response rate first as it is informative on a number of levels. Despite multiple recruitment efforts made, the end sample size was smaller than expected, may be due to a number of reasons. From these reasons we can hypothesise about the non-respondents and look towards future research.

Firstly, in relation to the nature of individuals with eating disorders, there may be a high degree of ambivalence both with regard to their own attitude to change but also their attitude to taking part in the research. As Geller and Drab (1999) pointed out, resistance can be encountered when trying to implement treatment programmes to those with eating disorders and the same could be applied when trying to conduct research. Despite being informed that the results would be used purely for research purposes and would not affect their treatment, it may have been that the sample group did not believe that they strictly had an eating disorder or wanted to change. Subsequently, this ambivalent stance may have affected their desire to take part. Also with regard to resistance, the point highlighted by

Sullivan and Terris (2001), questioning the suitability of a questionnaire as a tool for exploring complex behaviours such as eating disorders, may be a valid one. It remains a complicated issue though, as the current study is validating a tool, not exploring an in-depth topic and to this extent a psychometric measure is needed. Nevertheless, ambivalent groups of patients are most in need of such research and tools that would inform practitioners about this particular area would be most beneficial. A possible resolution to this problem may then be a measure, which incorporates more open-ended responses and provides the opportunity for a more diverse range of views to be both given and analysed.

Again, in relation to the sample group, it is important to consider the target age range and its effect on the response rate. In comparison with adults, young people present with a lower level of motivation to change their symptoms due to their developmental stage (Winters, 1999). The tasks of adolescence such as developing autonomy and individuation require a lot of questioning and pushing against authority figures (Miller & Rollnick, 2002). Thus, for young people, ambivalence about change is common. This ambivalence and overall lack of motivation may then have impacted on their willingness to complete the questionnaire.

Such practical difficulties of having a specific sample group can mean that the more stringent the inclusion criteria, the harder it is to gain participants. Mintz (1981) called this Waskow's Law:

"As soon as you completely specify a population, it will disappear."

Also, large samples are hard to come by when targeting specific diagnostic groups and many of the recent studies on young people with eating disorders have consisted of sample groups ranging from 34 – 70 participants (Gusella et al., 2003; Rieger et al., 2000).

In critique of the sample, the sample group could also be considered not specific enough, as the broad range of participants, i.e. with different diagnoses and at different stages of treatment, may have produced a pattern of results with reduced generalisability.

In comparison to the previous studies of the URICA (McConaughy et al., 1983, McConaughy, DiClemente, Prochaska and Velicer, 1989; Greenstein, Franklin,

and McGuffin, 1999), this study broadened the sample to include recently discharged patients as well as in-patients. The aim of this being to broaden the scope of where particular clusters of individuals may fall in relation to the stages of change. For example, by including those who have been discharged, it is likely that there would have been a proportion of respondents in the 'maintenance stage', who are working to maintain the changes they have made. The nature of the clinical sample is such that within each setting, the group would be very heterogeneous in their attitudes towards receiving help and their wish to change. As a result of this, some of the items did not apply to all participants.

Lastly, at follow up and throughout the procedure, a number of personal accounts from parents were received, stating why their child would not fill out the questionnaire and also giving their own views on the research and their child's eating disorder. These included:

- Having recovered from an eating disorder, their child didn't want to think about it any further;

- Their child denied having an eating disorder altogether;

- Their child was currently too unwell to consider taking part in research.

The education of the parent/s is vital and after-care very important to ensure maintenance of the changes.

The overall sense of the views of the parents was that they were more willing to engage in the research process than their children and seemed keen to assist wherever they could. This reflects the point that it is rarely the young person's decision to enter the treatment process (Elkind, 1984). It also begs the question; "who's motivation is it to change?" and highlights the importance of considering both the parental influence over the change process but also the parents motivation to change and its alignment with that of the young persons.

5.4.5 Conclusion/Implications for future research

From these findings, it is very clear that ambivalence is a key factor to consider when researching and working with the issues of motivation to change in young people with eating disorders. As noted by Miller and Rollnick (2002), passing through ambivalence is a natural phase in the process of change. It is when people get stuck in ambivalence that problems can persist and intensify. Counselling Psychology as a discipline is focused on strengths-based work and helping people to realise their full potential and an awareness of an individual's motivation to change is an important first step in the clients process of self-actualisation.

The results from this study clearly highlight the ambivalence present in this sample and inform us that it is possible to be in many stages of change at the same time. They also provide evidence for the internal consistency of the adapted URICA and indicate that a further larger study would be required before we can make suggestions as to how to shorten the questionnaire.

Having discussed the potential influences on a young persons report on their motivation at any one time, it can be concluded that the construct of the stages of change is a useful and informative model but can be limited when exploring moving into a position of change, due the fluid and cyclical nature of the process.

The implication that The Transtheoretical Model of Change could be adapted/shortened when applied to young people is an interesting one and requires further exploration. As mentioned earlier, research focusing on the predictive validity of a tool such as the one used in this study, will help us to establish if reports of motivation to change are meaningful in a clinical environment that focuses on outcomes. Another direction to take some of the findings of this study is down a more systemic path, comparing young peoples perception of their stage of change with their parents perception. This is a very important factor as when parents move into action before the young person, there can be high levels of confrontation at home, which can counteract the non-confrontational approach of the eating disorders clinic (Treasure et al., 2003).

Overall, it can be said that the nature of a young person's motivation to change their eating disorder is a very complex issue. There are many ways to approach these issues but in relation to Counselling Psychology the direction for future research should be to establish 'meanings' particular to groups or individuals. What is the meaning of what is being measured? When a young person rates their motivation to change, do they mean what they say they mean? Will they act on it and will it predict engagement with help? These are all significant questions to follow up and will help to progress a field of research that is still in its infancy.

6. - Section B - Part 2 – A systemic perspective

6.1 Introduction

6.1.1 Motivation to change in the context of Counselling Psychology

The professional practice of Counselling Psychology is built on two important elements: firstly, a humanistic understanding of the therapeutic process which provides the basis for both the working alliance and therapeutic change. The second factor is the research based scientific knowledge, which provides the structure and clarity essential to an informed change process.

More specifically, psychotherapy/counselling is designed and implemented to foster positive behavioural cognitive and emotional change yet it has long been known that psychotherapy/counselling does not always produce positive outcomes. For example, Luborsky, Singer and Luborsky (1975) reported that although different kinds of therapies tend to be equally effective, all clients do not necessarily demonstrate equivalent positive improvements. One possible reason for a client's less than optimum or poor response to therapy/treatment is thought to be lack of motivation.

It is important here to explore what is meant by motivation but when looking for a precise definition of motivation, a consensus is lacking. Woolfolk (1997) noted that motivation is often defined as an internal state responsible for arousing, directing and maintaining behaviour. This reflects the etymology of the word 'motivation' whose Latin root means 'to move' (Weiner, 1993). Neelyara and Nagalakshmi (1996) suggested a more broad and useful definition of motivation:

"Motivation is the set of all variables which arouse, sustain and direct behaviour" (p153), and one, which seems the most appropriate to use in the context of this review.

With the knowledge that a clients motivation could be an explanatory factor in how well they 'recover', research has focused on how motivated an individual is to change and whether this has an impact on the success of the treatment intervention, especially with an underlying need to maintain positive outcomes. The importance of looking at the area for motivation to change, within a framework of

Counselling Psychology lies within a focus on wellbeing and the process of 'becoming what one is capable of becoming' (Rogers, 1951) and an individual's motivation to change could be seen as the beginnings of what Maslow termed 'self actualisation'.

6.1.2 Stages of change model – How applicable is it?

Within clinical practice, methods currently used to change behaviour include: individual therapy/counselling, family therapy, behaviour modification, education and advice and self-help groups. Underpinning many of these methods are a variety of different theoretical models, including the theory of planned behaviour, learning theory and social learning theory. In addition to such models, there are also stage theories or stage based approaches to behaviour change, including the transtheoretical model. Over the last two decades there has been much interest and research into the use of the 'transtheoretical' or 'stages of change' model (Prochaska & Diclemente, 1986) in understanding and treating addictive behaviours and more recently eating disorders. The key focus of the research has been into how we can understand an individual's position in the change process and thus tailor subsequent interventions accordingly.

The "stages of change" model is a theory that describes stages through which people's motivation and intention to modify their behaviour can progress. It consists of five main stages that are: precontemplation, contemplation, preparation, action and maintenance. Each one of these phases or "stages" describes an individual's attitude toward behaviour change. According to the stages of change model, people who are currently in one stage display different behavioural and cognitive characteristics from people in other stages. The model suggests that a person changes by passing through this defined sequence of qualitatively distinct stages. As a stage theory it also proposes that the barriers people face in trying to change, will be different at different stages. The implication of this approach for behaviour change is that one type of intervention would not be expected to work for everyone, because the barriers people encounter are different at each stage.

Although, this model has received much attention, little of this has been focused on outcomes and the clinical effectiveness of the model. In a systematic review (of 516 papers) of the effectiveness of interventions based on a stages of change approach, Riemsma et al, (2003), found that despite widespread use of this stage based model, there is little evidence available about the effectiveness of this approach in changing behaviour.

Even with the lack of evidence supporting its clinical effectiveness, this model continues to be applied both in research and clinical settings. This is not to say that there is little value in considering individuals passing through different thought and behaviour processes when embarking upon psychological and behaviour changes, more that we need to be cautious in categorizing individuals into distinct stages, which during stage based assessments are found not to be empirically distinct. Sutton (2001) highlights this particular problem with the use of multi dimensional questionnaires such as the URICA, which have been specifically developed to assess the stage in which an individual is currently positioned. He has found that respondents can and do score highly on more than one stage, which is inconsistent with the assumption that the stages are discrete. To the extent that the instrument fails to distinguish between the different stages into which participants fall, thus rendering a tailored intervention somewhat meaningless. In attempting to provide an alternative way of thinking about the change process, an earlier review (Oldenburg et al, 1999) recommended that practitioners might want to consider integrating key concepts of social cognitive theory. This may then enable them to recognise the wider determinants of behaviour change choices and place the individual in the context of their life circumstances and environment, thus addressing personal barriers to change.

6.1.3 Change in context of eating disorders and adolescence – contributory factors.

In the context of motivation to change and when thinking specifically about children and adolescents it seems inadequate to consider them in isolation from the context in which their behaviour is occurring. It is clear that child behaviour and development is directly and indirectly influenced according to complex contextual relationships.

Family

Many studies have confirmed that there is a very strong association between the psychological well being of children and adolescents and the characteristics of their family and wider context (Faubert et al, 1990).

In the focused area of eating disorders, Gowers and Bryant-Waugh (2004) echo this notion in that irrespective of any consideration for aetiological variables, parents will usually need to be involved in the management of younger patients. This is highlighted in the treatment of anorexia nervosa and bulimia nervosa, which includes aspects of behavioural management where there is a definite need for parents to be involved in the handling of these if the treatment is to be effective.

Family interventions have thus developed as treatments which mobilise family resources whether delivered as 'conjoint' family therapy, separated FT in which parents and child are seen separately) or 'parental counselling'.

Overall, family therapy addresses the eating disorder as a problem of family life affecting all family members. With adolescents, the parents can often be helped to take a very active role to oppose the anorectic eating habits, with a major focus on ensuring the child's food intake is sufficient (Lask, 2000). Therapy usually emphasises the importance of parents working together on a consistent plan of management as well as offering mutual support to each other throughout this process.

With this emphasis on involving the family in the treatment of young people with eating disorders it therefore seems important for the impact of family and other systems to be considered when exploring motivation to change.

Peers

Most developmental theories recognise the important role of the environment in the development of children and adolescents, particularly through difficult transitional periods such as adolescence. Peer relations and friendships play an important role in a child's emotional and intellectual growth and it has even been suggested that at some stages of development peer groups are as significant as parent child relations and genetics (Kymissis, 1996). It is widely accepted that the environment, life events and experiences can delay, speed or change the developmental process, and a child that has suffered a traumatic experience can be affected developmentally. It follows therefore that positive events such as peer experiences can foster and facilitate further development and that children coming together in a group is a natural and effective way to encourage this.

Bandura's social cognitive theory (1989) suggests that most social learning takes place by observing others and the result of their actions. In addition children may learn from models and heroes, such as older peers, siblings or group leaders; imitating their behaviour and developing new judgmental standards

Davies (2004) brings to our attention an increasing recognition that individuals with eating disorders have social difficulties (Troop & Bifulco, 2002), suffering physical isolation, emotional withdrawal and restricted communication (Trelfa & Britten 1993). It has also been suggested that they are stuck in an earlier stage of development as anorexia is often seen as reflecting the individual's fear of avoidance of growth, sexuality, and independence – a phobic avoidance of puberty or growing up (Crisp 1980).

With these points in mind it seems important therefore to reconsider the use of a theory that was originally developed to focus on the individual. Within this theory, motivation does not take into account the wider context of an individual's eating disorder and what influences their motivation.

This is not to conclude that we must not focus on the individual at all, more that we need to revisit the theory behind the notion of 'motivation to change' especially when treating young people with eating disorders where the need to combine interventions aimed at both the family and the individual is paramount.

6.1.4 What has been done so far? – A review of papers

When exploring the factor of motivation to change in young people with eating disorders, there is a serious lack of research completed. However, the little research that has been done has produced interesting results.

Due to the problems that have arisen with the assessment tools associated with the transtheoretical model such as the URICA, a portion of the research has directed its main aim towards developing a new assessment tool to fit the client group. Gusella et al (2003) have developed the The Motivational Stages of Change for Adolescents Recovering from an Eating Disorder (MSCARED), which was designed to assess readiness to change based on Prochaska and DiClemente's model (1986). The questionnaire also takes into account the multidimensional nature of eating disorders and that eventual recovery requires taking action on a number of behaviours (e.g. eating purging, expressing emotions). As Geller & Drab (1999) highlighted, it is important to have a measure that allows the adolescent to indicate what specific actions are being taken. The MSCARED was administered to 34 adolescent (12-18 yrs) girls with four other eating disorder measures (not of motivation) before and after a course of group therapy. The test-retest reliability of the MSCARED was found to be high and the concurrent validity to be significant between the interviewer and the young person and the young person and their mother. Stage of change was also found to be the best predictor of outcome, showing that on average individuals moved up one stage of motivation

from beginning to end. It is also the first demonstration of a motivational shift forward for young people attending group therapy. This study seems to bring to our attention the benefits of working outside the realms of individual therapy and using a group to help shift readiness to change. From this and with future research in mind, it brings about such questions as; does this work because of the importance of peers at this age and the need to be alike? And if the group is shifting towards recovery then is it more likely that most members will shift with it? The difficulty in interpreting the results from this study is that there is no control group to establish whether the shifts in motivation would have occurred anyway with these patients.

Within this study and that of Gowers & Smyth (2004) the questionnaires have been kept short and focused with singular statements for each stage of change, which may be beneficial to this particular age group. On the other side of this point is that by using a limited number of items, the possible responses are limited, leading young people to answer in a directed way. The benefit of the URICA in this area is that it uses 8 items to measure one construct, allowing for a more reliable gauge of response.

Gowers and Smyth (2004) used a 6-item questionnaire to determine the impact of a motivational assessment interview on initial response to treatment in adolescent anorexia nervosa. In this pilot study the motivational questionnaire used comprised of 6 questions covering readiness, conviction and confidence (Treasure & Schmidt, 2001) and was rated on a 4-point scale. After the interview the mean motivational score increased from 12.5-14.2 and 27 out of 42 participants demonstrated an improvement. Although as the study states there were clinically modest improvements after 6 weeks of treatment, motivation did predict weight gain. Those who were better motivated put on an average of 2 kg whereas those who were poorly motivated put on an average of 0.2 kg. Due to this study being a pilot, it is not possible at this stage to say whether these improvements would have occurred without interview, but until the authors planned randomized control trial is complete it provides some promising results. Further thoughts that stemmed from this study relate to the impact of family engagement on the young person's

motivation and outcome and may be an interesting factor to consider in the future study.

At this point, it is important to review an adolescent study that although was developed for a different client group provides some interesting results and thoughts. The purpose of Bauman et al's (2001) study was to develop and validate a multidimensional, adolescent specific instrument to measure motivation to change in substance abusing adolescents and to develop a typology of stages of motivation to change applicable to adolescents. To develop the subscales of the questionnaire they interviewed 497 adolescents (USA) over 16 programmes and categories such as, perception of life skills and desire for change were found as having potential explanatory power with regards to motivation. Although this scale was developed with a different symptomatology in mind, the concept of developing the questionnaire based on potential explanatory factors for their motivation to change is an idea that could be applied to young people with eating disorders with some useful results. From a cluster analysis of the subscales, Bauman et al found evidence of 3 groups; 1) non-users or experimental (not a category included in the transtheoretical model) and precontemplators and contemplators, which are the first two stages of Prochaska and DiClemente's (1986) model. This pattern of results may have been related to sampling issues in that none of the participants were in the action stage. It could also be hypothesised that for adolescents, a more restricted range of stages is found and that a more complete understanding of those stages would be fruitful. From this study it is also important to note the need to revisit a theory or a model when applying it to a different age group from what it was originally intended and to consider the factors that may be specifically related to that age group both in relation to their particular problem and the process of change.

Another study that is focused on adolescents but of a different presentation is that by Greenstein et al (1999). This is an important study to review here, as it is the only one that has examined the use of the URICA amongst an adolescent population. The URICA (with some amendments related to age group) was administered to 89 inpatient adolescents with emotional and behavioural difficulties.

They found that adolescent's scores were similar to those of adults (McConaughy et al, 1989) and that the internal reliability coefficient was satisfactory. A cluster analysis of the scores revealed that a 3-cluster solution best accounted for the data. These clusters were identified as 'precontemplation', 'uninvolved' and 'participation'. Similarly to Bauman's study (2001), there were few participants in the 'action' cluster, again depicting a more restricted range of stages with this particular age group. Within the study, it is noted that the URICA is not recommended as a means of assigning an individual to a stage, more that the scores are best interpreted in terms of a stage profile, yielded by a cluster analysis (Rossi et al, 1995). This point again seems to throw into question the nature of a stage theory if individuals are said to yield a 'stage cluster', indicating a range of processes occurring simultaneously. When considering the clinical application of this questionnaire, it also seems impractical to have to go through an advanced analysis of scores to obtain an individual's 'profile'.

Returning to the client group of focus, Serpell et al (2003) were also aware that children and adolescents are very under represented in the research literature and aimed to validate their questionnaire, the Pros and Cons of Anorexia Nervosa (P-CAN) in children and adolescents with Anorexia Nervosa and compare the results with those from the adult study. Although this was developed as a motivational measure rather than a measure of stage of change, it is evident that by exploring and understanding the beliefs of individuals with Anorexia Nervosa, it may be easier to better predict why so many patients find it difficult to change. Serpell et al also highlight the importance of focusing on both positive and negative aspects of the disorder as both play a large part in maintaining the disorder. 48 young people completed the 101-item P-CAN and the Eating Disorders Examination and validity appeared to be good in the younger patients. When looking at the relationship between the severity of the disorder in adolescents and the P-CAN, it was found that EDE score was related to both pros and cons but children and adolescents scored lower than adults on certain items. This particular study did not support the claim in the adult study that more severely ill patients are overall more positive (but not more negative) about their disorder. From these results it is evident that young

people conceptualise their eating disorder differently from adults making it essential to explore the subjective views of the young person before fully being able to understand how to enhance therapeutic change and motivation to change. When thinking about the application of the P-CAN in a clinical setting the questionnaire may be a bit long and it is also important to consider other outside factors that may be influencing motivation and to combine them with the views of the young person when planning treatment interventions with a view to increase the likelihood of long lasting change.

The reviewed studies create a varied picture when considering motivation to change in young people with eating disorders. There has been evidence both supporting and questioning the transtheoretical model in its entirety, with some key points relating to young people falling into a more restricted range of change processes (Bauman, 2001; Greenstein et al, 1999). Where the TTM and it's assessment tool the URICA have seemed to come under most scrutiny with regard to eating disorders, is it's inability to separate different motivations to change different behaviours within the varied symptomatology (Gusella et al, 2003). With this in mind it seems that researchers and clinicians have devised their own or similar questionnaires, aimed more specifically at the range of behaviours and cognitions within eating disorders (Geller & Drab, 1999) but there still remains a lack of research solely looking at the long term benefits of depicting and being informed by a stage of change. One tool that has been shown to predict outcome and overcomes many of the criticisms here is the Readiness and Motivation Interview (Geller, 2002), which is a clinician lead semi-structured interview that explores motivation to change separate aspects on eating disorder symptomatology. However this would need to be used more extensively before reaching a point where we could generalize from these findings.

It could be speculated that due to some of the lack of fit between theory and client group, that it makes it very difficult to proceed with researching more concrete areas such as outcomes and predictors of engagement in treatment/therapy.

6.1.5 A reconsideration of the stages of change model

Currently, and in line with the findings from Part 1 of this study, there is a small but growing body of literature that either suggests a different repertoire of stages to that suggested by Prochaska and DiClemente (Cady et al, 1996, Bauman et al, 2001) or refutes the stage model completely as it's reliability and validity is fundamentally flawed (Sutton, 2001).

Of those studies, two have been conducted with adolescents and suggest that the latter stages of action and maintenance are not endorsed within this age group, thus indicating a possible variation in individual goals and attitudes towards illness recovery, i.e. eradicating the problem behaviour may not be considered an option and other goals may be more appropriate at this developmental stage.

Adolescence is often characterised with a lack of concern for the long-term future and thus considering the negative consequences of an eating disorder in the years to come and the need to totally eradicate eating disordered behaviours may not be perceived as necessary, which in turn has an impact on the maintenance stage as this is not a stage conceptualised by some adolescents.

In light of this the aims of part two of this study are:

- To examine the attitudes towards change of young people with Anorexia Nervosa and explore the views of family and professionals about factors that might influence the young person's motivation or ability to change (recover).
- To compare the perspectives of both parent/carer and child on factors influencing the recovery process, which may inform clinical approaches in this age group.

6.2 – Methodology

6.2.1 Introduction to grounded theory methodology

Within the realm of qualitative research there are methods, which allow free exploration of a research field or question, where little or nothing has already been deduced from the data set in question. 'Grounded Theory', the method of research used in this study, is an example of such as method. The approach allows themes, patterns and potential theories to emerge from a new, relatively unexplored area in psychology, in such a way that assumptions, judgments or pre-held theories do not get in the way of understanding what is happening.

Using the principles of symbolic interactionism whereby the researcher is required to enter the worlds of those under study, interpret actions and interactions and develop a theory which incorporates concepts of 'self, language, social setting and social object' (Schwandt, 1994, p124), Glaser and Strauss set out to develop a more defined and systematic way of analysing qualitative data.

Within their first book, *The Discovery of Grounded Theory*, 1967, part of the rationale for developing this new method explained that within the existing field of sociology there was too much emphasis placed on the verification of existing theories and a resultant

"de-emphasis on the prior step of discovering what concepts and hypotheses are relevant for the area one wished to research.....in social research generating theory goes hand in hand with verifying it; but many sociologists have diverted from this truism in their zeal to test existing theories or theories that they have barely started to generate.'

(Glaser and Strauss, 1967, p1-2)

What differentiates grounded theory from much other research is that it is explicitly emergent; it does not test a hypothesis. It sets out to find what theory accounts for

the research situation as it is. In this respect it is like action research: the aim is to understand the research situation. The aim as Glaser (1992) in particular states it is to discover the theory implicit in the data.

As Rennie (1994) points out, such a human science approach is similar to the practice of Counselling Psychology in that it focuses on subjectivity and stresses the achievement of an understanding as opposed to a demonstration of truth; it stresses collaboration with participants rather than a subject-object dualism; and it emphasizes holism in contrast to fragmentation.

6.2.2 Rationale for using Grounded Theory

Qualitative research is built around the collection and analysis of people's accounts of their experiences and aims to clarify the meaning of social actions and situations. In line with this philosophy, Counselling Psychology emphasises respect for individuals as unique and separate. It stresses the subjective world and experience of the individual and the importance of the therapist working together with the client to understand their inner reality and the meanings they place upon things. As both the therapeutic process and the qualitative research process seek understanding rather than explanation, it is evident that there is a degree of fit between the two and an informed rationale for using a qualitative approach in this area.

Under this umbrella of research there are then many ways to approach the data so why Grounded Theory?

As highlighted in the literature review, there is currently limited evident literature addressing the issues specific to young people's motivation to change their eating disordered behaviour. Much of the adult literature has been adapted to suit this client group but seems to fall short of tackling the complexities of this particular age group. What is then required is a method, which doesn't presuppose categories onto the data collected but allows patterns to materialize. Grounded theory in particular, as opposed to other qualitative methods such as IPA, works towards the aim of developing new theories, which aren't adaptations of pre-existing ones or

amalgamations of several theories but are able to evolve from the experiences of those individuals in question. Patterns can be identified within reports of complex experiences (such as receiving psychiatric treatment) and new understandings can be developed.

The stance of this piece of research is largely 'constructivist' in terms of epistemology, ontology and axiology . Constructivism emphasizes an interpretive understanding of an individual's meaning in conjunction with the interpretative process itself to assess bias in the researchers approach (e.g., through processes such as note taking, self-reflection, or memoing) and advocates studying people in their natural setting to better understand their lived experiences (Charmaz, 2000).

In their earlier works on this method, Glaser and Strauss (1967) and Glaser (1978) have stressed the importance of theory generation more than theory verification. More recently, Strauss (1987) shifted toward advocating a method of internal verification of categorization, reworking the process to include a strict and complex process of systematic coding. Glaser felt that Strauss had gone on to simply describe a methodology and had moved away from grounded theory. He responded vehemently to this change in approach stating that'

Strauss's book is without conscience, bordering on immorality producing simply what qualitative researchers have been doing for sixty years or more, forced, full conceptual description.

(Glaser, 1992, p.3)

There have clearly been a number of shifts in how grounded theory is approached over the years, a discussion of which cannot be had within the limits of this study. However, the use of the grounded theory method in the present study was in keeping with Glaser and Strauss's earlier approach, as have been the majority of investigations within Counselling Psychology involving the method (Rennie, Phillips & Quartaro, 1988). The main rationale for using this particular version is that it

remains flexible and creative, allowing the emergence of theory from the data, whereas later versions have become more prescriptive, introducing a deductive element that seems to undermine the original purpose of Grounded Theory.

6.3 - Methods

6.3.1 Sample

The sample was made up of adolescents and their families presenting to clinical services for help with an eating disorder. Subjects were recruited from specialist eating disorder services.

6.3.2 Sample size

Sample size calculations are not applicable for formal qualitative research. The accepted methodology for Grounded Theory, both to ensure exhaustive findings for a data set and for demonstrating credibility of findings in a wider sense is to conduct observation and interviews until 'saturation point' is reached in the coding process. Saturation point is defined as the point in data collection/analysis when no new features related to the research question turn up in the most recently collected data. That is, the data are exhausted for that site on that question. This tends to occur after about 10 interviews.

Initially we aimed for 15 index participants with 2-3 informants for each index participant i.e. parent, sibling and individual worker. There was no control group. At time of commencing the research the current approximate numbers of patients available to be approached for recruiting were:

NHS Eating Disorders Service -	Open cases = 20
Independent Eating Disorder Inpatient Unit 1 -	Inpatients = 17
	Outpatients = 20
Independent Eating Disorder Inpatient Unit 2 -	Inpatients = 23
	Total = 80

In pure Grounded Theory, sampling is not determined at all and is directed by the data. Initially researchers are expected to start in the obvious places but may be gradually lead to interview other participants in the same or different places in order to strengthen findings. This is known as 'theoretical sampling' which is 'the

process of data collection for generating theory whereby the analyst jointly, collects, codes and analyses the data and decides what data to collect next and where to find it, in order to develop the theory as it emerges. This process of data collection is 'controlled' by the emerging theory (Glaser, 1978 p36).

As the interviews were being carried out it was evident from some of the data that was emerging, that some issues were exclusive to inpatients. At that time the sample consisted wholly of inpatients, and it was felt that data from outpatients were needed to ensure that a range of views had been collected. Data collection was extended to include this subgroup and interviews continued until saturation point was reached. This sample thus remained limited to those clinics for which approval and consent had been gained.

11 index participants were interviewed altogether until saturation was reached, 9 of which were inpatients, 2 were outpatients. All were female.

7 complete sets of interviews were recorded, 2 excluded an informant due to the index participant not consenting to have a friend/sibling take part and 2 were incomplete due to unavailability of the individual worker for the young person.

6.3.3 Inclusion and exclusion criteria

Young people aged between 12 and 16 being treated or having recently been treated for an eating disorder, including Anorexia Nervosa, and Eating Disorder not Otherwise Specified were included in the study.

Exclusion criteria included diagnosis of an eating disorder other than those stated above and if the child or parents do not have an understanding of the English language. The reason for this is for a thematic analysis of discourse from the interviews meaning may be changed through the translation process.

6.3.4 Ethical Procedure and Issues arising

The main ethical issues for this project were related to consent and confidentiality.

The main issue is that by consenting to take part in this project, the young person was consenting not only to talking about their eating problem, but also to others talking about them and their eating. Closely related is the issue of confidentiality. When the young person consents to take part they may be wary of what will be said in the individual interviews without them present but also wary of talking to the researcher about their eating disorder. By nature, young people in the grip of an eating disorder find it very difficult to talk about their illness as they may see it as a sign of weakness to acknowledge their difficulties. Also by discussing it with the researcher they may have concerns about what is done with the information and may not be truly honest for fear of saying something that may have repercussions.

To address the above issues we attempted to make the process as open as possible without the project becoming invalid. Firstly the letter and information sheets stated that the information gathered is purely for research purposes and will not affect treatment and this will be clarified in the follow up phone call. There were also clinicians on site at each treatment centre who could answer questions and aim to reassure people at this point. Secondly, if the young person consented, the initial meeting would be with their parents and the researcher, (a trained clinician) who would spend time talking to everyone and explaining the process with the aim of allaying any fears that may be present and helping them to understand why the project is being conducted in this way.

In order for the interviews to be meaningful, the interviews needed to be conducted confidentially (with the caveat that should issues indicating risk/child protection concerns arise that these will need to be disclosed). As a result, concerns may have arisen about what has been discussed. Although these concerns cannot be eradicated completely, we built into the process a feedback session at the end. The aim of this session was to feedback an overview of what was discussed and

allows those interviewed to ask each other questions and generally feedback about how they felt about the interview procedure.

The participants have also been informed that they will receive a summary of the research findings and can attend a presentation of the results of the research.

6.3.5 Procedure

Prior to participants being approached, full ethical approval was given through COREC (see Appendix 15). The research protocol had been reviewed by Professor David Skuse, Head of Brain and Behavioural Sciences Unit at the Institute of Child Health, and by Dr Andy Kuczmierczyk, Senior Lecturer and Tutor at City University, in addition to Dasha Nicholls as Principal Investigator and Carla Willig, qualitative methods advisor.

Potential participants were identified either by professionals who worked at the different treatment centres or by the participants themselves after an initial presentation of the research.

Identification of potential participants was approached in 3 stages:

- 1) Consent was gained from the institutions involved in the study. Good links were made with key members of staff to enable good communication flow throughout the completion of the study. Direct consent from the GP did not need to be sought as the participants involved were currently in treatment and their care under the responsibility of the lead clinician at their treatment centre.
- 2) Presentation of the research project at team meetings and a request for relevant professionals to think of people on their caseload who might be appropriate. Each staff member was given a copy of the research proposal (see Appendix 16) so that they were aware of the main ethos of the research and inclusion and exclusion criteria. A member of staff was identified as the main point of contact regarding the project e.g. Assistant Psychologist.

3) Once suitable participants were identified, contact was made with the main link clinician to obtain names and addresses of the relevant potential participants. At one clinic, participants volunteered themselves to take part and their details were then obtained from the staff.

Procedures differ slightly for the three sites of the study, all specialist eating disorder services for children and adolescents, due to differences in local policies regarding research recruitment and depending on whether the subjects are inpatients or outpatients.

For subjects under 16 the initial approach was to the parents. For those over 16, the initial approach was to the young person themselves. Patients and/or parents were initially written to (see Appendix 17) or approached in person by a clinician from their treatment centre telling them about the study. They were then given written information sheets (see Appendix 18) giving a detailed picture of the project and what is expected of them and inviting them to take part in the study.

At all three participating sites, the covering letter and information sheet was followed up by a telephone call within 2 days, with the aim of arranging an initial interview.

For those who agreed to take part, an initial interview was arranged at a mutually agreed time. Interviews took place either at the families home or at the treatment clinic depending on the family's preference and convenience. At the initial interview, consent was gained from parents and the young person (see Appendix 19). The young person could then nominate a sibling or friend to be the additional participant. The nominated sibling/friend then received a letter saying that 'x' has nominated you to take part in the following study' (see Appendix 20) and a copy of their consent form was enclosed.

If the participant was aged 16 or over, they had the option of the initial interview being carried out alone with consent sought to involve both parents and a friend/sibling. None of the participants' aged 16 chose this option.

6.3.6 Interviews

All interviews were carried out by the author (MJ) who is a counselling psychologist and experienced in the care of young people with eating disorders. Throughout the interviews the possibility of emotional distress was considered. The author is trained in motivational interviewing techniques, which are by nature non-confrontational and the interviewer/interviewee relationship is more like a partnership or companionship than expert/recipient roles. This style of interviewing hopefully maximized the relaxed potential of the interview. Using counselling skills such as active listening, summarising, reflecting and paraphrasing also enabled a relationship to be built and for information to be clarified helping participants to expand and fill out meanings of their experiences.

The interviewer was known to two of the participants; however the quality and quantity of the interviews did not seem to be determined by prior contact with the researcher.

Semi structured interviews were carried out to establish issues related to the young person's motivation to change their eating disorder. A minimum of four interviews per subject was conducted. Interviews were carried out separately with

- a) the young person with an eating disorder,
- b) a parent/carer,
- c) a sibling/friend and
- d) an individual worker involved in their treatment.

At the beginning of the interview the young person was asked to complete the adapted version of the University of Rhode Island Change Questionnaire (URICA) (see Appendix 21), a measure of motivation adapted to assess motivation to change eating behaviour and validated in terms of its psychometric properties.

The URICA consists of 32 items answered on a Likert scale ranging from disagree (1) to agree (5). The URICA item generation was based on behavioural criteria for the five stages of change (Precontemplation, Contemplation, Preparation, Action and Maintenance). Reliability and factor analyses generated four scales

(Precontemplation, Contemplation, Action and Maintenance) with eight separate items loading on each of the scales (McConaughy et al., 1983). (See Part 1 for full report of this) and the Eating Disorders Examination Questionnaire (EDE-Q) (see Appendix 22) (Fairburn & Beglin, 1994). The EDE-Q is a self-report version of the Eating Disorders Examination, the well-established investigator based interview (Fairburn & Cooper, 1993). It provides firstly frequency data on key behavioural features of eating disorders in terms of number of episodes of the behaviour and in some instances days on which the behaviour occurred. Secondly, it provides subscales reflecting the severity of aspects of the psychopathology of eating disorders. The subscales are Restraint, Eating Concern, Shape Concern and Weight Concern. The parent/carer and the individual worker were asked to rate the participant's illness severity using the CGAS (Child Global Assessment of Severity) (see Appendix 23) and the parents also completed a parent version of the adapted URICA (see Appendix 24) as above. BMI centiles were also measured.

All participants were asked 8 probe questions. The questions were devised to be as open as possible to allow individuals to talk freely about their experiences. The structure was flexible with room for further exploration and expansion in keeping with the evolving nature of the research process according to Grounded Theory. Biases and leading questions were also avoided as much as possible so as not to place an agenda onto the interview structure and prompts were kept to a minimum and were more related to process rather than content, such as encouraging further elaboration of the individual's responses.

The main interviews were the individual interviews, with the additional initial meeting to obtain consent and at the end when a group feedback session allowed for information to be shared about the process.

The initial questions were as follows:

1. *How did you come to be in treatment for your eating difficulties?*
2. *Probe: When was the last time you remember thinking about wanting to get better?*
 - a. *What was it that made you think about wanting things to change?*
 - b. *Did anything happen/how did it come about?*
3. *Probe: Can you tell me about a time when you have found it really difficult to think about getting better?*
 - a. *What was it that made you feel like this?*
 - b. *Did anything happen/how did it come about?*
4. *When you are at home, are there things that make it more or less likely for you to feel like getting better? [Note: Is this most likely to come about from within the individual or through interaction with others?]*

What about when you are at the hospital, are there things that make it more or less likely for you to feel like getting better?
5. *How do you feel at the moment about getting better and the changes you have made or plan to make?*
6. *When you have been doing well have you noticed things that can set you back?*
7. *Looking ahead, what are the things that might get in the way of getting better?*
8. *Who/what has helped the most since your eating difficulties began?*

The questions were adapted by replacing 'when you' with 'when 'x'' for the interviews with parents, siblings and individual workers. Such as 'who/what has helped the most since your eating difficulties began' would change to "Who/what has helped the most since Amy's (example name) eating difficulties began". Another example would be, "When you have been doing well have you noticed things that can set you back?" would change to "When Amy has been doing well have you noticed things that can set her back."

All interviews were recorded on audiotape. Separate consent for recording was obtained.

Interviews lasted between 10 –35 minutes. These times were not as long as predicted, however, when interviewing young people (some siblings were under 12 years), one cannot expect lengthy responses to questions. Interviews often also took place within a day of treatment for the individual or meetings for the parents; therefore long time slots were not an option. The interviews that were able to extend to the longer times were those carried out at the family's home. Although it appeared to be more fruitful, conducting interviews at a family's home always remained an option and in all other cases they felt it was more convenient for them to be interviewed at their relevant clinic.

In line with the grounded theory approach, there was some revision made to the questions and questions/comments added, based on the emerging data collected in previous interviews. The two main examples of this were:

- Question 1 and 5 sometimes elicited the same answer so generally question five was changed to just asking about future plans they had regarding change.
- After some discussion in the interviews it was apparent that the young people's idea of what getting better means was different to that of those around them and therefore it became important to ask what getting better meant to each individual.

Feedback sessions were held at the end of data collection for each subject, with the aim of ensuring that all parties were comfortable before leaving and whether there were any questions, particularly from the young person.

6.3.7 Data Protection

All data was recorded in anonymised form using a coding system involving initials and a number. This allowed for multiple data from the same patient to be correctly matched but not for the patient's identity to be disclosed. All data was analysed initially at GOS where it was anonymised and stored on a password-protected laptop. Dasha Nicholls and Melanie James have access to the data and Dasha Nicholls acts as custodian for the data.

6.3.8 Data Analysis

The tape-recorded interviews were transcribed verbatim. The transcripts were then reviewed for accuracy by re-listening to the interviews whilst reading the transcripts to check for anomalies. (Full transcripts have not been included in this study to protect the participant's anonymity – for all category quotes see Appendix 25.)

The first phase of the analysis was the line-by-line analysis of transcripts, also known as open coding, which allows the researcher to discover and describe the significant initial categories of the phenomenon from the participants' perspective (Charmaz, 2000; Glaser and Strauss, 1967). Each line of the interview transcripts was analyzed and initial codes were assigned to each unit of meaning. These codes are then compared within and between the transcripts in search for a shared higher order of meaning. To allow for an emergence of categories, words or sentences were spread out over a large surface and groupings were formed using both the interview data and the memos. This eventually results in the construction

of a hierarchy of categories, with the higher order or 'core category' at the top. The core category represents the overarching theme of the data and is grounded in the categories from which it was built and those beneath are grounded in the ones below and so on to the codes that are grounded in the data.

Throughout the cyclical data collection and analysis process, notes or 'memos' were written as themes emerged or initial interpretations were made. As further interviews were carried out, more categories emerged and others were expanded or changed as the process unfurled. The gathering, checking and sorting of data continued until 'saturation point' was reached whereby no new categories were arising from the interviews.

Having explored the differences between the original method of grounded theory and Strauss & Corbin's (1990) later, more prescriptive form of analysis, I had decided to adhere to Glaser's approach as it seemed to allow more freedom within the analysis of the data.

6.3.9 Evaluation of the quality of the research findings

Without the concrete tools that quantitative research relies on to measure quality, Henwood and Pidgeon (1992) have devised a number of factors of which the quality of qualitative research can be assessed and are concerned with ensuring accuracy whilst acknowledging creativity and the unconventional in the research process. They describe a variety of good practices that I have attempted to follow in the present study. The subsequent sections describe how these have been applied.

The importance of fit

Henwood and Pidgeon (1992, p105) state that 'a basic requirement of good qualitative research is that the categories constituting the building blocks of emergent theory should fit the data well'. To translate the initial conceptual classifications of the phenomena into a visual process to the public or the reader, detailed definitions should be made available; alongside a clear rationale for the

labels categories are given. This allows the researcher and others to evaluate the fit and in the present study, definitions are summarised in the results chapter and illustrated directly with excerpts from the interviews.

Integration of theory

Henwood and Pidgeon (1992, p105) state that 'good theory should be rich, complex, and dense and integrated at diverse levels of generality'. In the present study the memoing process contributed to the development of theory and illustrates part of the complexity of the process with links being made to developmental, change and systemic theory. The relationships between the categories and their connections within general theory will be explored further in the discussion.

Reflexivity

In line with the constructivist approach, the researcher should acknowledge their part in the process of research and the impact they have on the data. Within the current study, the documentation of the reflexive process has been attempted throughout.

Documentation

To ensure again that both the researchers internal and external processes throughout the study are made public, it is necessary to demonstrate an inclusive and comprehensive record of what was done and why. This has been attempted in the present research by remaining transparent throughout the research, for example: by highlighting the rationale for changes made and using the data to clearly illustrate the emergent theory.

Theoretical sampling and negative case analysis

As stated earlier sampling is led by the data and should reflect an exploration of cases that expand or elaborate or disconfirm the emerging theory. Within this particular sample as a bias related to inpatient treatment emerged, attempts were made to broaden the sample to expand and enrich the emergent process.

Sensitivity to negotiated realities and respondent validation

Although there are often limits to the usefulness of participant validation due to the personal nature of the experiences given, attempts should be made to understand the differences that may exist between the researchers' and participants' interpretation of the data. This has been illustrated through the detailed and transparent documentation process, as described above.

Transferability

In the place of 'generalisability' within quantitative research, the extent to which findings from a qualitative study are said to have more general significance beyond the research context has been termed 'transferability'. The contribution that the present study makes to the general fields of developmental psychology, Counselling Psychology and behaviour change theories is explored in the discussion.

6.4 - RESULTS

6.4.1 Introduction

Results are presented primarily as the young person's response, followed by the responses of family and professionals, with the data labelled to indicate the origin of the comment i.e. YP, young person, P parent, S sibling, F friend and IW individual worker. Prior to collecting the data, it had been hypothesised that there would be systematic differences between the responses. However these were not significant overall and there were fairly united views in terms of what influenced the young person's motivation to 'get better'. What separated the young people from their families the most was the illness itself and their attachment to it.

Of the 20 individuals approached, 11 agreed to take part. Out of the 9 who refused to take part 8 of these were due to the young person not wishing to talk about their eating disorder any more than necessary, some feeling that they wanted to move on. The parents of those who refused were very willing to contribute to the research; however this was not possible due to the consent of the young person being needed for the interviews to be carried out.

There were a number of reasons for there only being a small number of potential participants approached from the outset. Firstly due to many not falling within the inclusion criteria due to age or diagnosis, secondly due to severity of illness at the time of the research and their ability to take part in interviews and thirdly due to already taking part in other research projects whether currently or recently and not wanting individuals to feel 'over researched'.

Ten sets of interviews took place at the treatment clinic, with one set being conducted at the family's home. After half of the interviews, families felt that they did not require a feedback session. No one expressed any need to debrief about issues that were raised throughout the interviews.

In addition to the interviews, participants and their parents completed questionnaires to measure illness severity and motivation to change allowing for

associations to be made between the results of these measures and the interview data (see Table 12).

Within a clinical setting, motivation to change can be viewed slightly differently depending on illness presentation. Within the addictions field, motivation to change is seen as a motivation to 'give up' something. When focusing on eating disorders, it could also be viewed that the goal is to give up anorexia, however it is generally linked to 'recovery' and how motivated the individual is to recover from their illness. As recovery as a term did not seem age appropriate for this sample, 'getting better' was used in it's place.

Age	Status	BMI z score ¹	% BMI ²	URICA(participant)/stage mean score ³				URICA (parent) stage mean score ⁴				CGAS parent score ⁵	EDE-Q global score ⁶				
				PC	C	A	M	PC	C	A	M						
1.	16	Inpatient	-0.812					3	1.75	1.75	2.625	2.375	3.5	4	3.625	68	4.04
2.	16	Inpatient	refused					2.875	2.25	2.25	2.375	2.625	3.875	3.625	3.625	52	4.04
3.	15	Inpatient	0.263					2.125	3.5	4.5	4.75	3	2.875	4	2.75	45	3.94
4.	13	Inpatient	0.180					1.875	4.5	4.25	4.25	1.875	4.5	4.75	3.5	85	0.3
5.	13	Inpatient	-3.56					3.75	2.125	3.25	2	4.75	2.875	3.25	1.5	42	0.85
6.	16	Inpatient	-4.21					3.125	2.375	2.125	2	3.5	1.75	1.875	2.625	40	4.61
7.	15	Inpatient	0.096					4.5	2.25	1.75	2.25	4.625	1.625	1.375	2.875	81	3.93
8.	13	Inpatient	-1.494					1.875	3.5	3.75	3	2.75	3.125	3	2.875	55	3.93
9.	13	Inpatient	-0.027					1.25	4.875	4.875	4.5	2	4.25	4.125	3.875	41	1.61
10.	12	Outpatient	refused					2.625	2.75	3.75	2.25	3.75	3	3.125	3.575	62	4.2
11.	13	Outpatient	refused					-	-	-	-	-	-	-	-	-	-

Table 12. Scores table to indicate stage of change and illness severity

¹ BMI z score (0 = median for age and gender, -1 = 1 SD below the median, -2 = 2 SD below the median etc)

² % BMI (100 = 0 SDS or 50th centile). 2nd centile is approximately equivalent to 80% BMI or -2 SDS

³ URICA scores (1-5) reflect a mean of the raw scores where 1 = low identification with the stage and 5 = high identification with the stage.

⁴ Parents URICA scores apply to their perception of their child's motivation and are scored the same way as the young peoples'.

⁵ CGAS scores (1-100) where 100 is the highest level of functioning.

⁶ EDE-Q global score represents sum of four subscales divided by four. The community norm for a global score is 0.932 (Fairburn & Beglin, 1994).

6.4.2 What does getting better mean?

The experience of being an inpatient and the impact that this has on the individual's reports of their motivation to change their eating disorder is important in terms of what it means to 'get better'. After the first few interviews had been conducted, from examining both the transcripts and reflections in the memos, differences in terms of definitions seemed to be arising between the young people and also between the young people and those around them i.e. their parent, sibling, friend or individual worker. It became apparent that it was necessary to ask what meaning individuals placed on getting better and what it involved for them before exploring what influences their motivation to get better. The particular comments that lead to this change was from a parent talking about their daughter:

"It depends what you mean by wanting to get better, I think getting better for her is getting to a point where people don't consider her eating disorder to be a serious risk. She can only consider herself better when she can accept the way she looks and without eating what everybody wants her to eat. So her idea of getting better is not the same as everybody else's."(P.6)

To highlight the differences between individuals' construction of what it means to get better, the following are excerpts from the young peoples' responses:

"Well, I'm trying and I don't really think of it as getting better I think of it as trying to get better and I don't really know if I can sometimes as it's not really working. Getting better means not worrying about what I'm eating and eat normally, like I haven't eaten sweets or chocolate or chips or anything like that for three years. So eating normally, maybe having a MacDonald's or something once or twice a week and not worrying how much I've got like one day I might have a big lunch and then the next day I'll have a small

lunch so that would be better. Not look at myself in the mirror and see a fat person.”(YP.10)

“To me it means going back to what I was before and I don’t want to be like that”(YP.7)

“I don’t really know what getting better involves so I don’t really know what I might have to give up or do. Because of that it makes it difficult to know whether I want it or not. Can’t really prepare myself because I don’t really know.”(YP.9)

These three very different responses highlight the range of meaning that can apply to the term ‘getting better’ and also highlight different pieces of clinical work, which may need to be carried out with each young person. It also begins to show the emerging importance of looking at *what* influences an individual’s motivation as well as *how* motivated they are.

Some of the responses gained from the group of participants around the young person also showed slightly different perspectives, some recognising the difference in opinions:

“...so if she could be at home, in school, without having to eat and without having to have these horrible feelings then that would be okay and that’s where we differ I suppose.”(IW.6)

“I think it means being able to come home, being able to go back to school and being able to mix with her friends again but still being able to be slim, that’s how she would see it, still have some control over her eating so that she doesn’t get, I wouldn’t say fat but she doesn’t want to be average, she always wants to be slim...for S it’s I get to this weight and then I’m better rather than the weight is really irrelevant it’s how she’s thinking and being able to cope with her life.”(P.8)

"Getting better for H is – if someone says to her oh you're looking better she sees that as oh you're looking fatter but whereas I would think that was good. So that's where I think she still wants the illness and doesn't want to look better and doesn't like people telling her that she looks better."(S.1)

From these comments, the complexities involved in a young person wanting to 'get better' and the different types of motivating factors that are influential in the process begin to become evident. There appears to be an internal conflict for the young people in terms of wanting to get back to a 'normal life' but wanting to do this whilst remaining very thin, thus not disrupting both of their goals. This can then lead to external conflicts with others (particularly professionals and parents) with regards to what is possible when considering their low weight.

Once the meaning of 'getting better' had been established and after categorising the themes that emerged from the data and the memos from the process, it was evident that the categories were, although distinct, very much linked to each other.

As analysis of the results was being carried out and further data was collected it was becoming apparent that a theme of 'getting back to normal life' was emerging as a positive influence on the individual's motivation to get better. It seemed that individuals and their families were keen to resume normal activities such as going back to school, seeing friends and playing sport, with efforts from everyone being made to create a supportive and structured environment to enable the young person to move on.

Getting home, being normal and all that entails was very much the end goal and seen as an overall motivation in terms of adhering to the treatment plan to reach the goal. With the overarching goal being going home and getting back to normal life, within this were sub categories such as, friends, activities and school. If this can be seen as a long-term goal, where the overlap occurs is that when an inpatient, aspects of normal life can also be experienced as a motivation to get

better or an incentive to adhere to treatment plans in the short term. For example, an activity such as playing the drums in the evening can be used as an incentive if treatment goals are being reached. To illustrate further, it may be useful to see the inpatient unit as a safe and contained place to initially begin to practice aspects of normal life that have become unmanageable for the individual/family due to the impact of anorexia.

Although linked to 'normal life' and forming very much a part of it, there were also a group of categories that if you visualise a tug of war between normal life and anorexia, they would form the rope in the middle and depending on how they were managed or how strong the young person felt, either side could win. These factors were more 'process' categories; the elements, which support the process of change and that if not managed effectively, can, make change more difficult. They include, emotions/feelings, change, choice/control, support and understanding and being an inpatient.

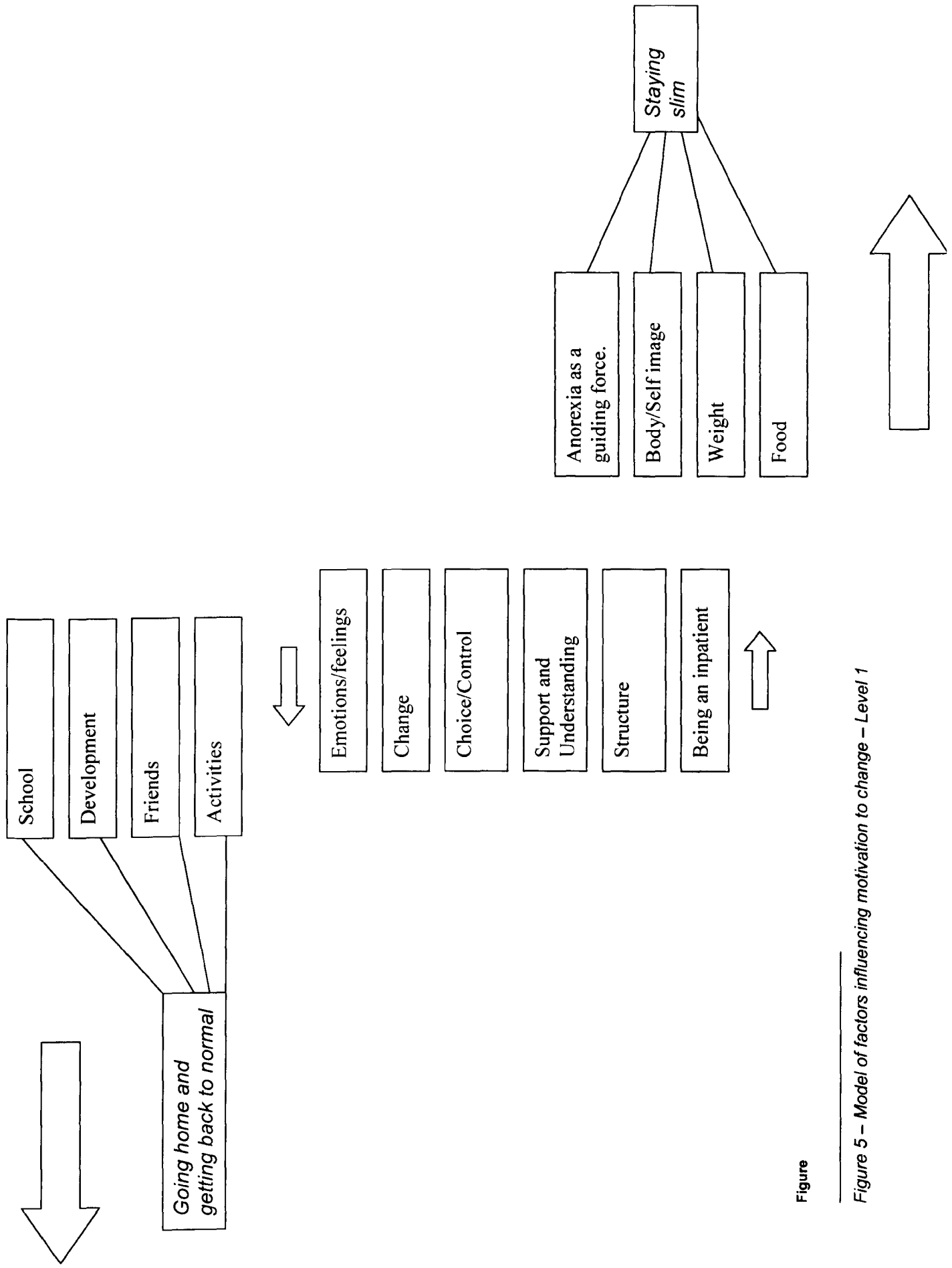
With this clear running theme emerging, the distinct part of the data that did not fit under the category of 'normal life' and in fact seemed to operate against it were largely core elements of Anorexia, namely staying slim. It remained important to the individual and acted as a negative influence on their motivation to 'get better' thus creating ambivalence, a central tenet of the disorder.

Despite having a negative influence on motivation, the young people identified factors of Anorexia as positive and even a guiding force in their life particularly when they are stressed or under pressure emotionally or practically. The perceptions of these influential factors separated the young person from their family and individual worker, where for the majority of other factors they had been joined in their views.

Although initially I tried to use Glaser and Strauss's method of determining a core category that encompassed all categories that emerged, it became apparent that this organising principle did not lend itself to the data I had collected and a different

approach was needed. It helped at this point to use imagery to free my thinking and develop a different way of organising my data. What materialised was an image of the young person walking towards a normal life with all the necessary elements of support and structure to guide them but being held back by something that they felt was comforting to them and gave them a purpose and protected them from the future and the challenges it held. The strength of this opposing force was impacted on by emotions such as anger and worry, which when experienced, would lead the young person to hold on to the object with a firmer grip, particularly if the emotions felt unmanageable.

Seeing this image, which will be further explored in the discussion, led to the following representation of the data (Figure 5).



Figure

Figure 5 – Model of factors influencing motivation to change – Level 1

6.4.3 The concrete goals

6.4.3i GOING HOME

In the data collected for this study one of the themes that seemed to run throughout, was the young persons desire to go home, which was something that all parties interviewed were aware of; the desire to go home seemed to become the overriding force.

The difficulty of being away from home and the desire to return this creates as a result often becomes the motivating factor for beginning to get better. Within a positive framework, the distance and space that the inpatient experience gives the individual from 'normal life' can allow them to begin to crave what they have been missing and move away from being firmly allied with the anorexia. This in a sense is beneficial to the individual but can create problems in terms of a 'full recovery' (if this is seen as possible) as getting better can be seen by the young person as synonymous with going home rather than recovering from the anorexia:

"That's why all her motivations are wrong wanting to come back here, it's not about wanting to get better. But I do think she does want to get better, something's changed within her, in that life outside is more tempting than staying in because it wasn't tempting for a long time." (P.1)

"I don't think she's ever expressed a wish to get better except to get out of here."(P.3)

"I think although here I still don't want to change my eating patterns at all, I do want to go home so in that sense I do want to get better"(YP.6)

"If I have been doing well it's only because of the motivation to go home." (YP.6)

Being within the restrictive inpatient environment can create frustrations within the young person and their families, which then lead to an increased desire to be discharged and return home. In terms of motivational theory, being an inpatient seems to create ambivalence towards the illness, generally tipping the scales from it being seen as having benefits to impeding their overall life and goals. Missing out on activities, being with friends and generally being at home, become motivating factors and can be used in terms of goals for the individual.

".. thoughts of wanting to get home and contact from friends at home, time on the internet and drums, things like that motivate her really well."(P.5)

"I've missed out on so much, I've missed out on two holidays, I was meant to be in two shows at one of my theatres and I was devastated. I couldn't sing because there's nowhere to sing in here. I couldn't act, I couldn't do any of the things I love doing. Whereas if I'm out I can still be doing them and just coping with it (the anorexia) being there."(YP.1)

"I think she is motivated by being sick of being in an inpatient setting and not being able to see her friends. She's very sociable and has very good social skills, so not wanting to be here."(IW.8)

These comments link back to thinking about the individual's construction of what it means to get better. For example, if getting better means being able to sing and act then these activities can form the goals of a treatment programme that is meaningful to the Individual and can help illustrate the impeding nature of the illness. Although overall, going home is a positive driving force, it is important to remember that for some individuals at a different point in their illness, going home can mean leaving the security of the inpatient setting and facing responsibilities and stresses that they have been able to avoid since being admitted. This is illustrated by two inpatients' comments:

"I'm scared of getting better although I've accepted that that's what needs to happen. And going home is also quite scary because I've been used to being in hospital." (YP.6)

"Well sometimes I think it would be better if I could just stay ill because it's safer here but then out of here seems a bit safer sometimes." (YP.9)

6.4.3ii 'NORMAL LIFE'

Within this sample and possibly for many individuals with eating disorders, the level of restriction that having an eating disorder can place on living a 'normal life' is quite high, and is heightened when the individual is admitted to inpatient care. Throughout the interviews conducted, going home and living a normal life emerged as the core categories and overarching themes with many related and interesting sub-categories. The term being 'normal' has been chosen to illustrate what arose from the data and was taken from the transcripts themselves as it was described in different interviews:

"The fact that we're surrounded by each other all the time, it's like calorie, calorie, food, exercise, just all about food, food, food. That's not normal and I don't think anyone can start to recover from it until they're out of here and start living a normal life.....until you get out into the real world and experience real world experiences, you're not going to get better." (YP.1)

"I really want to get better and be normal, no plans, in a way I'm hoping other people will help, I try to get better myself but nobody's really helped that much either." (YP.2)

"She is genuinely trying at the moment and just wants to be a normal teenage girl, buy teenage clothes and shoes." (P.4)

*“Well hopefully it’s starting some **normal activities**, getting back to school, she’s not going back to her old school, she’s going to a new school and starting a work placement in a nursery organised by the school.”(P.2)*

These examples are illustrations of what ‘normal life’ or being ‘normal’ can mean and how it can influence someone’s motivation to get better. As is evident in the excerpts above there are many components, which make up normal life as depicted in the diagram of the categories (see Figure 6).

6.4.4 Factors that make up ‘normal life’

As the term normal life began to unfold, different categories were emerging but most were common across each set of participants, i.e. parents and young people. The categories are stated in order of how highly they were endorsed, i.e. those reported by a number of participants first and those reported by the least participants last.

6.4.4iv FRIENDS

An influence, which carried significant meaning across all the interviews, carried out, was that of **friends**. Friends seemed to perform many positive functions for the young people including providing loyal support, motivating them to progress, and encouraging more healthy behaviours. Friends seemed to act as positive role models, demonstrate appropriate social behaviours and listen to, accept, and understand the frustrations, challenges, and concerns associated with being an adolescent.

The young people’s comments are grouped together here as they describe the impact of their friends differently. They talk about just wanting to be with and talk

to their friends as if the most important thing is just to be back within the friendship group again.

"I want to get better but I don't want it to take a long time because I want to see my friends."(YP.5)

"..it's really disappointing and it would be nice to be with your friends and not worry about eating stuff..."(YP.4)

"..so I've got a rabbit now and sometimes I talk to my friends on the phone and we arrange days we can meet. I didn't usually see my friends a lot, only in school but now I go round theirs or they come round mine."(YP.10)

"When I'm here, talking to my friends makes me want to get better.." (YP.5)

"I think seeing people back in Leicester did help, not that I was able to make improvements but I was more able to think about things."(YP.6)

A friend also echoes this:

"Friends that she's met, that has helped her along."(F.2)

"...the fact that she's doing something now and she's made friends, good friends, is pushing her along."(F.2)

The comments from the individual workers and parents spoke about friends more in relation to the anorexia, recognising the supportive aspect of the friendships and the impact that contact with friends has on the young person's behaviour:

"....she's got one very good friend who's been very loyal to her and sees her nearly every weekend she comes home and I think that's helped her a lot.

Having that friendship, a lot of children with anorexia, their friends just disappear after a while but this particular friend has been unbelievable for a 12/13 year old girl to be as amazingly supportive to S, so I think that's helped a lot.”(P.8)

“But I just think it's healthier now because she will come and say can I go round and see one of her friends, I'll be back by a certain time. A lot of them are the old friends and where they couldn't deal with the situation when it all first happened they sort of lost contact with her and they're now slowly coming back again.”(P.10)

“I'd say her friends are just as important to her and seeing other young people do and can make changes..”(IW.6)

“..she has 2 girlfriends that have been writing to her and she's been writing back a lot and I know she's been putting in her letters the same sort of things she's been talking to us about and neither of them have judged her.”(P.1)

“Her friends have been motivating for her in some ways, supporting her”(P.9)

“Friends has come up recently, we're doing a trip on Sunday to the cinema for the first time in ages and that's reminding her of times she's been to the cinema with her being able to do that and she's thinking about that but wanting to do it without going home I think but it's early stages.”(IW.6)

As with most friendships there are also elements that can cause distress or there are times when friends can have a negative influence on the young person thus affecting their emotional ability to move forward.

"I don't think her friends help her that much, she's got a few friends who are ok but some of her friends say things to her like oh you look fine, you look fine at the weight you are, which is really the worst thing she could hear."(S.8)

"A lot of it revolves around friendship patterns and the inability to cope with all the dynamics of what was going on."(P.5)

"I think it's going to be really hard, going to make new friends who don't know about it because I'd have to tell them."(YP.7)

"Friends and being around people, I know the minute she feels a bit lonely or is hurt by a friend or gets into the wrong crowd, that will knock her back again."(F.2)

Although describing friends and friendships in a different manner, it is clear that all groups hold the same views in terms of the importance of friends in the young person's life, highlighting the needs of this particular age group to be within a peer group.

6.4.4ii ACTIVITIES

Although school, seemed to provide a much needed distraction and focus for the young people interviewed, when talking about particular interests that they had, an emerging sense of passion arose from the data. Having a love for something or enjoying something and having fun seemed to have a significant impact on the young person's motivation to get better and returning to interests and hobbies that have been on hold or restricted whilst they have been an inpatient seemed to increase their drive.

General hobbies/interests

When talking to two young people and their families, a particular love and talent for music shone through in their interviews and played a vital role in keeping the young person interested in life outside of having anorexia and became a individual goal for them to work towards.

"When I go home for the weekends I do a lot of singing and acting, that's my passion, I just love it. I did some singing for three and a half hours with a guy that I perform with but I hadn't done for about 5 months and it felt so good. I loved it and I really wanted to do that so I guess that's in the right direction for wanting to do other things because before when I was really underweight I didn't want to."(YP.1)

"Music has helped her, M, H and M love music, dissect it and each week she has another CD she gets into heavily and that's helped her with her work and music has been a big part of her recovery."(P.1)

"...she loves playing the drums, she's good at that and she's very good if you give her goals to reach, she's good at motivating herself to reach them.."(IW.5)

Keeping active and taking part in family activities was also important both in terms of distraction and having fun.

"I think the things that help are, I don't know, just doing something really, something like watching a DVD or TV or something like that."(S.11)

"I thought of stuff that I wanted to do and I knew that I couldn't do it if I've got anorexia. Like hobbies and things when I'm older and stuff like that."(YP.11)

(What helps?) "Going places, having fun."(YP.11)

"Go walking or play badminton as a family, she has fun despite herself, she has fun. She is laughing now and it's a long time since we've seen her laugh."(P.2)

Having a pet

For me, one of the most interesting activities and one that seemed to have a profound effect on the individual's motivation and progress was keeping a pet. The responsibility that came with having to care for an animal seemed to provide a reason to take part in life in a different way, as if giving the young person something to become more active for. For this individual it was what enabled them to change from spending hours sitting behind their bedroom door to spending time in the garden, feeding, cleaning and playing with the rabbit.

"The thing that's made a huge difference is getting her a rabbit, now that might sound silly but once we got the rabbit she totally started to change and so she had something to care for, something to live for, responsibility.....But once we got the rabbit she was out in the garden, she involved us with the rabbit and things moved on from there."(P.10)

In terms of having this responsibility and the effect it has, these feelings were echoed by another young person who was given a puppy shortly before she was discharged and it became an important part of her recovery.

"We bought a dog now, we bought a puppy because we always agreed

that when she was 16 she could get a dog and it coincided with her discharge so we've got a puppy at home and that belongs to S, so that has given her some motivation to come home because up to a few weeks ago she didn't even want to come home."(P.2)

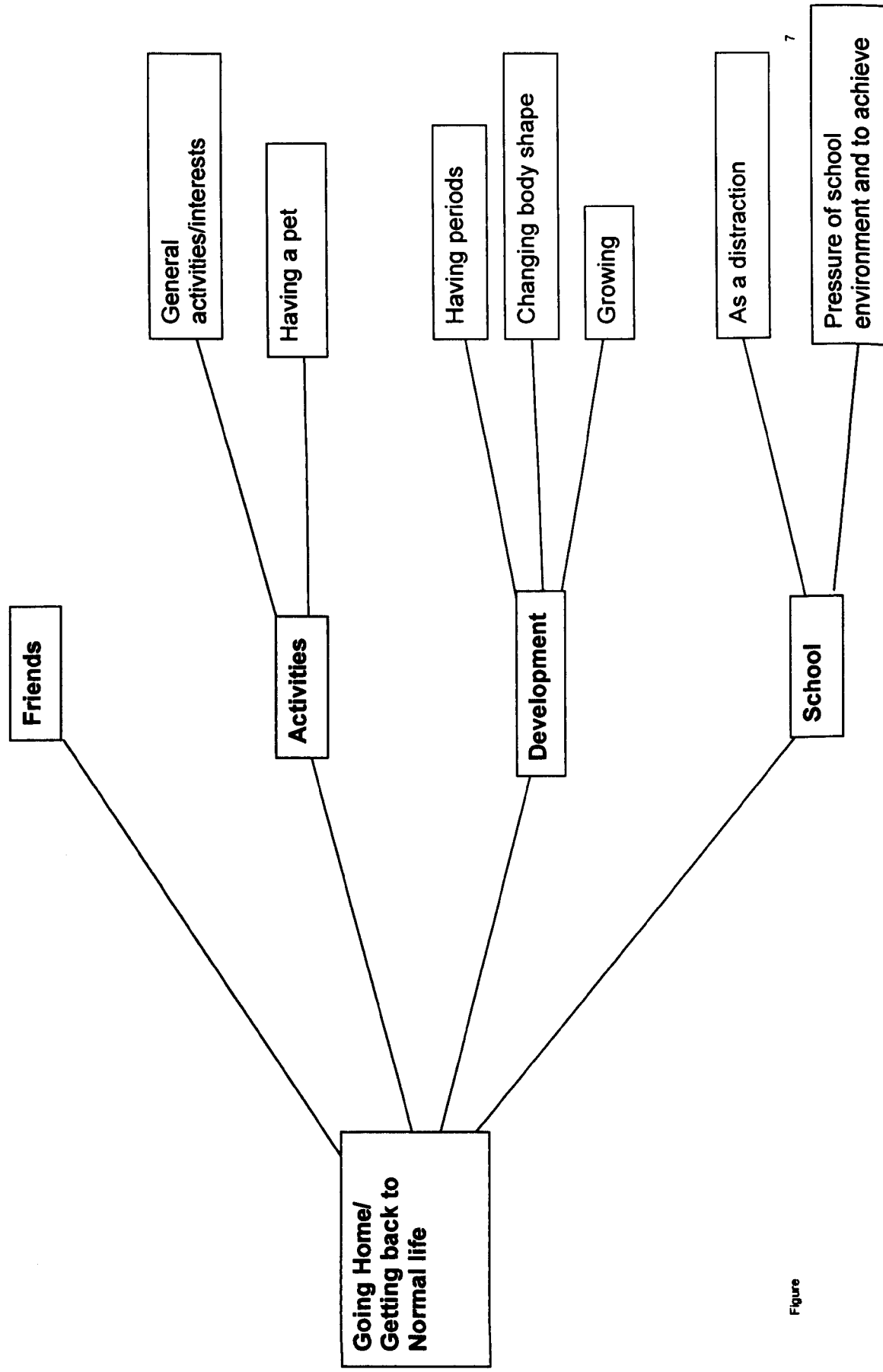
"All the time, there are flashes now when she can think about taking the puppy to obedience classes which is something she can look forward to which is a new thing."(P.2)

6.4.4iii DEVELOPMENT

Getting back to normal life not only included the external changes and activities but also resuming a normal physical functioning and state of development. Having anorexia destabilises and often halts physical development, which although can be desired in terms of an unconscious process of not wanting to become an adult, it also can be an unwanted effect of having anorexia. As a result, having your body return to a normal state of growth and development can be a motivation to get better.

Having periods/children

This included for many of the young people, getting their periods back, which seemed to be a definite sign that they had reached a healthy weight and which subsequently meant for some, an imminent discharge.



Figure

Figure 6. Model of factors influencing motivation to change – Level 2 - 'Going home'

"Umm, I don't know. It could have been possibly when she started her period again which was a few weeks back now, because she so badly wanted her periods back and that was a sort of a target for her to get to that point. Then she knew and we knew that she was getting better and almost the right weight and I think she might have possibly thought that she wanted to get better."(S.1)

"I know when she had her first weekend that really helped. When she got her target lowered because she got her periods that influenced her and it didn't seem too bad."(F.2)

Not only in terms of current development but also with regards to future goals, having periods was important to some individuals' as it is necessary to achieve a long-term goal of having children. Such future goals provide an important source of motivation.

"And I do want to have children and I'd have to sort it out then because I wouldn't want my child or whatever to get it and they say you're much more likely to get it if you're parent had it or whatever so I wouldn't want them to get it."(YP.7)

"She says little things like her periods have come back, I'm pleased that my periods have come back, well why, well it means I can have children if I want to. Well it's also to do with them lowering her target weight, the majority being about the target weight. But for me that's encouraging because the tiny bit can become better."(P.1)

"She wants to have children so she wants that part to get back to normal."(S.7)

Changing body shape

With many of the different influential factors of motivation, there are positive aspects that are experienced but also perceived negative aspects and in this case there was a clear fear of development evident. Although not verbalised by the young people themselves, parents identified that there was a definite fear of what going through puberty brings, particularly with regards to the resulting changes in body shape and how this is perceived.

"Fear of change, I really think it boils down to fear of change, fear of developing umm not so much fear of independence but fear of maturation so changing body and weight."(IW.5)

"Another thing I think is de-motivating for her is seeing her friends and thinking they've got fat. Obviously they've gone through puberty and are just normally developed but she is scared that if she goes through puberty she'll end up fat like them."(P.9)

"We say to her that as you get older your body will change and she can't seem to understand or can't see or doesn't want to see that difference."(P.10)

Growing

For two of the younger participants, growing to be taller seemed to be highlighted as a meaningful goal and a known result of their efforts to adhere to their meal plan and other treatment plans.

"Growing is what I'm looking forward to most."(YP.4)

"She was quite squeamish about any kind of physical development. When we talked to her about the effects of her being underweight for a long time, her main preoccupation was that she wanted to be taller; she certainly didn't want to be anymore physically developed as a young women."(IW.9)

6.4.4i SCHOOL

As a distraction

What seemed to be emerging in terms of what motivated the individuals to get better were things that kept them busy occupied their time and distracted them from thoughts about food, weight or shape. It seemed unbearable for certain individuals to have hours of spare time such as school holidays, particularly when being an inpatient, as one sibling illustrated:

"Things that distract her like school work, when she's doing things and when we had half term I'm really pleased I get a week off but for her she's here and they didn't get a week off and she was really happy about that because she gets bored.'(S.1)

School seemed to act as a key element that fulfilled this need for distraction both for those as inpatients and outpatients. It seemed to provide a very concrete and positive focal point in which individuals can direct their energies and consequently begin to think about moving forward.

"We're getting towards exam time and she wants to be back at school, back with friends so that's going to be a motivation..."(IW.6)

With regard to the anorexia, school also provided a reliable distraction from anorectic thoughts such as being fat with individuals expressing some relief in being focused rather than letting their thoughts take over.

"When I'm at school and I'm talking to people, it's like if there's 12345 things in my head say, it's like the second thing instead of the first, it's usually the first but not always and I'll still like even when sometimes I'm very withdrawn when I'm talking to people but probably when I'm talking to people or when there's a lesson or something but I'm getting quite withdrawn in class at the moment but it's probably better when there's something to do."(YP.10)

Pressure of school environment and to achieve

Within the 'school' sub category however, not all perceived school as wholly positive. The stress that school life can engender seemed to keep some individuals held back in terms of their progress due to the pressure to achieve and the lack of understanding that can add to the pressure.

"School and the pressure she goes to quite a high performing school and she feels that's too much, that might not help because the school don't seem to have a very good understanding of eating disorders at the moment so the teachers have got quite a lot of work to do there to take the pressure off a bit."(IW.6)

"The worry of anticipating going back to school, she would say I'll eat tomorrow or I'll eat when I go back."(P.5)

Although looking forward to going back to school, the expectations that are held by individuals are not always met and it seems to be unexpected difficulties that can affect motivation to change.

"Well she's starting a different school in September so that could be difficult because she's up to community college. She's looking forward to it but you just don't know until she gets there, because she looks forward to things and then they come and they're not as she wishes they would be."(P.11)

"I can imagine that if she doesn't settle at school or has problems at school or problems with friends might make her lose her footing again." (F.2)

With the independence that the school environment brings, difficulties in terms of managing on your own also seemed to be experienced, particularly in relation to food.

"I think my concern is when she's back at school, at the moment she's motivated and trying but that won't last and we'll revert to well she's not having lunch."(P.5)

6.4.5 - The Process

Within the categories that affect motivation are the process elements of change and how these can have both a positive and negative effect on the individual's path to recovery. As the young people are working towards getting back to a normal life and striving to get back to activities such as singing and walking the dog, there are certain factors that they aid or impede their progress.

The next six categories (see Figure 3) represent the factors that affect the day-to-day stability of the young person and if they are managed effectively, progress should be achieved and are depicted as the central force in the overall representation of the data (see Figure 1). However, many of the categories and sub-categories can change as a part of everyday life, yet it seems that the management of this is the critical component.

In relation to anorexia, the management of emotions and change for the young person can be particularly difficult, especially negative emotions and change that induces stress or fear. The effects of this on the individual are highlighted in the age group, as adolescence is notoriously a difficult time of change.

The factors that are linked to these are support/understanding, structure, control/choice and assist the young person and their families in managing the difficulties.

Being an inpatient can become part of this process and has been for all of the participants at some point. Some of the issues change when the young person becomes a part of the inpatient community however many of the themes and processes are also common to home life.

Again the categories will be placed in order of how many participants raised it as an issue with the most highly endorsed first.

6.4.5iv SUPPORT/UNDERSTANDING

Consistent support and feeling understood is essential in terms of recovery from an eating disorder and in terms of motivation to change the eating disorder, the support and understanding is not always about 'getting better' but should reflect the position of the young person at that time.

"Her individual therapist, she felt her and her family really understood her and I think he played a major part in her recovery. And that she was being held in mind by people, certainly for her esteem." (IW.9)

"Certainly, (therapist) when he came to visit S in hospital and actually understood her thought pattern and made a connection." (P.9)

A significant prelude to this category is to consider, not only as the sub headings state, support from or understanding from a certain person or people but also who is receiving or valuing the support. What emerged from the data was that although most of the young people were inpatients, support from individual workers and the staff team in general, was only mentioned by one young person. A question that can then be raised is whom is inpatient treatment supporting? As can be seen from the first four separate comments in the following section, there is an awareness within the families of the fact that the young people do not perceive inpatient units as helpful, yet they themselves are clear that they do help, as this parent states:

"The hospital definitely, when she was in hospital it was good how, we were informed how things were so we could act the same way so we weren't going in different directions and things because that was so important because she'd play anybody off."(P.11)

From individual therapist/nurse and staff

***"From my point of you I think the staff here have worked wonders because she's no longer harming herself, she's no longer talking about suicide and killing herself, all the stuff she was talking about before she came here. So from my point of view just being here has transformed things enormously but I don't think she sees that and she will probably say nothing has helped."**(P.5)*

***"She would actually say that no-one helped her get better, only herself and being on (inpatient unit) didn't make any difference but it did, but she won't admit to that. Just by getting us to eat together, we couldn't even sit at the table together at one point and on (inpatient unit) we were able to do that."**(P.10)*

***"(Inpatient unit) did help her get back up but she wouldn't see it as help."**(S.7)*

***"She says that clinics don't help but obviously they have helped a lot."**(S.8)*

***"I think her individual work helped as well and you know the way she copes, she's been taught how to cope."**(P.11)*

***"She's found the individual therapist very helpful, she's found that very motivating. She also had a course of CBT to help her with some of her rituals and she found that very helpful but that's finished now,"**(P.9)*

"..her key nurse and the school has really helped, the teachers here have helped her to believe in herself and helped her to cut off from her illness

which has been very successful. I think it's so terribly important and by believing in her it's given her a sense of self-confidence."(P.8)

"While she was in Leicester she had therapy with a psychiatric nurse looking at the thought processes that go along with anorexia and she found those quite helpful and while she's been here a similar support worker has helped her and has used the support well to talk over her problems."(P.6)

"Probably her therapist here and her therapist at home, both of whom are quite motherly people and I do think that gives her a lot without feeling judged and she's starting to do this work as there's something she's never told anybody before and that does seem to be working and she seems more confident in herself and more able to be herself."(IW.6)

The discrepancy between who perceives treatment to be helpful is illustrated well by one young person who acknowledges that professionals have helped but only when she decided she wanted the help.

"I think that some people's approaches have helped but I had to kind of decide for myself that I wanted the help and to use it because otherwise what everyone else does doesn't really make much of a difference."(YP.9)

From parents/family

"My parents probably because they haven't given up, they kind of, they do accept me for who I am and feel uncomfortable saying you look better but people here have told them to say that, tell the truth and I respect that. They do try really hard and will do anything and they kind of like have been through a bit of a rough year and are still ok about it. So my parents probably."(YP.2)

"(Who/what helped?) My family"(YP.11)

"She has become very close to my husband which is lovely for me to see and he does seem to be able to say the right things, He has been an absolute rock for her."(P.1)

"I think Mum and Dad, they've been amazing because however hard it's been they've taken so much from her, they've taken so much grief and I think it's helped her to realise how serious it is."(S.1)

"I don't know her family, I mean all of her family have been really supportive of her so that has helped her a bit."(S.8)

"I think her sister has also been very supportive and I think sometimes it's easier for a young person to talk to their sibling rather than their parents because they're of a similar age and she doesn't take any rubbish."(P.8)

"Well E helped me quite a lot because she kind of, well she was the same as me but different, cos everyone's different but like probably E because I was going to have to have a tube on (inpatient unit) she helped me eat something so I wouldn't have to have the tube. Well I should say my Mum but I don't think she's helped that much because sometimes in family therapy she listens to her and not to me so she has helped me a bit but not a lot, not as much as E I don't think."(YP.10)

"It's the one thing that like distances her from us, she'd rather talk to people that have had it and understand than us."(S.7)

It is clear from the families' and young people's comments within this category that they have a very different view to others about what is helpful. The young people

highlighting family and fellow peers on the inpatient unit as supportive but patent acknowledgement overall (in relation to individuals at different stages of their treatment) that the young people would not recognise inpatient treatment to be beneficial.

6.4.5vi BEING AN INPATIENT

It was evident from the data that the experience of the young person having been an inpatient had a great impact on their views and attitudes to recovery. With particular reference to motivation, there were aspects of being an inpatient that seemed to have an effect on the individual's motivation to get better, whatever that meant for them. As someone journeys through the inpatient process, what motivates them one day can de-motivate them the next but overall the following themes played a part in the individual becoming more motivated to get back to their 'normal life' rather than stay an inpatient. The significance of this in terms of considering possible treatment settings will be discussed.

It is also important to note that although professionals and families tend to view inpatient treatment as a beneficial intervention, it is evident from the data gathered that the young people do not appear to share this view. As a result, their motivation to go home may increase and they reach a healthy weight, however this is not a motivation to recover from anorexia and with restrictions placed on them, their determination to keep anorexia as their 'friend' can increase.

Guidance from other patients

Despite the difficulties and obstacles that can impede motivation within the treatment setting, there are positives of being with others who are the same as you, similarly to a peer group in the community. Having the support from others with

anorexia or seeing others get better can increase an individual's own motivation to get better.

"There's another patient who's suddenly making a lot of changes who's E's quite close to so she's got motivation from him so that's making it easier.."(IW.6)

"She saw people that couldn't get better and she'd be like I've got to get better to get out because I don't want this to control my life and other days when she was with a group of people like her friends in there and they all talked about it and they all clubbed together and it was like it was their thing and she felt like she was part of something and in a way she quite liked being part of that group."(S.7)

Within these support systems also seems to be a process of being helped by others to helping others as you progress:

"Well, when there was like L and E (other anorexic patients) there, it kind of, I don't know if it made me think about getting better but they helped me think about getting better, or like that, well E helped me start eating again, then I was like E to L, because I helped L start eating again."(YP.10)

This young persons mother echoed her feelings:

"I think at one point she thought, why's this happening to me and nobody else and I think seeing children in the same situation and seeing them get better helped her."(P.10)

The importance of feeling understood and supported, particularly by your peers, is highlighted in these excerpts and is a feature of inpatient treatment that can contribute to a successful recovery.

The impact of other inpatients on the individual was a very clear theme for all of those interviewed. The effect of seeing others more unwell than yourself was seen as both motivating and destabilising at times and having support from other people, that were experiencing the same things as you, helped.

Competition to be more ill

"...obviously there are disadvantages to having everybody with anorexia and there probably are advantages too, recently somebody's come to this clinic and they're very very unwell and I think it really scared S, she's very obsessive about this young person who's very ill and I think in a strange kind of way I think it's motivated her to want to get better, being able to see outside herself and see the sadness to the illness. But basically I think she would find it easier not being with other children with eating disorders."(P.8)

This parent encapsulates the impact that other inpatients can have on the young person and that although overall it can be motivating, that there are disadvantages to it too as the next two quotes from young people highlight:

"The not wanting to get better is probably when new admissions come in and it throws everybody off because everyone starts thinking oh I came in that low and things like that. "(YP.2)

"Sometimes when you see other people here struggling you think I wish I was like that but then you were there and you think I don't want to get back like that so that can make a difference to how you're feeling about things"(YP.9)

The difficulty of being with other individuals at different stages of their recovery is recognised by parents as creating difficulty; comparing yourself to others and

struggling with ideas of not being 'ill' enough and the competitiveness that this can instil.

"...there's something about being very ill and there's a kind of jealousy about that and that it's not good to be getting better so sometimes she doesn't want to show it."(P.9)

"She finds it difficult being one of the old ones here because all the new ones are small and thin and she hates it when new ones come in and are tiny, she feels a frump."(P.2)

"When she's motivated and on track is when there's school because I think she finds it very difficult being in a clinic with lots of other children with the same kind of illness as her and it's difficult to be motivated when there's others that are much more motivated and some that are thinner and worse than yourself."(P.8)

Peer pressure to cheat system

Similarly to the positive guidance that can be given within peers, there can also be negative guidance evident in the form of peer pressure to go against the treatment plans.

"One of the things is like peer pressure within the unit and there are people that cheat the system and you think well should I be doing that, does that mean I'm just fine now, maybe I should be doing it.....I think that's the biggest thing that can make you slip up, thinking people have got away with doing it so maybe I should be doing it."(YP.1)

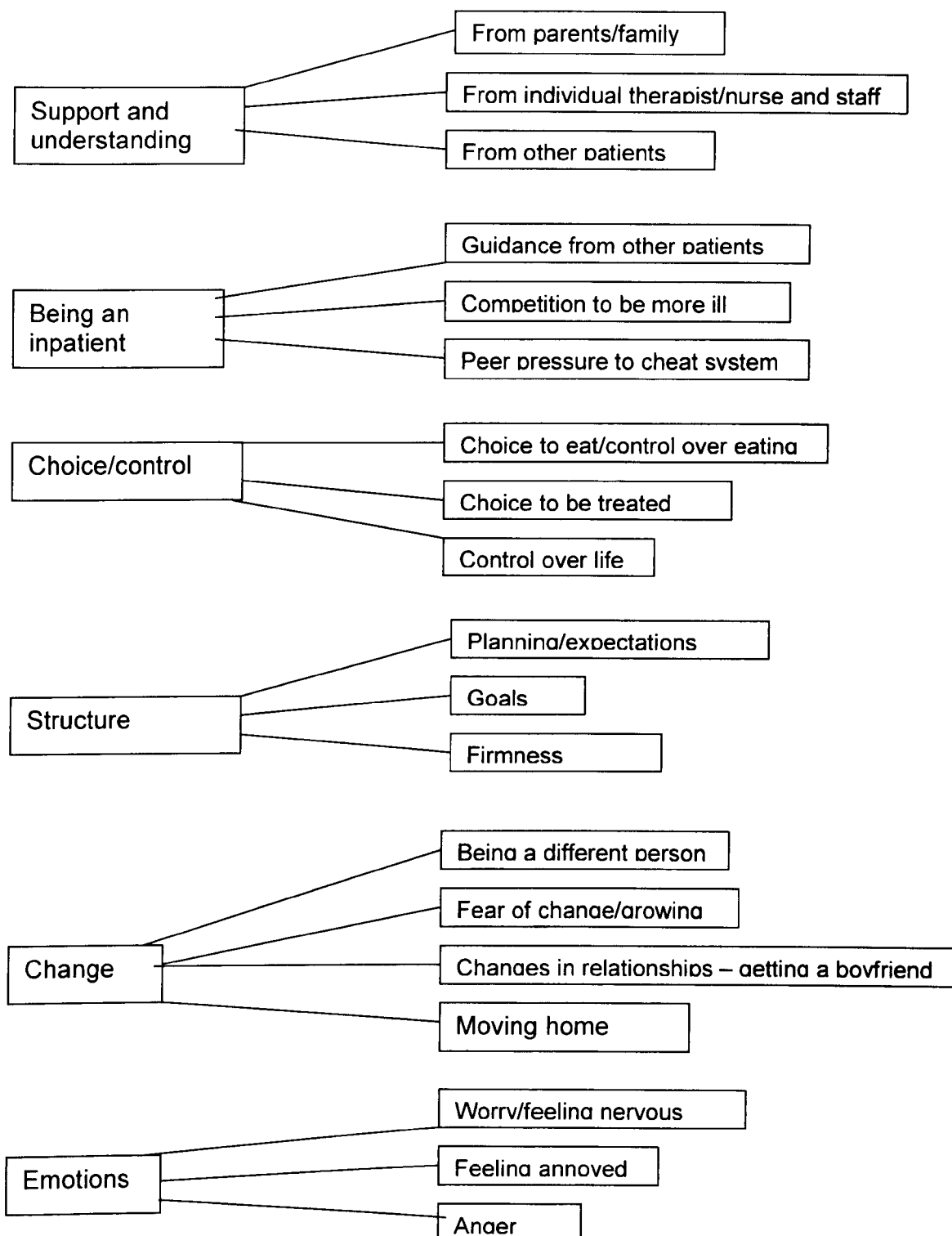


Figure 7. – Model of factors influencing motivation to change - Level 2 - 'The Process'

6.4.5iii CHOICE AND CONTROL

An aspect that arose as a motivational factor solely for the young person was the degree of choice or level of control that the individual has within their treatment programme and after being discharged. This feature is particularly important with the age group of this sample as their parents still hold the ultimate control and can make decisions on their behalf should it be deemed beneficial for them.

Initially, the choice to receive treatment is not generally taken by the young people themselves and often they do not want to be treated. After this decision is taken, further issues around choice arise within the treatment plans such as what and how much to eat. These issues are also prevalent in the home environment but after having been an inpatient it seems that choice is highlighted and seems to be valued more by the young person.

Choice to eat/control over eating

"Well I can deal with it by thinking I can be at home and lose weight but then again I would have to come back here and eat all the crap, like chocolate, cheese and chips and nobody's illness in their right mind would choose to eat that. That would be motivating me, the food I'd have to eat if I came back here because it's just junk. Whereas if I was at home I could eat the things I want to eat, be sensible about it but make the most of the fact of eating healthy. Once you come to terms with the fact that you have to eat, you may as well eat what you want to eat, so I'll eat pasta and vegetables and fruit and I'll eat meat. I think that will be motivating."(YP.1)

"I just feel rough all the time, I've just had to accept that I don't have a choice, I accept that I've got to be this weight, I don't have a choice."(YP.2)

"I can't imagine myself without it being there, I just can't. Yeah it's like there's two parts to the illness, there's the psychological part, the body

image the eating problem and then there's weight loss, the physical change and when you come in here that part is taken away from you and suddenly you can't be underweight anymore you can't lose weight, you've got no control over it at all. The psychological part is automatically going to take over, so before I came in here I was eating, I wasn't eating much whereas now if I had a choice I wouldn't touch a thing."(YP.1)

"....you don't have a choice so you were just kind of eating and trying not to worry about it. It wasn't really me wanting to but I just wanted to get home and didn't want to be tube fed."(YP.7)

Choice to be treated

"I find it really difficult because I'm not here by choice, they forced me to come. I don't want to change by choice but I've got to because if I don't change when I get out I'll have to come back and I don't want to so I may as well do it while I'm here."(YP.3)

'I've probably had the thoughts of getting better when being questioned about being put on a section and wondering if I could do anything to stop this happening."(YP.6)

Control over life

As one parent describes it below, being an inpatient can be a necessary process that has to happen to enable someone to think and behave more healthily and having the control taken away is seen, in this case, in a positive light.

"So she's been pretty deskilled really in terms of choices but she's had to be really to get her to eat. She's got to relearn now how to make informed choices. The food is almost like a side issue now, she can't refuse food

here or at home, that bit's cured now but it's more about becoming a mini adult."(P.2)

6.4.5v STRUCTURE

"The structure, the structure of not being able to get away with anything."(YP.3)

Having clear boundaries and a set structure is a known pre-requisite particularly for any inpatient treatment but is also effective within outpatient treatment, with goals and limit setting providing the basis of a nurturing yet containing environment. Most of the data in this category originates from the families currently receiving outpatient treatment, focusing on the need for plans, goals and firmness to enable positive progress. A process that may become more pronounced without the immediate support of the inpatient environment.

Planning/expectations

"It's all when she's better she's going to have another dog and it's all planning ahead but it's not dealing with issues now."(P.11)

"I think if things don't go according to plan, she likes everything planned. E went on holiday last week and it didn't go according to plan because there wasn't a children's club for E, the weather was bad and it was supposed to be hot. You know it's things like that, she stopped eating twice last week but we managed to catch it up but as soon as she's thrown, she struggles and then to get herself back on track she has to give herself an incentive."(P.11)

"We literally live day to day, the only plan we actually do is like she's already saying what we doing at the weekend, are we out Saturday night, she seems to need pre warning if anything's going on and then she can get herself sorted out in her own mind, what she's got to do but we don't actually plan ahead. She's nowhere near ready to take that responsibility I don't think."(P.10)

What also emerged for the young person was the issue of expectations in the sense of having a clear idea of what it means to get better and the need for a shared understanding.

"To be honest I think that people expect too much, they expect me to be completely back to normal like what I was before but I know that I can't do that."(YP.7)

"I do want to get better but I'm not sure about doing things that that might involve, kind of in the middle."(YP.9)

"I don't really know what getting better involves so I don't really know what I might have to give up or do."(YP.9)

Goals

"Definitely having goals, having something to work towards"(IW.5)

"If things are going E's way it's easier, if she's got something to look forward to it's easier. But I think she's, definitely if there's something to look forward she's, it's seems sometimes she's able to eat and be fine if she's got something that she knows she's going to go and do but if she's got nothing to look forward to I think it really throws her."(P.11)

Firmness

“Her parents being really firm with her has helped and them if there’s two of them being consistent and providing a united front. So you have to be really firm with her, I mean that helps her. What doesn’t help her, umm, is when Mum feels unsupported or tired or she’s had enough.”(IW.8)

“So it’s just structure and being really firm, if she thinks she can get away with something, she will try really hard and be manipulative and will use behaviours to push her parents buttons and scare them and drain them down so they give in and it’s really difficult not to.”(IW.8)

“I would have said some of the staff as well, because with J, you have to be firm with her, if you gave her an inch, she took two and once the staff established that, right this is what’s happening J, no negotiation. Firmness but in the nicest way, obviously, that worked and we obviously learnt to do that at home eventually, that made a big difference.”(P.10)

Planning, goals and firmness have emerged as influential factors on motivation to change but appear to support the families’ motivation as a whole, rather than the individual, with these factors enabling everyone to be clear of how to manage day to day and how to move forward.

6.4.5ii CHANGE

As noted earlier, adolescence is a well-documented time of change and anorexia can be seen as a method to avert changes such as pubertal growth. Fear of change can paralyse the individual in terms of wanting to ‘grow up’ and although this may not disappear completely, from the data it is evident that individuals can begin to look forward to change and being ‘a different person’.

It is important to note that all except from one of the comments in this section come from either the professional or family/friends, which may be significant in terms of who is able to recognise that change is a difficult issue.

"I think the fact that she never thought her life would change and actually feel a bit happier and she does now and she's starting to accept it and not feel so bad about it."(F.2)

Being a different person

"It was a bit later than Christmas because she came back so it would have been around February time that she decided she wanted to be seen differently because she saw herself as or her parents referred to her as someone who exercises and that's how she built up her personality and that was her only interest so she wanted to be seen differently and responded to differently. She was going to be starting a new school and thought it would be a fresh start, so she thought it would enable her to be a different person as there was a lot about her that she wanted to change."(IW.9)

"She'd been here a long time and she'd seen a lot of people come and go and umm some of the time was quite envious of their position really, I think there was always a desire to change so when thinking of that, what set her back was a real sense of whether she was able to, just a fear I suppose."(IW.9)

Changes in relationships/getting a boyfriend

"So yeah, I suppose that was the position she'd taken up in her family as well and she would often refer to her siblings as being quite different from

her. She worried about whether they would be able to relate to her as this new person when she made all these changes. It was almost like she had this role in the family and how well would they be able to function if she took up a different role so that was quite difficult for her.”(IW.9)

“Relationships, boyfriend, that will be a huge change for S, she’s lost all her confidence. She’s had a few fleeting relationships but they’ve been bad choices and she knows that, she’s just attracted to challenges.”(P.2)

Fear of change/growing up

“She seems to have a problem with changes. She doesn’t like changes, she’d be quite happy to revert back to when she was about 7 years old when it was just me and her, she’s often said that.” (P.3)

“...so she’d probably say that she’s really keen to move forward and in a lot of areas she’s very thoughtful and she will think about those things but when it actually comes to physically making the changes it just becomes too overwhelming for her and it’s just too big.”(IW.5)

“..you can’t stop change it’s there but I think she wants to change it back to when she was younger but she can’t.

She doesn’t like changes at all, she doesn’t want to grow up, that’s one of the main things, she’d prefer to be a little toddler when everything’s done for her and she doesn’t have to worry about anything I mean we could all feel like that but.”(P.3)

Moving home

"I found it really difficult when I was at home because I was upset with my parents because I didn't believe they would go back again, go back to England and I wanted to stay in Beijing."(YP.5)

It is evident in this category that these changes may not be significantly different from those that any young person may go through, however, *how* they are experienced seems to be the key factor.

6.4.5i EMOTIONS/FEELINGS

Eating disorders are often conceptualised as a way of managing negative feelings, with avoidance of negative emotion playing an important part in maintenance. A fear of or inability to manage negative emotions was identified as important by the young people and others both on a day to day basis (coping with weight changes, anxiety about change) and in the longer term (becoming depressed).

"I think it's easier in one way that she can move forward as things are so much more structured here and there aren't the emotions involved that there are at home and they can move on to planning phase and they're likely to meet resistance by adhering to the plan but they're more likely to stick at it and get E to think through and stick at it so it's easier from that point of view although but I guess what I'm trying to say is that it will be easier to achieve here without the emotional attachment of home. I think what's difficult for E is easy to achieve."(P.6)

The young people also highlighted the impact that negative emotions have on progress. They identified feelings such as worry or anger, affecting both their internal and external processes.

Worry/feeling nervous

"If I get upset or told off or something I get worried about doing badly and I do do badly and if I am doing well I get worried that I can't keep it up and I'll do badly and people will be disappointed and I'll be disappointed."(YP.4)

"It's hard to imagine being better but I still want to get better it's harder when it's really bad. Sometimes it's because I'm worried about something but sometimes it's anything."(YP.4)

"...she was always someone who was able to think very well but so worried and anxious what certain people thought of her or thought of her ideas so that was hard for her sometimes and she found it very difficult to communicate her feelings and whenever she felt overwhelmed or was experiencing a lot of feelings she always put it into having too much energy so she started to develop a way of being able to communicate or even recognise what she was feeling and put words to it. That was when her activity began to drop off, as she wasn't using it as a means of communication."(IW.9)

"We always know that if you have to tell C off about something or she's upset then it's almost impossible and the danger with C is that once she gets in a bad place she spirals downwards and it's very difficult to get out of that spiral."(P.4)

Feeling annoyed

“So when I’m annoyed or angry I don’t really think about getting better, like nothing’s better and all that. But when I’m feeling like sad but it’s just a normal day like now, I feel sad but like everyday it’s sad but sometimes it’s different like you can feel more sad or more annoyed. It’s kind of hard then. It depends what’s going on around you.”(YP.10)

Anger

“Well on (inpatient unit) when people were having difficulty not just with eating but with say anger, it was kind of hard then because there was loads of stuff going on outside and loads of stuff going on inside and you didn’t know what to do.”(YP.10)

“I think anger is a huge thing with S, she finds it difficult to express her distress and it tends to come out in anger about the system and about the nurses, about the doctors and I mean everybody here is horrible, obviously.”(P.2)

Although others recognised emotions as being an obstacle for the young person, from the above quotes it becomes clear how significant they are to the individual. It is also evident that without effective coping strategies, the task of ‘getting better’ can become very difficult.

6.4.6 Staying slim - the object in the way

Adolescent anorexia is characterised by an immense sense of dissatisfaction with bodily appearance and a preoccupation with weight, shape and food. These factors can cause distorted cognitions about weight and/or shape and impaired concentration due to the amount of time spent thinking about weight, shape and food. The most common reason for refusing food is a 'fear of fatness'.

The following categories (see Figure 8) caused much deliberation in terms of trying to build a core category as Glaser and Strauss suggest. They did not fit neatly under the broad theme of going home and getting back to normal life and seemed to operate both in opposition to, or in conjunction with this broad theme, depending on participant group.

Whereas some of the parents saw anorexia as a negative force, describing it as an 'addiction', the young people viewed it more as a guide, providing comfort and giving purpose. In terms of recovery, the anorexia was perceived by the young people to be something that remained with them after being discharged and in the future, allowing them to get back to normal life but staying slim.

Within the same grouping, were categories that are at the core of an eating disorder, such as food, weight and body image, factors which can affect motivation to change both positively and negatively on a daily basis.

The items are in order of frequency in which they featured in interviews.

6.4.6i ANOREXIA AS A GUIDING FORCE

Provides comfort

"I can picture myself going out and doing all the things I love but just coping with it being there. It's like a comfort and that's why I don't want to get better."(YP. 1)

"It's almost like the whole thing is a contradiction, what sort of comfort makes you upset and makes you cry all the time and makes you ill. But actually it does actually feel like a guidance, it's guiding you in the right direction, like a god."(YP.1)

"When she's alone she said the anorexia is like her only friend and the anorexia is there with her, so she'll cry and she'll think about it but when she's doing something it's taking a back seat."(S.1)

"Now she's at her target weight and she's happy about that but I don't think she wants to move on from the anorexia, it's still there. She's still afraid about seeing people that she knows, she wants to move on and she wants to come out but she still wants the illness with her."(S.1)

Gives life a purpose/provides guidance

"When I think about it properly it's really difficult because it's not something I really want to do but at the same time I don't want to be in here. It's difficult because it's not something I want to give up, anorexia gives me a purpose and it helps me make sense of my life and I feel if it wasn't there, there would just be a void and I'm not sure what there would be to fill it."(YP.6)

"I like to feel it as a part of me, like an organ and without it I wouldn't be able to function properly, I wouldn't be able to think properly or do things the right way."(YP.1)

"Not because of anything is wrong there she's working on some difficulties in therapy and we're not quite sure what they are at the moment but it does seem to be something to do with her personality and she's worried about how her parents deal with that and it's something that she has had for a long

time even before becoming ill and having anorexia has completely taken that out of her life so she's worried that if she gives up anorexia that and this thing comes back then her parents won't like her so to her it's easier to stay here and be anorexic."(IW.6)

Addiction

"it seems that anorexia is like and addiction S is now saying that she doesn't want to be ruled by the anorexia, she wants to rule the anorexia."(P.9)

The way in which anorexia is viewed by the young people as having a positive function in their life, is important in terms of motivation as it places them in a very different position to professionals and their families. This in turn impacts their motivation to 'get better' and again raises the issue of what it means to get better and how important it is to establish this at the beginning.

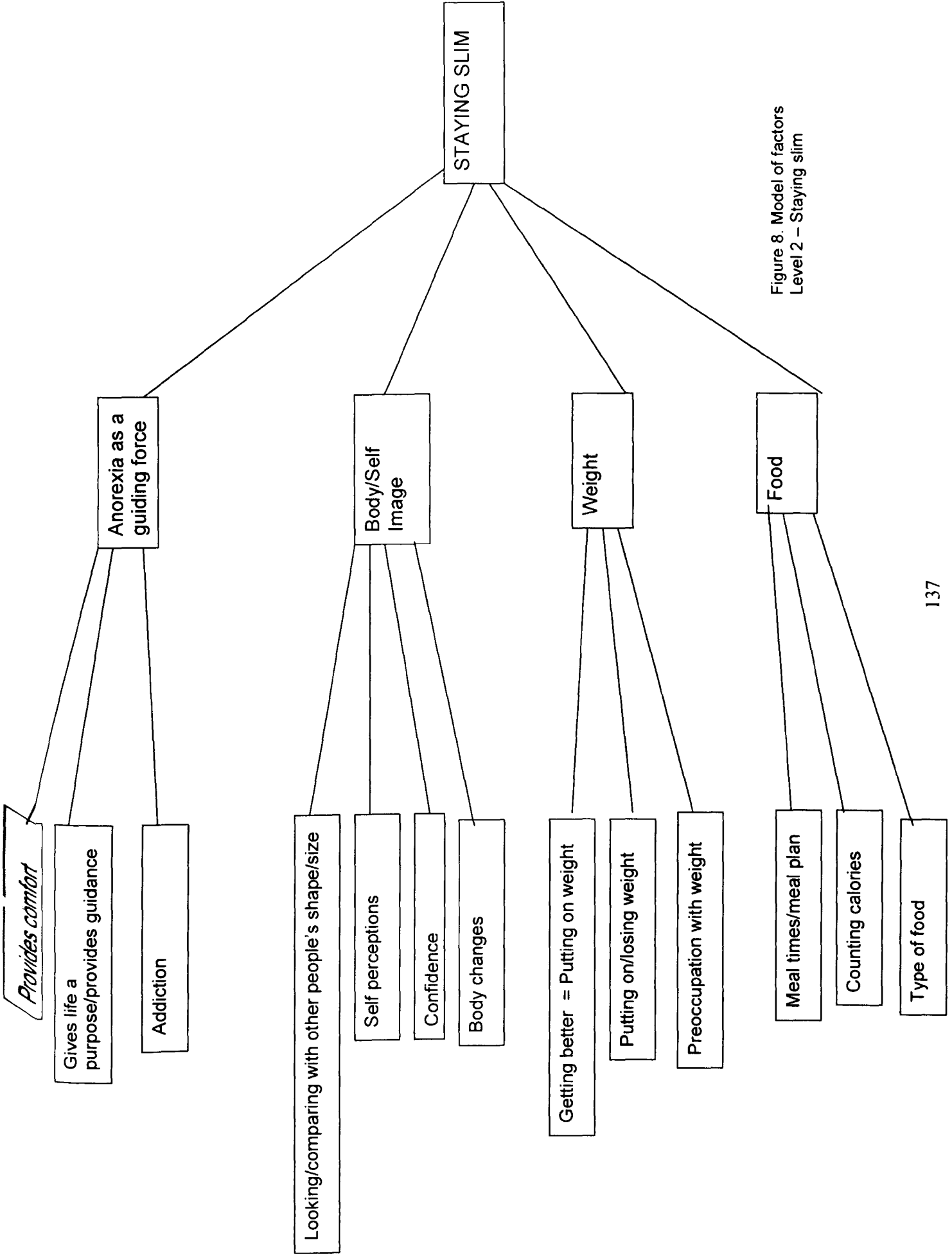


Figure 8. Model of factors
Level 2 – Staying slim

6.4.6ii BODY/SELF IMAGE

In terms of an obstacle to getting better, the individuals' perception of their own size and shape can create a great degree of ambivalence and internal conflict. Wanting to go home, get better and stay slim was a common theme. This category is strongly supported by data from the young people who were outpatients or about to be discharged, indicating the continuing difficulties that are faced after inpatient treatment.

Being faced with others who are perceived as thinner either in the immediate environment or in the media can affect motivation to get better negatively as if faced with the truly desired goal. If then the self-image that is seen in the mirror does not fit this goal, again motivation is affected.

Looking at/comparing with other people's shape/size

"Looking at other people does affect me, people I want to look like." (YP.2)

"If someone came in now and said oh I'm so fat, if they think that then I should think I'm fatter and if they're fat then I'm even bigger because they're thinner."(YP.10)

"...and it's harder when other people talk about their shape and they're like oh I'm so fat when they're really skinny. Do you know what I mean, like people at school sometimes, not a lot but sometimes say I'm so fat, when they're not. That makes me think about myself more because a skinny person to me, I think of myself as big cos like if you're next to small person then you feel fat so it's worse then."(YP.10)

"It's just like seeing really skinny people, like celebrities on TV or whatever, also like when my Mum or my sister, like because they're normal people and they go on diets or whatever, that can be really hard. I have to eat

everything, which I really hate and if they don't want to, they don't have to."(YP.7)

"The pressure too in the media of being thin and being perfect."(S.7)

Self perceptions

(What sets you back?) "Just err, when like you look in the mirror and you don't look nice and you feel rubbishy."(YP.11)

"Well it's like if I look in the mirror and I see I've got a spot or something then that will completely throw me off because I've got a spot and I'm spotty and horrible."(YP.2)

"The way she looks I think is a big thing with her, I think it's how she looks in the mirror, if she thinks she looks bigger than she was then she doesn't like it so that's when she has a tough time."(S.11)

"If I don't feel like big then I feel alright but sometimes I just feel like down and stuff and I think if I didn't have anorexia then I might get big because if I haven't got it then I might put on weight."(YP.11)

"We've got some family but she finds it difficult to see anybody that knew her when she was at her lowest weight because if they see her now she thinks they'll see a fat S. The way she copes with that is she puts loads of layers of clothes on, she calls it a space suit and just hides her shape completely."(P.2)

Body changes

"S's never been this weight ever and I think it's going to be challenge for her going out into society being the size she is now, she's got a completely different image than she had when she was growing up. But it's not so much about size with S, it's about body shape, S's a very curvy girl, she's got a big backside and a nice bust so she's got an hourglass figure and she hates that,"(P.2)

"Most of the time, she says she actually doesn't want to get better but she knows she has to, I don't think she can think about getting completely better, getting past 6 and a half seven stone, she can't think about. I think it's mostly the self-image thing that she can't countenance looking any bigger than she does now. She has a terror of not wanting to look any different than she does now."(P.6)

Confidence

"I think it will be difficult with the singing because I'm not confident about myself and I really want that back. I used to wear skimpy clothes and not care whereas now I just cover up which I hate because I want to feel confident, look in the mirror and say yeah I look good today and go out and face the world but I can't. "(YP.1)

"Her increasing confidence has helped too and she has realised that she can be herself, she doesn't have to be a low weight to get friends or anything."(F.2)

Aside from the last positive comment, this category has an overall negative impact on motivation to get better or return to normal and seems very difficult for the young people to believe they would ever feel differently about. The power of the young people's negative images of themselves is extremely evident and the resulting impact it has on the way they live their life and their confidence and self esteem. It is also one of the categories that sets them apart from others in terms of understanding, as the distorted bodily perceptions that only the young people can see can often lead to a constant conflict of opinion.

6.4.6iii WEIGHT

As food and body image can occupy daily thoughts, the concrete measure of the result of eating, i.e. weight can also cause rumination and distress. Getting better is often seen as synonymous with getting fat among the young people and for them, reaching a healthy weight is very difficult to come to terms with. Seeing a higher number on the scales can result in depressed mood and further resistance to eat, whereas if the weight had gone down, the young person's mood would be elevated and they may be more able to take part in daily activities.

Getting better = putting on weight

"I can say I didn't want to get better in that I didn't want to put on weight but I knew that I needed to in order to be healthy but I didn't really care about that. I don't know. I've never wanted to become better in my head because, I can see why people think I need to be better in my head but I don't think I do because that's how I've always thought. (The getting better bit is getting to a healthy weight) but I don't really want to do that, I'm not happy about that."(YP.2)

"She doesn't like coming to terms with putting on weight and that's when she has bad days when she thinks she's put on weight or she's not done anything to try and prevent putting on weight."(P.11)

"Umm well she wants to get better now but she finds it hard. I think she just finds it hard because she can't take in that she has to eat to get better; she wants to try and find another way. Stay thin and get better."(S.11)

"She occasionally comes out with stuff though when she's talking about wanting to come home and that she's desperate to leave and then she says she can't bear putting on anymore weight and you realise it's not all peachy."(S.8)

Putting on/Losing weight

"I think when she thinks about oh I'm eating things and I don't want to put on weight so I better do something or say something, I don't know just to say something to take your mind off it or do something to lose the weight or try and lose the weight."(S.11)

"She doesn't want to get better, even though she's been given a target weight of 52.5 she doesn't want to be 52.5 she wants to be lower."(P.7)

"Gaining the weight for her is what she sees as the obstacle to getting better."(IW.5)

"I think she did have better days when at home but they were days when she wasn't being pressured to eat more or being weighed. I think she always used to feel better when she got weighed and it had gone down. When she was weighed and the weight had gone up then they were not good days."(P.6)

Preoccupation with weight

(Looking ahead, what are the things that might get in the way of getting better?)
"Changes in my meal plan, putting on weight, not being fixed on weight."(YP.11)

"Some days she wants to get over it and other days she wants to stay her target weight, she doesn't want to go over, she wants to be thin all the time."(S.7)

There is a clear message from all groups here that gaining weight is the feared end result of getting better, affecting motivation whenever it becomes an issue and therefore preventing commitment from the young people to progress on their path to recovery.

6.4.6iv FOOD

Thoughts about food and any times of the day when food is involved is another area when motivation can be challenged. Scenarios have been described when the young person is acting 'normally' enjoying 'normal' activities yet when the time to eat arrives there is a total change in behaviour and mental state as the anxiety around food consumes the young person. Counting calories and rigidity around types of food eaten and places to eat become a major part of daily thoughts thus affecting returning to 'normal life' in every aspect.

"I think at the moment she doesn't want to put on any more weight and I think she'll be telling people she wants to get better but there have been times when she does genuinely want to get better and move on and not have to think about food all the time."(S.8)

Meal times/Meal plan

(How do you feel at the moment about getting better and the changes you have made or plan to make?)

"Sometimes nearer than others it just depends how I manage my meal plan and we were going to go fortnightly but I'm not sure now. I want to be discharged by next year."(YP.11)

"When they increase my calories too much it's too hard and I can't eat it all and want to eat less."(YP.5)

"At home we recognise that as long as it's nothing to do with food she's probably back to her normal self except that she's quite distractible. I can't imagine she's be able to sit down and do a lot of homework, she hasn't got a huge amount of concentration span, And sort of about 20 minutes before each meal she gets quite depressed and anxious because of the worry about eating."(P.8)

"If they increase her calories she will find it really hard and she gets upset."(S.5)

"We said the only way you can come out of hospital is by sticking to your meal plan and showing them that you're able to do it so that's what she was able to do and show us that she wanted to get better."(P.10)

Counting calories

"I don't want to get to a point in a few years when I can't get in my jeans or when I'm 17 or 18 and I've still got to count all my calories, it's just pathetic and it's never gonna go away as soon as you've been in here it scars you for life, for the rest of my life I know I'm gonna have to be all pathetic and counting my calories."(YP.3)

"I think if she didn't have to worry so much about food and calories and about being fat, then we might be able to move on to the next stage, I think that's her main worry at the moment on how she's going to get better if she still thinks about all these different issues."(P.10)

"I think maybe going out with friends and meeting people and anything related with food and her just getting on with her life normally. We just have breakfast, lunch, dinner and snack or whatever and I think she'll still be counting calories. Just the whole food thing will get in the way of her trying to move on with it."(S.1)

Type of food

"Well I can deal with it by thinking I can be at home and lose weight but then again I would have to come back here and eat all the crap, like chocolate, cheese and chips and nobody's illness in their right mind would choose to eat that. That would be motivating me, the food I'd have to eat if I came back here because it's just junk. Whereas if I was at home I could eat the things I want to eat, be sensible about it but make the most of the fact of eating healthy. Once you come to terms with the fact that you have to eat, you may as well eat what you want to eat, so I'll eat pasta and vegetables and fruit and I'll eat meat. I think that will be motivating."(YP.1)

"If I have to eat food that I don't really like it's hard or going out to places to eat is difficult."(YP.7)

"Well sometimes Mum and Dad talk about going out for dinner and that's, I find that hard, and I can't do that yet, so I like have my own meal before I go, I don't have restaurant food, that's kind of a thing."(YP.10)

There is evidence within this category that as food and eating is something the whole family takes part in, it then affects every member and parents and siblings alike recognise the enormous impact that food has on daily living. The young people see overcoming this fear and preoccupation with food as a huge task but is a large factor preventing a full reintegration back into normal life.

Summary

From the data gathered, 14 main categories emerged within three core categories of going home, the change process and staying slim. Of the 14 categories, those linked to going home were equally important to young people as those around them. The factors that most distinguished young people from their family and professionals were choice/control and structure, the people different groups viewed as a source of support and the young persons positive attachment to anorexia.

6.5 - Discussion

An important aim of the second part of this research project was to explore what affects the ebb and flow of an individual's motivation to change their eating disorder as currently it seems that it cannot be measured accurately until we understand the concept, particularly for this age group, more fully.

The thorough and emerging nature of the grounded theory approach allowed an exploration of an area that is relatively under researched, in a way that is collaborative and allows the researcher to understand the phenomena 'as if' they were in the individuals position. This approach seems to bridge the gap between research and practice as many of the central features of counselling are employed throughout the research process with the difference lying in the role and task of the researcher. As stated, qualitative interviews employ many of the central tenets of therapy such as collaboration and empathic understanding, where it is different is that, the researcher, unlike a therapist, does not have a role in encouraging change or offering alternative ways of coping and will need to address this sensitively throughout, possibly offering information of where more therapeutic input can be received if needed.

6.5.1 Motivation to change eating behaviour – limitations of current models and why this study is important.

Throughout the process of this research both practically and as a result of thoroughly exploring the literature it is evident that motivation to change is a fluid and dynamic process rather than a static measurable variable. What has also become clear is the complexity of an individual's motivation to get better in terms of what it means to them, what they will gain or lose and how they feel about it from one day to the next.

There are limitations to the value of the stages of change model, as highlighted in Part 1 of the study as an individual can be in two or three stages at once. In relation to this point there are continued unresolved issues related to the measurement, reliability and predictive validity of the transtheoretical model of change (Sutton, 2001). What also arose from the scores of the questionnaires completed in the current study was a pattern similar to that in Part 1, of a reduced repertoire of stages. The scores indicated distinct differences between 'Precontemplation' and 'Contemplation', yet when individuals scored higher on Contemplation they also scored similarly on Action and Maintenance. In their work with adolescent substance abuse, Bauman et al (2001) also question the stages of change model in it's entirety and again find a more restricted range of stages in line with the findings of Part 1 of this study. The transtheoretical model has been adopted into a number of fields including that of eating disorders with little or no formal assessment as to whether it's concept of change matches that of the population in question. In relation to the current sample group, when treating adolescents, the systemic context should always be considered; yet the transtheoretical model is based on the individual's motivation to change with little consideration for the wider context.

Although these findings suggest caution with regards to the stage model of change, this is not to say that we shouldn't think about how motivated and ready someone is to change but that it may be valuable to spend time exploring what this means to the individual as well as measuring it on a questionnaire. It seems then that it is important to continually assess all of the above to enable the individual to feel understood and supported in the challenging process of recovery.

The current study has been important in terms of exploring in detail, the change process for this sample group and placing it within a wider context, it has questioned the value of measuring the motivation to change as if it were a static variable and has focused on what motivation to change means to different individuals and groups of people, aiming to ensure that the findings reflect the views of those whom are affected by the eating disorder.

6.5.2 Current findings

6.5.2i Review of the current model

An important initial finding of this piece of research and something that emerged from the interviewing process and analysis was that 'getting better' was very much individually defined and although common themes arose, the individual differences are important in terms of treatment approach and goals. The significance of this is two fold. Firstly, in terms of Counselling Psychology and the theoretical underpinnings of this project lying in constructivism and the value of finding meanings that are significant to the individual in terms of their own lived experiences. Secondly in terms of both research and clinical practice and the need to work collaboratively with young people but being lead by the individual's goals, as long as they are not deemed harmful. This is very much a consideration that has to be taken into account with young people with eating disorders. If an individual's goal is to stay dangerously thin, this can often present clinicians with a dilemma in terms of working collaboratively. At these junctures, motivational interviewing techniques can be used to help illustrate the negative effects of an eating disorder through the patients' own discovery rather than having the facts enforced upon them at times where they may not be ready to receive them. The elements of choice and control are also important to note here, particularly in relation to young people as they may feel they have little choice or control to influence others decisions to block their goal to stay thin and it is important to try and balance duty of care and the patients health being priority, with collaboration.

The current model that emerged from the findings displays a dynamic system of factors impacting both positively and negatively on the individual's motivation to change. The model reflects the views of the young person and significant others and leads to a more comprehensive formulation of the adolescent's process of changing their eating disordered behaviour. The model aims to encompass the systemic differences that exist and provide a guide to the factors that need to be

considered when formulating treatment plans. It differs from models such as the stages of change model as it focuses on what influences motivation to change rather than how motivated someone is to change and although in its formative stage, appears to provide a more accurate reflection of the change process for this sample group.

6.5.2ii Systemic perspectives, similarities and differences

Prior to collecting the data, it had been hypothesised that there would be systemic differences between the responses, with the young person having different views to those of their parents or individual worker. It was thought these differences would have reflected a difference in terms of future goals with the young people also having different aims of treatment to those of their parents. This is important to consider as families and the wider system play an essential part in the young person's recovery from anorexia and are currently viewed as an integral part of the treatment programme. Different motivations are important to take into account as they can lead to difficulties within treatment, for example if the parents are motivated and pushing for increases in calorie intake when the young person is still unsure of whether they have a problem or not, this can result in many battles. From the concepts of Motivational Enhancement Therapy for eating disorders (Treasure & Schmidt, 2001), to enable progress, it is important to align the whole families views with the young person's current attitude to their illness and future goals.

What emerged from the current study was that there were no significant differences overall and there were fairly united views in terms of what influenced the young person's motivation to 'get better'. This seems to be at odds with the knowledge that lack of motivation is a common feature of AN and may indicate that the shared views and attitudes towards motivation may be indicative of the sample's inpatient bias. The united views on goals and direction seem to reflect that everyone is working towards getting the young person home. This is understandable and important but the drive to go home seems to cloud or override

the goal of 'getting better' and what this entails. The shared views may also reflect the impact of family therapy and overall treatment due to families being encouraged to talk together and share their views on a regular basis.

What separated the young people from their families the most was the illness itself and their attachment to it, the impact of emotions on their motivation and the degree of choice they have in decisions and levels of control, something which is particularly pertinent for this age group. These factors are all important as they have a significant impact on the progress made in treatment. They are represented in the process element of the suggested model and their management seems to either lead the individual towards their future goals or remaining allied with their anorexia. Overall, parents rated their child's motivation higher than the young people rated themselves, possibly indicating incongruence between what behaviour is displayed to others by the young person or a 'towing the line' in terms of treatment and how the young people perceive change internally. Other differences occurred in structure and support and understanding in terms of what helps whom to move forward. Understanding the differences in terms of what the different groups find supportive or helpful allows us to build a better understanding of the individuals belief system related to their anorexia and to tailor different aspects of treatment to fit with the needs of the different groups e.g. young people or parents. For example, being aware that parents value the staff's input and young people value support from their friends at home, interventions reflecting these values can be implemented.

As well as the categories demonstrating the young people's attachment to their anorexia (e.g. 'anorexia as a guiding force'), the following categories highlight the differences between young people and others in terms of what influences motivation to get better. Although goals were shared, it was the aspects that support or destabilise the journey towards these goals that created discrepancies between the young people and their families or individual workers.

Important factors for young people

Firstly, the category 'Emotions' is important to highlight as from the viewpoint of the young person, emotions can have a big impact on motivation to get better and seem to act as a powerful variable in the process. 'Emotions' as a category was not highlighted by parents and may signify the personal nature of the impact of emotions on the individual's process to recovery. The young people identified both the fear of and inability to manage negative emotions as interfering with their progress. It seems that the impact of emotions can quickly destabilise the young person in terms of working towards their goals, thus how the young people are enabled to cope with such emotions is vital. Within a developmental context, ideally children acquire the social skills and judgement necessary to cope with life stressors. Adolescents with eating disorders, however, have significant difficulty in spontaneously recognising and freely expressing a full range of emotions and many use eating behaviours to neutralise overwhelming feelings (Lask and Bryant-Waugh, 2000). When strong feelings are experienced, they appear to act as a block to progress and can draw the individual back towards the eating disorder, thus negatively affecting their motivation to get better. An important part of creating an environment that can facilitate change is tolerating distress and setting an atmosphere of trust and hope (Treasure et al., 2003). This can often be difficult for parents and they may need guidance in becoming more effective in giving support. For the young person, the management of overwhelming or difficult feelings is then crucial to the process of change.

Secondly, a category virtually solely identified by the young people in terms of what influenced motivation to change was 'choice and control'. Young people highlighted that having more choice when they are discharged is a motivating force and on the reverse being controlled and having little choice as an inpatient can be demotivating. Tan et al's (2003) work supports this finding and explores the views of adolescent patients and parents on control and compulsory treatment in anorexia nervosa. They discovered that compulsory treatment was not effective for more

than short-term weight gain and did not help engagement with essential psychological treatment. Also consistent with the current study's findings, resistance was expressed by the young people in the above study, particularly related to being dictated to about treatment and future plans. Consequently, there are often difficulties experienced by parents and staff in terms of 'taking control' to prevent further deterioration but at the same time encouraging the young person to take responsibility for their recovery (Jarman et al, 1997).

The young people identified their family and fellow peers as a source of support and motivation to them. With references to peers, both having support from other patients in terms of sharing experiences and by friends at home, acting as 'normal' influences, were important to the young person. In terms of developmental stage, the impact of peers is very significant and plays an important part in the recovery process. Although the sense of understanding and support that fellow patients provide has been recognised in the literature (Colton & Pistrang, 2004), there has been little research on the use of 'healthy' peers in the treatment of anorexia nervosa. However, it is also important to note the reverse can be possible with regards to peer support, in that there can be strong competitiveness between individuals to be the thinnest and patients comparing their treatment or relationships to others, often resulting in a sense of unfairness.

Important factors for parents/siblings

Often in contrast with the young person's views, 'taking control' can be seen as necessary as the one parent in this category noted. Parents often feel taking control is an essential part of the recovery process but unfortunately as reflected in a relevant study, this would often be against the young person's will (Cottee-Lane, Pistrang and Bryant-Waugh, 2004). Lock et al's (2000) model for family therapy is quite explicit about the need for parents to take control and focuses on the family as a resource for recovery, putting the parents in charge of re-feeding their affected

child. This type of treatment approach with young people could have negative implications in terms of their motivation to change their eating disorder. As control is increased and the young person has no choice but to adhere to the treatment, their motivation to change may then become directed towards doing the required work to alleviate the control as opposed to recover from the disorder.

Structure and the need for goals and boundaries, was strongly identified by parents as a factor that supports motivation to get better. As similarly identified by Treasure et al (2003), it is important that parents are able to adopt clear firm limits and boundaries about food and other anorexic behaviours. With relevance to an inpatient population, being supported and given the opportunity to practice providing effective structure may be valued more by the parents than the young people, thus enabling parents to remain strong and motivated. This category being endorsed by parents is consistent with findings of parent's experiences of anorexia nervosa in for example, the need to become highly structured and organised about mealtimes, when managing anorexia (Cottee-Lane, Pistrang and Bryant-Waugh, 2004).

When engaged in inpatient treatment, the support that is provided comes in different forms, both from with the clinic and from at home. Sources of support identified by the collective group of participants were families, friends, fellow patients and staff. The differences emerged when exploring whom different groups identified as a support to the young person. For example, while parents and siblings perceive the inpatient unit to be helpful to the young person, they are aware that this would not be the view held by the young person. In line with issues around taking control (Cottee-Lane, Pistrang and Bryant-Waugh, 2004), it would seem that the guidance from staff to families with regards to structure and boundaries is seen as helpful by all but the young person in many cases. This may be linked to the individual's motivation to change and severity of illness but these associations are not clear.

6.5.2iii Understanding different perspectives

a) The egosyntonic nature of anorexia

In connection with the categories within the model associated with 'staying slim', Vitousek et al (1998) have related the features of denial and resistance to change, within patients with anorexia, to the egosyntonic quality of the symptoms, highlighting the positive regard that individuals can hold for the disorder. In line with the young people's views in the current study, anorexia has been reported by individuals to have perceived advantages such as protecting the individual from adulthood and independence and serving as an organising principle for individuals who value simplicity and predictability (Crisp, 1980). This is important to consider in the treatment of anorexia as working against such views of anorexia can lead to confrontation and further resistance on the part of the young person. When thinking more about the young peoples perceptions of anorexia as a comfort and a guide, links can be made to literature that uses externalising techniques to help individuals separate from their anorexia. In relation to this issue, Serpell et al (1999) explored the attitudes of individuals with anorexia nervosa towards their eating disorder using the method of writing letters, one addressed to AN as their friend and the other to AN as their enemy. The results highlighted commonly expressed benefits of anorexia nervosa such as feeling looked after or protected and gaining a sense of control. The importance placed on these benefits goes some way to explaining the resistance to 'getting better' and understanding the individual's attachment to their eating disorder. Highlighting the 'cons' or costs of the disorder can then lead clinicians to exploring and working on the areas, which are 'ego-dystonic' thus hopefully leading to increased motivation to change. The information gathered from this study then helped to develop the P-CAN, which is a measure devised to operationalise the pros and cons of anorexia nervosa (Serpell et al, 2002) and can be used to quantify aspects that were assessed qualitatively in the author's previous study.

A further exploration of Treasure's (1997) work also seemed to produce some similarities to both Serpell et al's (1999) and the current findings with the anorexia is externalised and thought of as separate to the individual. With Treasure's work, anorexia is described more negatively as a "minx" which sits on your shoulder and whispers instructions to you about how to behave. Sufferers are encouraged to view the minx as having a destructive influence over their life as a first step to battling the illness. Although within the current study's sample one of the parents acknowledged the negative influence of the anorexia, describing it like an addiction, the young people did not verbalise this view, talking mainly about the anorexia in positive terms, as if it were their friend. It is also significant to note here that the participants holding these views scored higher in the pre-contemplation stage on the adapted URICA.

b) The inpatient factor

Consistent with the literature on young people's experiences of being an inpatient, the present study revealed findings that highlighted different aspects of the inpatient experience and in this particular case, the aspects that influenced motivation.

Although conducted with different aims in mind, a key qualitative study of adolescent eating disordered inpatients, which has illustrated many similar themes to those in the present study is that of Colton and Pistrang (2004). Their findings displayed both positive and negative views of inpatient experiences, with the young people's (12-17 yr olds) accounts being characterised by conflicts and dilemmas. Within the five themes that arose, parallels can be drawn from four of them to the categories of the present study.

The first and second themes identified in Colton's study, *what is the illness I have;* and *do I want to get well?* seem to raise similar ideas to, **what does getting better mean?**, looking at the meanings that individuals place on their illness and recovery. The third theme, *being with others: support vs. distress*, shows a parallel to the sub-categories, **guidance from other patients** and **impact of new admissions**.

Similarities can also be shown with the fifth theme, *collaborating in treatment vs. being treated*. This final theme can be compared to **Choice/Control** and **Structure**, with the focus being on the degree to which individuals play an active part in their treatment and decisions made and how this affects their motivation to move forward.

A conclusion that can be drawn from both studies and consistent with previous research is that according to the stages of change model, individuals can hold attitudes and display behaviours of more than one stage at any one time (e.g. McConaughy et al, 1989, Ward et al, 1996).

The difference that is important, predominantly with regards to the rationale for this piece of research, is that the current study highlights a systemic view of motivation, with the aim of drawing out the factors related to motivation to change that are particularly relevant to different groups. For example, elements of structure such as goals and firmness being mentioned, and possibly deemed more important, by parents as affecting motivation but not young people and anorexia being viewed positively by young people and not others. The themes and categories may not be different, but it does impact on the way in which motivation to change can be thought about both in terms of a Counselling Psychology focus on individual meanings of getting better and a systemic rather than individual view of motivation. For example, recognising that elements of inpatient treatment may be more helpful to parents than young people, and the importance for young people of being motivated by activities in normal life that are meaningful to them.

Cockell et al's (2004) findings, in a study focusing on what promotes the maintenance of changed eating disordered behaviours following discharge, also bear many similarities to the current research in terms of what supports the process of recovery and what hinders it. Clients within their grounded theory study reported that focusing on meaningful aspects of life, not related to their eating disorder, supported recovery behaviours. As within the present study, clients reported leisure activities and new responsibilities such as getting a pet as

examples of what supports a decrease in eating disorder behaviours. Being involved in 'normal' activities, particularly with a normal peer group was a goal that was consistent across all interviews (within the current sample) and a clear influence on motivation to get better. In line with the present study, Cockell summarised that 'having something in life that was meaningful and satisfying was part of many clients' experience of recovery following discharge' (pp 531).

c) Recovery and what it means

Motivation to change can be seen as motivation to get better but this may mean different things to different people. Over the course of conducting this research there have been numerous differences arise in terms of the use of language and it's meaning, in particular the language of 'getting better'. Getting better may be viewed as synonymous with recovery, yet recovery was a word seldom used by the participants within this study. This may reflect the age group of this sample or may be a term more popularly used by professionals. The above terms have become interchangeable within the current study yet when working with individuals, a term that is meaningful to them should be applied.

Getting better or 'recovery' from anorexia nervosa can be defined in many different ways and there have been many attempts to describe what should be included in an operational definition. There are broad definitions, which include physical, psychological and social aspects of functioning and there are narrower definitions looking simply at the DSM IV criteria no longer being met. Within Couturier and Lock's (2006) research exploring various definitions and outcome data, it appeared that there is much confusion about what constitutes recovery and a resulting variation in reported recovery rates. It was felt that an agreement was needed in order to compare outcomes, which should generally include both weight and psychological symptoms. With relevance to this piece of research, what was interesting about how Couturier and Lock defined recovery was that it was based on concrete measurable factors rather than asking the adolescent how they perceived recovery. The confusion around recovery seems to reflect the fact that

recovery will mean different things to different people, but what is important, and a limitation of the above study, is that the young person and their family is included in determining definitions that are meaningful to them. Adopting this approach Nilsson & Hagloff (2006) explored adolescent patient's perspectives of recovery from anorexia nervosa. The important factors in the recovery process that arose from their content analysis of interviews seemed to match the findings from the current study and included friends, own decisions, activities and their own family.

6.5.3 Strengths and limitations

6.5.3i The sample

Due to the small numbers of participants and homogenous sample group, the findings are limited to this sample profile but provide interesting and rich preliminary findings on motivation to change processes specific to this age group.

With regards to demographic details, all participants were white and all of the index participants were female and if the study were to be extended, it would be important to have a more varied sample in terms of ethnicity and gender. However white females do reflect the majority of those affected by anorexia nervosa in the UK at least.

The sample selected was predominantly inpatient biased and further work targeting individuals that haven't been affected by the experience of being an inpatient, may be necessary to gain a clearer view of what impacts on the adolescents' motivation to change their eating disorder. Nevertheless, the current study appears to reflect the reality of sampling this population as they are notoriously difficult to recruit, which has been suggested to be related to the hostile and avoidant nature of the illness and the ambivalence that accompanies it. Another factor that is important to note is that individuals with eating disorders in the UK who are under 18 are often treated in an inpatient unit, thus decreasing the number of participants who may have had no contact with inpatient services.

Within the sample of young people that have been interviewed in this research, the fact that 9 were and 2 were recently inpatients plays a significant part in the interpretation of the results and is important to mention to put the findings in context. When realising that being an inpatient placed a particular influence on getting better, in line with purposive sampling it was decided at this point to aim to obtain the viewpoints of outpatients to broaden the application of the emerging theory. Out of four approached, 2 outpatients agreed to take part in the project. However, when their transcripts were analysed few differences emerged and it was at this juncture that saturation was reached. Saturation is "the state in which the researcher makes the subjective determination that new data will not provide any new information or insights for the developing categories" (Creswell, 2002, p.450) and at this point there was no new data emerging relating to the categories that has been found. It can be hypothesised at this point that as the two outpatients interviewed had been inpatients within the last six to eight months there may not have been enough difference between them and the current inpatients. It is important to note however, that when researching a clinical population there are limitations to consider with regards to 'theoretical sampling', as any extension in participants, then needs to be passed by the ethics committee. This limitation may impact of the generalisability of the study as it draws from a homogenous sample. Further work in this area could be directed towards adolescents who have not received inpatient treatment, although this may add further disparity in relation to participants' illness severity. Also, as noted above there is only a small proportion of this sample group who would not have had any contact with inpatient services.

6.5.3ii The method

The advantage of using the grounded theory process is that it was able to adapt and flow with the changes and variations in people's responses in that it was/is a constant reflexive process, moving in response to relevance and fit of topic, something which motivation also seems to do. With reference to reflexivity, there may have been many ways to depict the data collected so it is important to be

aware of the researcher/author's involvement in the process and the interaction between them and the data, which led them to illustrate the results in this particular form. As I have worked in the field of eating disorders in different capacities for a number of years and currently practice as a Counselling Psychologist, it is also important to consider what I bring to the research as a practitioner. McLeod (1996) highlights that as we construct the inter-subjective reality that we experience, any knowledge of the social world that is created, for example, the findings of this research study, is *knowledge from one perspective*, hence the importance of both the researcher and the reader to consider the researchers perspective and it's impact on the data.

A difficulty with the grounded theory approach was the selection of a 'core category'. The selection of a core category, that as Glaser (1978) notes, should account 'for most of the variation in a pattern of behaviour' is at odds with a sense that there is more than one theme from the data that meets the criteria for a core category and to select one not only presented difficulty but also seemed to go against the philosophy of grounded theory of not looking for a fit in the data. As Dey (1999) notes, there is no reason why only one category should meet the criteria of being central, stable, complex, integrative, incisive, powerful and highly variable.

6.5.3iii Validity

A debatable methodological limitation concerns the validity of the responses gathered from participants and whether they are a 'true' reflection of the phenomena in focus. As with the majority of qualitative research, the emphasis is placed on gaining an understanding of the thoughts and feelings of the sample in question rather than trying to find an objective truth. In support of this study is the validation of themes that occurred between groups due to a high proportion of the same categories being reported by the different groups of participants, i.e. young people, parents, professionals and siblings/friends. If resources and time had allowed, it would also have been beneficial to have a second rater to verify the

categories that emerged from the data. Supervision and external research consultations with experts in the field were used to achieve some face validity for the categories that evolved.

6.5.4 Clinical implications

In terms of application of the findings to clinical practice, particularly in the role of a counselling psychologist, the importance is focused on developing a shared understanding of the meaning the young person and their families place on getting better. As highlighted by Treasure et al (2001), it is important to be able to manage and understand different agendas and help parents to avoid behaviours such as critical confrontation that can impede the young persons' process of change.

The experience of inpatient treatment seems to make it difficult for young people to think about their eating disorder because they are so preoccupied with focusing on how and when they can be discharged. This raises larger issues of whether inpatient treatment is effective or not, of which there is not scope to explore in the present study. Other clinical issues relating to inpatient treatment are those of control and responsibility and their central role in terms of influencing motivation. Encouraging young people to take more control and responsibility through decision-making, within healthy limits, can have a positive effect on their progress. Understanding the positive value that the young people can place on their eating disorder can also aid motivation in terms of communicating with the young person in a way that they feel understood. Being aware of what function the eating disorder has and the motivation for keeping it such as providing comfort or guidance, can enable parents and professionals to develop areas in the young person's life that could alternatively provide comfort and guidance. Serpell et al (2003) in their development of the Pros and Cons of Anorexia Nervosa (P-CAN) Scale, have recognised the need to explore both the positive and negative aspects of anorexia nervosa in children and adolescents. Although preliminary, their findings suggest that adolescents differ from adults in terms of their perceptions of the illness and for example due to their developmental stage and lack of concern

for long-term outcomes, may be less concerned with the negative impact of the condition. This is important to consider in terms of what information and techniques can be used to motivate young people to change, as they may be characteristically different to adults.

Also with regard to developmental stage, the importance of peers in the treatment process is particular to adolescents and is identified as having a positive influence on their motivation to change, specifically in terms of returning to friendship groups in the community after being an inpatient.

The use of 'healthy' peers in treatment has been pioneered in the drug and alcohol field as a way of providing positive role models and helping adolescents to move on. Multi-dimensional Family Therapy (MDFT) (Liddle, 1999) has been used in America with the objective being for the adolescent to transform from a drug using lifestyle to a developmentally normative lifestyle. What is particularly relevant is that adolescent drug use is understood in terms of a network of influences (individual, family, peer, community) with the overall therapeutic strategy being informed by knowledge of normal adolescent development and focusing on maintaining positive peer relationships and developing pro-social activities. In Britain such outpatient treatment programmes are also being facilitated such as the Maudsley family based treatment model (Le Grange et al, 2003, a treatment that involves families, but that opposes the tradition of finding families pathological. Instead, Dare takes an 'agnostic' view of the cause of AN and suggests that the family is the most important resource at the therapists disposal to ensure recovery. The main difference between the two approaches being the additional use of peers in the American model and a possible future direction for treatment models in this country to extend to.

Also pertaining the importance of the family is that support for parents is essential, as they are an integral part of the recovery process and support the young persons motivation to get better as well as needing to remain motivated themselves.

Finally, in terms of developmental stage and motivation it may be important to begin to consider the notion of a simpler model of motivation to change, as discussed, there is evidence to suggest that the most distinct difference for

adolescents is whether they are precontemplative or contemplative and there is less evidence to support the original stages of change model as set out by Prochaska and DiClemente. This in turn has an effect on how treatment approaches and techniques are used with the field of adolescent eating disorders and may operate as a starting point to a more comprehensive reworking of the transtheoretical model.

6.5.5 Areas for further research

Firstly, due to the limitations of the sample in the present study, there may be value in extending the current work to a wider sample population and also to return to the young people with the proposed model to receive their feedback.

In line with the findings that young people value the support from their peers at home in terms of keeping them motivated and the work being pioneered in America with using healthy peers as part of the treatment, further research is required to both explore young people's views further in this area and consider the use of healthy peers in treatment in the UK.

An interesting piece of further work would also be to consider parents and siblings motivation to change their own behaviour rather than reporting on behalf of the young person. For example how motivated may a sibling be to adjust their daily routine to enable positive change for the family and the individual with the eating disorder or how motivated are the parents to review their relationship and how they work together as parents to facilitate change. This would be valuable in terms of further understanding motivation in a systemic context and would also consider different obstacles to progress that may not result from what is commonly thought to be the young person's lack of motivation.

6.6 Synthesis

6.6.1 - Background

An individual's motivation has been shown to influence engagement in treatment and motivation to change had been demonstrated to have a significant impact on outcomes of treatment interventions (Geller & Drab, 1999). As people with eating disorders differ in their readiness to change and willingness to engage in treatment, there stands a need for a means of identifying level of readiness to be able to tailor treatments to the individuals needs. Working with ambivalence in a counselling relationship can be difficult and may result in therapy feeling 'stuck' at times. It is important then to understand individual's thoughts and feelings related to changing their behaviour and their impact on the treatment process. These processes are further complicated in adolescents (young people), in whom ownership of the change process is influenced by their dependence on others, and lack of choice they often experience in receiving treatment, and by developmental factors influencing their sense of self and of knowing their own wishes.

6.6.2 - Counselling Psychology and Motivation to Change

The stages of change model (Prochaska et al, 1992), has become a much-used framework within healthcare settings, particularly the addictions field and more recently the field of eating disorders. When working directly with this client group I began to explore the relevant literature on motivation to change in adolescent eating disorders, which raised a number of methodological and clinical questions. As a Counselling Psychologist, my working philosophy is based on the importance of developmental stages and individual differences; the existing literature did not appear to acknowledge these factors. The original model had been developed with adults in mind and did not seem to account for the impact of developmental stage on motivation to change. Existing measures of motivation to change and new adaptations within the field of eating disorders appeared to assume that the stages of change model applied to adolescents, without further exploration of this link. Sutton (2001) had also begun to raise questions about the measurement reliability and predictive validity of tools that were based on a model that had not been sufficiently validated.

Within the literature questions were beginning to be raised with regards to the applicability of the URICA, based directly on the stages of change model, to the field of eating disorders. Rather than develop a new measure for this client group based on the stages of change model, as other studies have done, the initial aim was to validate the properties of the original assessment tool and through it explore the validity of the four stage model for change in this group.

6.6.3 - Aims

From the outset, the wider aims of this study have been both to contextualise the motivation to change literature within a counselling psychology framework and to review and revise the current theoretical and practical applications of the transtheoretical model of change for the sample group in question.

More specifically the aims and objectives for each part of the study were:

Part 1: *To explore, in a sample of young people with eating disorders, the psychometric properties of an adapted version of the URICA (McConaughy et al, 1983), a questionnaire measure of motivation based on Prochaska and DiClemente's four stage model of change, and to ascertain if this sample fall into subgroups predicted by previous studies in other samples*

To identify key constructs in the URICA, so that it can be abbreviated for ease of use with younger patients.

Part 2: *To examine the attitudes towards change of young people with Anorexia Nervosa and explore the views of family and professionals about factors that might influence the young person's motivation or ability to change (recover).*

To compare the perspectives of both parent/carer and child on factors influencing the recovery process, which may inform clinical approaches in this age group.

The aims and objectives of both parts of the study have been met, areas for further research have been identified, and the limitations of both parts have been acknowledged.

6.6.4 - Results

From the findings of Part 1 of the study, it became evident that despite the psychometric properties of the questionnaire being sound, the profile of responses displayed by the sample group (n= 39) failed to distinguish the four hypothesised stages of change. Although there was some evidence for the first two stages of change, i.e. Precontemplation and Contemplation, a more complex picture seemed to be emerging for the sample in question. The data found a different response pattern to that of adults, suggesting a different process of change for this client group and calling into question the applicability of the stages of change model in this sample. What became apparent from the data was a dynamic process, whereby individual's endorsed multiple stages at the same time. These findings would benefit from replication in a larger, representative sample of adolescents with eating disorders.

6.6.5 - Background to Part 2

Within Counselling Psychology, the individual's experience and sense of meaning is central to the therapeutic work and the findings from Part 1 of this study support developing a level of enquiry that leads us to question the suitability of assessment measures and the theory they are informed by. The measures used should also accurately reflect the experiences of the population they are intended for. A number of possible explanations for these findings were considered. It seemed possible that this complex picture might result from the fact that adolescents, more than adults, are subject to external constraints, and influenced by developmental and systemic factors. As a result, the focus of part two of the study became an exploration of motivation to change from a systemic perspective.

To enable these preliminary findings to be extended to explore the experiences of adolescents with eating disorders, a qualitative methodology was employed, specifically grounded theory. Employing 'methodological pluralism', which is strongly encouraged within Counselling Psychology research (Barkham, 1990), allows selection of the most appropriate approach for the question being asked at the time and fulfils the role of scientist practitioner. The second part of the study aimed to consider a wider context and explore, from a number of perspectives, factors thought to have an impact on a young person's process of change and to influence their motivation. An important difference of the second part of this study to previous research was that it explored the views of those surrounding the young person, i.e. parents, siblings/friends and professionals as well as the views of the young person themselves.

40 interviews were conducted, relating to 11 individuals with an eating disorder. Of these, 9 were currently receiving treatment in an inpatient treatment unit, and two were outpatients who had had a period of inpatient hospitalisation. There were four informants per subject corresponding to four groups: young people, carers/parents, a professional directly involved in the young person's care, and a sibling or friend nominated by the young person.

6.6.6 - Results – Part 2

The three main domains that emerged from the data in terms of factors influencing motivation to change were:

- the illness itself
- the treatment process and,
- normal life.

A main finding from these qualitative interviews was that inpatient treatment heavily influenced the young person's motivation to recover from their eating disorder, according to the majority of informants. In particular, the inpatient experience

seemed to impact on motivation to the extent that the changes made by the young person are in pursuit of being discharged as opposed to 'getting better'. This is an important finding in view of the fact that inpatient admission becomes an inevitable part of treatment for a high proportion of young people with anorexia nervosa, and is a something about which young people often feel they have little choice. This finding also raises questions about factors influencing motivation to change in individuals who have not needed inpatient treatment, and further research in this area is suggested.

From a systemic perspective, the biggest difference between informant groups was in terms of the value they placed on the illness, with young people being heavily influenced by their anorexia nervosa *not* to change, a factor not emphasised by the other groups. The young people illustrated a positive attachment to the anorexia nervosa and demonstrated the degree of influence that it can have on their motivation to get better. All four of the informant groups identified aspects of the treatment process as important in enhancing motivation, with some elements were more helpful for certain groups than others. For example, parents identified the support and structure of treatment as important, whereas, young people stressed the importance of peers and the goal of normal development as positive factors. These findings are supported within existing literature (Tan et al, 2003).

6.6.7 - Strengths and limitations

A strength of the current study is that it recognises the significance of those close to a young person in determining outcome, as well as exploring the young person's perspective. Current treatment models for adolescents with eating disorders place significant importance of the involvement of the family in treatment and recovery process, which the family undertake as a unit. This means that the whole family need to be engaged in the process of change, shared goals identified and differences worked with.

The main limitation of these studies is the narrow sampling frame in terms of representing the severe end of the adolescent eating disorders spectrum, namely those receiving treatment at specialist, largely inpatient, units. Applicability of these findings to those presenting to clinical services needs further exploration.

6.6.8 - Implications and conclusions

What can be drawn from the findings is that different groups identify different needs within the treatment process. In line with the premise of Counselling Psychology, it is important to explore individual's experiences and tailor treatments to meet their needs. In addition it is equally important to explore what motivates the family as a group and what will enable them to join together as a unit and make positive progress.

Of clinical significance is the undue influence inpatient admission can have on a young person's motivation, such that true motivation to recover may be obscured. Related to this is the negative impact that limiting control and responsibility can have, as reported by young people. Within the arena of adolescent eating disorders there is ongoing debate about the effectiveness of different models of treatment, including the extent to which young people should be empowered to take control of their eating behaviour, and of collaborative versus authoritative stances. The evidence to date remains inconclusive. Findings from this study suggest that authoritative treatment approaches in which adolescents feel they have little control and responsibility may have a negative impact on motivation to change.

Nevertheless, the goal of 'going home' could be seen positively as it allows patients and parents, at least initially, to unite around a common focus rather than arguing about food and weight where their goals are likely to be different.

Also important is the recognition by those close to young people with eating disorders of the benefit of structure and boundaries in supporting recovery.

As Counselling Psychology continues to advance as a discipline within the healthcare system, at all levels, the findings from this study provide considerations to take into account when working with adolescents with eating disorders. Of paramount importance is the consideration of the wider system within which the young person interacts and its resulting impact on their motivation to change. This in turn should enable Counselling Psychologists to tailor treatments that both encourage common goals within the family and meet the differing needs of the individuals as they emerge.

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7. Section C – Professional practice A Cognitive Analytic Approach to Bulimia

7.1 Rationale for choosing this particular case

This case study highlights my work as a practicing Counselling Psychologist and provides the opportunity to demonstrate my therapeutic knowledge and skills in relation to working with eating disorders.

Since starting my own private practice, specializing in eating disorders, a year and a half ago, I have experienced a challenging and rewarding growth process in my role as a counselling psychologist. Working in an isolated context has been a significant change for me as a practitioner and this particular case illustrates a client that, in my opinion, has undertaken a major process of change and I wanted to share the progress that she has made. This client's growth contributed to my increasing confidence working in private practice and provided constructive learning experience.

7.2 Summary of the theoretical orientation

For CAT terms see Glossary in Appendix 26.

Cognitive Analytic Therapy was developed in an effort to make therapy more available in the NHS and aims to be structured, focused and time-limited but with dynamic depth. It was primarily designed for clients with anxiety-based disorders and also as a useful first intervention for clients with more serious difficulties including clients with poorly integrated personalities.

Anthony Ryle (1990) developed a theoretical model with the aim of uniting ideas from developmental, personal construct, and cognitive psychology with psychoanalytic understandings, especially those from the object relations school. It emphasises the actual experience of the child and the communication of parental patterns of behaviour (procedural sequences), both through the kind of care provided (e.g. abuse, neglect, conditional care) and through the meanings attached to such experiences.

The therapeutic process focuses on exploring the 'target problems' and adjusting the 'target problem procedures' that an individual has developed as a result of early ways of relating (reciprocal roles) but are still present as coping mechanisms in adult life. 'Traps', 'dilemmas' and 'snags' describe the maladaptive, unrevised procedures, which characterise the client's emotional distress and affect both the management of their relationships and of the self (Ryle, 1979).

The origins of these maladaptive behaviours are in the client's 'core pain', namely the feeling that they are trying to avoid but somehow is being maintained and reinforced. Transference and countertransference feelings are discussed and accepted, making both therapist and client aware of the relationship patterns that may occur in their relationship and provide the opportunity for new, more positive ways of relating.

Therapeutic change is enabled through a collaborative process of 'reformulation' and 'revision'. The aim is to identify, describe clearly and not collude with self-defeating patterns and to help the client to internalise new understandings and new forms of self-reflection, which continue to be available after termination of the therapy (Bennett, 1994).

7.3 The context of the work and the referral

After receiving two previous short-term blocks of therapy within the NHS, Jackie had decided to pursue therapy privately for what she hoped would be the last course of sessions necessary to alleviate her symptoms of bulimia nervosa. Jackie located my details in the list of registered therapists on the Eating Disorders Association website and made direct contact with myself to make an initial appointment.

Jackie had previously worked within a CBT framework with her therapist and although she had gained some insight and skills from these sessions, she was still 'clinging to' elements of her eating disorder and felt that she would like to try a

different approach. She also stated that when in therapy she has been able to progress but 'slips back into old habits' when she is on her own. After some discussion and guidance in terms of what therapeutic approach may tackle Jackie's problems most effectively, Cognitive Analytic Therapy (CAT) was the chosen model. CAT is proposed as a safe and accessible intervention for a wide variety of presenting and underlying psychological and mental health problems (Ryle, 1990). CAT in particular has been used to work with groups with hard to help problems such as eating disorders and personality disorders. Treasure et al (1995) reported a pilot study comparing the use of CAT to educational behaviour therapy with patients with anorexia nervosa. The results showed that weight gain was similar in the two groups but CAT patients reported greater improvements in global functioning.

7.4 Overview of the client

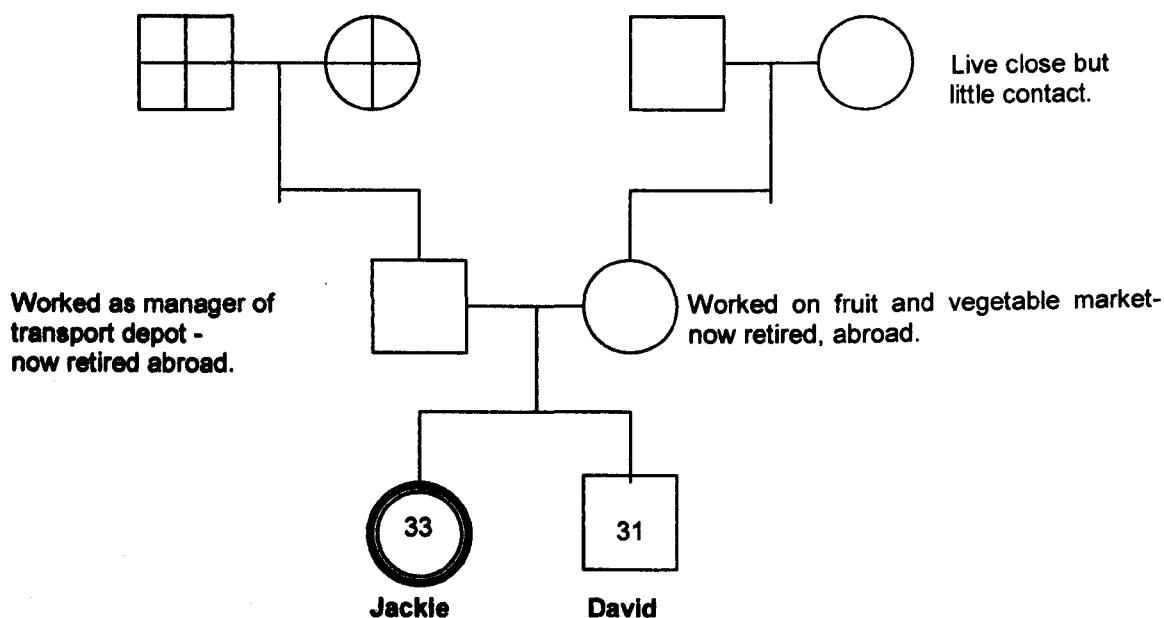
At the initial assessment interview Jackie presented as a casually dressed slim woman in her early thirties with pressured speech and a slightly 'manic' presentation of mood with rapid changes in conversation topic. She recounted a long history of struggling with bulimia nervosa that first started to become a problem for her at seventeen years old. For definition purposes, Bulimia Nervosa is characterised by episodes of overeating in which the person experiences a sense of loss of control, with accompanying attempts to avoid weight gain by self induced vomiting, laxative abuse, diuretic abuse, or food avoidance. Weight and shape concern are core features, as in Anorexia Nervosa, and are manifested by attempts to control weight and minimise the weight gain that might normally result from overeating. Self induced vomiting and laxative abuse, are the most common methods used to avoid weight gain (Abraham & Llewellyn-Jones, 1992).

Jackie lives alone and is an office support assistant and has lived in London all her life but now has very few friends in the area as they have all moved away. Jackie expressed that she likes living alone but finds it difficult to be alone with her thoughts and often uses going to the pub as a distraction. She has reduced her

bulimic symptoms greatly over the years and is currently being sick once a day. Jackie stated that she feels fat, which she measures by how her clothes feel, as she doesn't like looking in the mirror. Jackie stated that she has no one to share anything with and never really talked to her parents, just had general conversations.

Jackie's basic family structure has been detailed in the genogram below.

Jackie's parents have recently moved abroad and at the time of assessment, her brother was in rehab for heroin use.



7.5 Pattern of the therapy

The following section of the client study will take on the form of the structured protocol of therapy, which is argued to facilitate themes to unfold logically. The four stages demonstrated below illustrate the CAT process from beginning to end. The therapy sessions take place on a weekly basis.

Assessment (sessions 1-4) – Establishing relationship biography and personal history psychotherapy file.

REFORMULATION

Recognition and Revision (sessions 4-10) – Acknowledgement and starting to change, experience new acts and consequences.

PROCEDURAL SEQUENCE RECOGNITION/SDR

Ending Phase (sessions 11-16) – Acknowledging issues/feelings, especially loss/separation.

GOODBYE LETTER

Follow up - Feedback, Review, Reinforcement.

As the process of therapy unfolded with Jackie, it became evident that more long-term work may be necessary and Jackie requested ongoing sessions. The work has thus extended beyond the standard 16 sessions. The CAT framework is still being used but the middle section of recognition and revision has continued over 9 months. In the last 2 months, there have been tentative discussions about when to end the sessions as Jackie feels less justified paying for them now that she has eradicated her eating disorder symptoms. From these discussions, Jackie decided to reduce the sessions to a fortnightly basis. As Jackie began to reduce her number of sessions by attending fortnightly, it quickly emerged that this reduction may have been premature. An illustration of this would be that when Jackie was attending fortnightly she began talking as we walked up the stairs to the office as if

she were unable to hold on any longer. With the difficulties Jackie had experienced with her relationship and the impact it had on the rest of her life, there were many issues being raised and I raised my concern that fortnightly sessions may not be enough. Jackie also felt this, in that she was spending most of the session 'filling me in' with little time to work through difficulties. With financial constraints, Jackie is currently aiming to come weekly, however this is not always possible.

7.6 Assessment and Reformulation

The focus of these sessions is a collaborative information gathering process, directed towards the issue of reformulating Jackie's present difficulties and leading to an agreed written account of her past and how the past is reflected in her account of current problems and problem procedures. In the first four sessions I focused on building a relationship with Jackie using dynamic style open-ended interviewing to gather a detailed history of her childhood and build a picture her current adult life, constantly offering empathic reflections and summaries, checking that my understanding was accurate. Over these sessions, repeated patterns of thinking and behaviour were explored. Any interpretations were reserved at this point as the aim is for the client to feel listened to and understood. The reformulation process was aided by the use of the Psychotherapy File (see Appendix 27), which I gave to Jackie in session one alongside encouraging her to keep a diary to monitor her thoughts feelings and behaviour. The use of the File introduces clients to active participation in the therapy process and initiates them to the task of learning self-reflection (Ryle & Kerr, 2002). Reading the descriptions of traps, snags and dilemmas in the File allowed Jackie to identify which ones applied to her and then to discuss them further in the sessions as supported in Ryle et al. (1992). As a therapist, the process of reformulation is really useful for crystallising and consolidating your thoughts and feelings about your client and writing them down allows them to be transformed into a form of transitional object that can be used as a tool for change.

The reformulation letter set out the main features of Jackie's past life, what she experienced, how she coped with it and what was and wasn't her responsibility. It ended with a description of the negative and ineffective strategies developed in the past, which are now maintaining difficulty and resisting change. Diagrammatic formulations typically used in CBT, because of their shorthand nature can make it easy for the patient to stay somewhat distant from and avoid the impact of this. The practice of writing letters speaks to the client's emotions, and has been reported by clients as very valuable, they have expressed feeling validated by the therapist's effort on their behalf and feeling very understood (Lavender & Schmidt, 2005).

I will now use extracts from Jackie's reformulation letter (see Appendix 28) to illustrate Jackie's story and the problem procedures that will become the focus of the therapy.

Jackie seemed to find it easy to talk about her history and expressed a degree of insight into the impact of her childhood experiences on to her adult life. Jackie described difficult relationships with both of her parents, particularly when she lived at home. As a result of her relationship difficulties with her family she appeared to isolate herself from others, often spending a lot of her time alone. Although she described herself as fiercely independent, the transference that I felt and reflected to Jackie was a deep sadness.

"From a very young age you have been very independent, both as a result of feeling that your Mum didn't like you and your Dad refusing to deal with you due to the difficulties between you and your Mum. It seems from what you have said that your independence had grown more because you felt you had to be but what you really wanted was more love and affection."

Drawing from the content of the sessions that focused on exploring her past further and its link to Jackie's current negative patterns, I have highlighted below a 'trap',

which Jackie seems to re-enact. In trying to deal with feeling bad about herself she tends to act in a way that confirm her badness. Throughout the sessions, Jackie has displayed a propensity to be quite self critical, becoming frustrated that she is not able to act differently. When offering reflections in the sessions, I have been careful to ensure Jackie does not take any further blame for her difficulties, more understands their roots. I have found it helpful to reframe the self-blame and critique, stating that these procedures that may now be unhelpful were developed for a good reason at the time, often a protective one. When writing the letter, I used Jackie's descriptive words or phrases as much as possible throughout, to demonstrate a direct reflection of her experiences and to enable her to resonate more fully with the reformulation.

"Both growing up and currently it seems that you are anxious to fit in with others and often try and please everyone to do so, putting your own needs aside. You describe being in 'your own little bubble', which seems a protected space that you may have created to stop getting hurt or to stop people getting close fearing that you may not be enough for them.

Another area that seems to have had a big impact on your adult life was not having your opinions validated or encouraged, often being told that you were stupid. As you confirmed in the Psychotherapy File you seem to isolate yourself from social situations as you feel under-confident and are always 'second guessing' yourself. The anxiety around this seems to paralyse you at times, which may then come across to others that you are not interested so you become more isolated and convinced that you are not worth talking to."

An important part of the letter was to put the presenting problem in context and illustrate the reciprocal role that Jackie may have with food and the procedures that are linked to it. During the initial sessions, Jackie spoke with some ambivalence

about letting go of the bulimia completely, as it had become a valued coping mechanism in her life and she could not see how she would manage without it. She also spoke about how it had become to be part of her personality and that she wondered about whom she would be without it.

“After receiving a further blow to your confidence at 17 when your boyfriend broke up with you it seemed that you found something in food that enabled you to feel more in control but also may have given you a sense of achievement and a way of coping with feelings that you had stored up, not feeling able to deal with on your own.

This coping mechanism seems to have continued into your adult life and seems to have become a friend to you, something that you share things with that you feel unable to do with anyone else for fear that you may upset them or that they may not want to be around you.”

To summarise the main body of the letter and to provide the focus for the sessions to come, the following section from the letter details the main TPP's that have been identified and how they have developed.

“You recognised in the File how, feeling uncertain of your worth or your rights, you try to do what others want and as a result feel used and resentful and still more uncertain about yourself. It also seems that you Mum's seeming indifference to your emotional needs left you with the belief that you must either be totally self sufficient or emotionally involved and doomed to be abandoned. Having managed your life without deep involvements, intimate relationships in your adult life seemed to confirm the above dilemma and reinforced your relationship with the bulimia. I also wonder how much you believe you have brought about the trouble that has occurred throughout your life and as a result believe that good things can't last, always sabotaging them with a 'but' or a 'whatever'.”

The above procedures were constructed from exploring both the caring relationships that Jackie experienced as a child and her current patterns of relating both to herself and others. The first procedure above is an example of Jackie's 'traps'. The 'traps' maintain her negative beliefs about herself as they usually generate forms of behaviour, which appear to confirm the beliefs (Ryle & Kerr, 2002). The second procedure is a 'dilemma'. A dilemma can be seen as a false choice or a narrow option, whereby people continue to act in ways they are unhappy with because the other option seems just as bad or worse. Although stating that she often feels lonely. The last procedure is a 'snag'. This 'snag' can prevent Jackie from achieving goals because (or as if) she believes that their achievement is undeserved.

As transference and counter-transference are a key part of the process and act as indicators of the reciprocal roles that may be present, I expressed to Jackie that the above patterns may occur in our relationship. For example, she may feel the need to please me to be accepted and hence may feel angry with herself and me because of that. She may also feel that being exposed and vulnerable is too dangerous to risk and it is important then that such feelings and patterns are discussed and explored throughout the therapy process.

When the letter was read out, Jackie expressed that it was 'spot on' but that it also felt quite depressing. She was able to reflect that she avoids thinking about herself as it can become too overwhelming. At this point, whilst remaining empathic, it felt important for me to remain in a hopeful position, providing Jackie with reassurance that the problems could be worked through but also remaining realistic about the work that this will entail.

7.7 Recognition and Revision

7.7.1 Bulimia symptoms and Jackie's relationship with food

As Jackie became more aware of the role that the bulimia had in her life, and monitored the times that she was sick, she was able to begin to explore the relationship she had with it further. She expressed that it had become a ritual; releasing the tensions of the day and thus enabling her to cope with the evening at home alone. My awareness of her attachment to it led me to be tentative about working on reducing her binge-purge cycle and we also focused on exploring other areas in her life, which she could build up, providing stronger scaffolding for the loss.

With the aim of reducing Jackie's ambivalence towards letting go of the bulimia, I introduced a motivational exercise that encouraged Jackie to write about the future. The exercise taken from Treasure and Schmidt's (1997) workbook asks the client to write two letters to a friend, five years into the future, firstly describing life free of the bulimia and the changes that have occurred and secondly describing life with bulimia still present. The letters were explored within the sessions and although Jackie stated that nothing new emerged, it helped to reinforce a future vision for her to work towards. This was illustrated by the length of Jackie's first letter being longer, more positive and enthusiastic, whilst the second was shorter and more resolute.

Jackie began conducting what I encouraged her to think of as experiments, with food and eating patterns, to make them seem less daunting. As Jackie has used the binge/purge cycle as a coping mechanism for many years, the perceived loss associated with giving up this cycle was great and thus a gradual approach was needed. Much of the direct work with the bulimia symptoms was carried out using CBT methods within the context of the procedural model (Ryle, 2002); challenging Jackie's existing patterns of thought and behaviour and gradually introducing new

coping strategies and ways of relating. Jackie had stated that the main triggers for the binge/purge cycle were bad planning with regards to food, stress at work and avoidance of the feelings of loneliness. Essentially the eating disordered behaviours seemed to ask as both a comfort and an emotional release. Commonly the antecedent cues leading to bingeing are fear of abandonment and unexpressed anger or disappointment (Ryle, 2002).

Jackie began reducing the number of times she vomited during the week. She using distraction techniques discussed in the sessions such as phoning her close friend after her meal and eating lighter meals in the evening, making it easier to keep the food down with less resulting guilt.

Once started, Jackie continued to make gradual progress with her bulimic symptoms often with little support or guidance. I wondered whether the presence of the therapeutic relationship and the outlet it provided, offered Jackie enough support to feel confident enough in her ability to eliminate the remaining episodes of bingeing and purging. What was important at this stage was to consider Jackie's relapse signs so that she would be able to target any difficulties at an early stage.

Following a two week holiday to her parents villa, Jackie reported that she had only been sick once and after this period Jackie was able to resist bingeing or purging, which felt like a great achievement.

As Jackie left her old coping mechanism behind she began to experience some anxiety around feeling the emotions that she had so often alleviated using the binge/purge cycle. The emergence of these feelings and how Jackie coped with them became the next phase of our work together.

7.7.2 Issues of transference and countertransference

To enable me to bring the transference and counter-transference observations into the room, we worked on creating a sequential diagrammatic reformulation (SDR) or a map of Jackie's roles, procedures and core pain (see Fig. 9). As Anthony Ryle describes them

"In their simplest form they are flow charts, which may arise from an initial joint sketch of a patient's core 'subjective self', linking aims to outcomes and indicating how problem procedures fail to achieve the intended aim." (Ryle & Kerr, 2002)

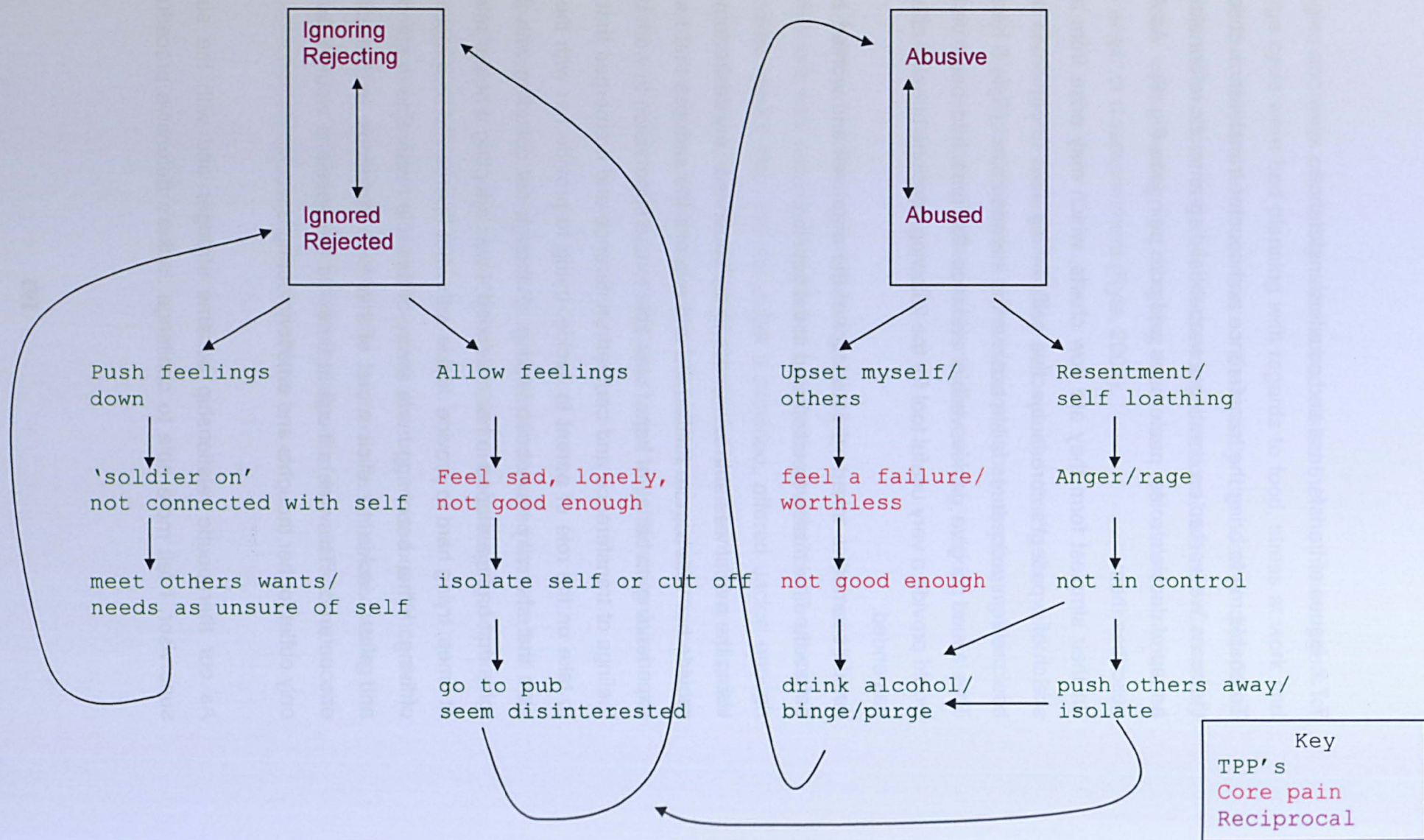
This aimed to give Jackie visible evidence that she had been understood and would provide a very useful tool for the following sessions but also after the therapy has ended.

Jackie seemed to take to the concept of the map well and worked on it at home before the final draft was completed in the session.

Using the map, I was able to express to my supervisor, my desire to nurture Jackie, provide her with a more fulfilled life and express the sadness that I seemed to be experiencing on behalf of her. I was able to use supervision to work through these feelings of transference and countertransference and it emerged that I was drawn to take on the role of parent to Jackie, trying to provide her with the elements of care that she may have been lacking. Although not colluding with the reciprocal roles that had developed in her childhood, I was adopting a helper role excessively at times, trying hard to provide Jackie with what I perceived as a more positive way of living. When becoming more aware of this role I was able to stand back from it and allow Jackie to elicit more of her own solutions to the difficulties she encountered. This was difficult at times as the sessions would often be Jackie's only outlet for her thoughts and emotions during a week.

As our therapeutic relationship became stronger and with the support of my supervisor, I felt more able to challenge Jackie's defensive procedures of either

Fig. 9 - Sequential Diagrammatic Reformulation (SDR) for Jackie



soldiering on or cutting off within the sessions. When these procedures were enacted, the transference that I experienced was different from the expressed affect. An example of this was Jackie saying that she was happy living alone, when the feelings that I experienced were sadness and hopelessness. Jackie seemed to have developed self-statements that she believed to be true and were protective but that didn't seem to be congruent with the underlying feelings that she may have learned to suppress, as they were too overwhelming.

7.7.3 Social anxiety and isolation

To avoid trying to provide too many solutions for Jackie, I worked in supervision on finding techniques to encourage Jackie to broaden her support network and occupy her time in a way that didn't reinforce her negative procedural sequences. Jackie expressed a lot of anxiety around entering social situations where she would have to talk to people she didn't know and engage in new conversations. Jackie's typical procedure in this situation would be to freeze with anxiety as she didn't feel that she had anything to say but appear disinterested from the outside, seeming to push people away, confirming her sense of her inadequacies.

Jackie also spoke about occupying her time by going to the pub most evenings to avoid facing her own thoughts. This coping mechanism allowed her to stay 'cut off' from her feelings and provided her with company although she did not speak to people. Jackie seemed reluctant to explore what the pub meant to her and often when she was speaking in the sessions, I would feel both sad and a desire to look after Jackie, feeling that she needed nurturing and to be valued.

At this time in the therapy, Jackie and I worked on increasing alternative activities in her life and I supported Jackie in conducting behavioural experiments as a way of challenging her negative attitudes/beliefs and beginning to have different relationships with herself and others.

As Jackie began to move away from her usual patterns of relating she became more anxious and unsure of herself at times and the sessions became a balance of supportive counselling, with empathic reflection of Jackie's difficulties feelings and more challenging, change focused work. Over the course of the therapy but particularly at these times, I wanted to offer Jackie a validating relationship, where she felt comfortable to express her feelings. The aim of this was to provide a positive reciprocal role for Jackie, different from those illustrated on her SDR.

In relation to CAT theory and the ideas of Vygotsky that are use to understand the process of therapy, this part of the therapy with Jackie seemed to illustrate working in the Zone of Proximal Personality Development (ZPPD). This indicates working within the space between current performance and the level of which could be achieved, particularly in developing 'self-processes', with the help of a more competent other (Ryle, 2002).

Examples of the positive changes that Jackie had been able to make were, joining a yoga course, sharing feelings with people at work and challenging herself to join in conversations in social situations despite feeling 'stupid' and 'uninteresting'. Jackie was able to show resilience and determination, despite feeling very anxious at times and this was reinforced in the sessions.

After undertaking some behavioural experiments such as attending different social events and sharing feelings that she would have usually kept within, Jackie began to see some positive results, which had a knock on effect on her confidence. This was evident in the sessions as she expressed her opinions more confidently and in her body language and visual appearance.

In my role as therapist, I was aware of what Jackie had told me at the beginning of the therapy about her pattern of slipping back into old behaviour when her sessions had ended and I wanted to work towards reducing the risk of this happening again. I was aware this was a difficult task as I felt it involved increasing reliable external

support structures and had to process the feelings associated with my inability to control these factors. I was also careful to monitor in supervision that the goals for Jackie came from her wishes and not from my own value system.

7.7.4 New relationships

A turning point in the therapy occurred when Jackie commenced a new romantic relationship. At this time, Jackie had not entered the binge/purge cycle for about four weeks and was continuing to progress in areas such as work, social life and self-confidence. Although Jackie expressed great happiness, I could not help but feel concerned about the timing of this relationship in terms of the impact it would have on Jackie's progress. This concern was discussed in supervision and seemed to be in contrast to wanting Jackie to increase her support network and reflected the need to protect Jackie I experienced. This countertransference became a theme in my relationship with Jackie throughout her relationship with Pete and was monitored in my supervision process.

From early on in the relationship it appeared that Jackie was repeating elements of the reciprocal roles on her SDR in that Pete seemed to provide conditional attention and affection leading Jackie to feel ignored and rejected at times. This at times would also lead Jackie to become abusive towards herself in her self-critique and subjugation of needs.

Over the course of the relationship Jackie would use the sessions to monitor her internal and external procedures and although aware that she may be repeating negative patterns such as trying to please Pete and putting her own needs aside, she found it hard to revise them.

We discussed and Jackie recognised how her sense of self 'disappeared' when talking about Pete and issues in their relationship, as if he was all consuming.

In supervision I explored my disappointment at how the relationship had interfered with Jackie's great progress and my anger towards Pete and his treatment of

Jackie. I was able to express some of these feelings to Jackie and we discussed them openly.

Although the relationship has now ended, Jackie continues to work through the impact it had on her and the rejection issues that are still a strong feature of her self-concept. We use the map/SDR to retrospectively explore the procedures that Jackie went through and the emotions she experienced. Although to Jackie, experiencing these emotions was distressing, we discussed how this reflected progress in that she would previously have turned to bingeing to cope. Jackie acknowledged this but also felt at times that it would be easier to be bulimic again.

This relationship seemed to raise Jackie's awareness of and bring to the surface her core pain of not feeling good enough and the fear of rejection that follows. Without the bulimia to guide her through this difficult time, Jackie has struggled with the intensity of the emotions she experienced but has shown determination and a belief in herself that has enabled her to continue to recognise and revise her patterns of relating.

7.8 Future work

Since the end of her relationship, Jackie is beginning to regain strength in herself and we are resuming work on increasing Jackie's sense of fulfilment from life and highlighting her strengths.

Jackie continues to struggle with directly experiencing and processing intense emotions, without the support of the bulimia and we will aim to develop new procedures and roles that will help her cope more effectively.

By offering Jackie a different relationship within the therapy I hope to continue to provide Jackie with validation and support, and the opportunity to express herself without being rejected.

Although there has been a lot of progress made in terms of the presenting problem of bulimia, without these symptoms, Jackie's core pain and the procedures

associated with this seem to be more exposed. This is now leading us into a new phase of our work, which for Jackie seems to be both overwhelming and productive.

7.9 Reflections on case and learning

It was difficult to illustrate nearly a years worth of therapy into one case study without feeling like there are parts missing. Within the study I aimed to show Jackie's journey and the progress she has made, alongside the difficulties and work still to do.

In support of the work that has been achieved, I believe CAT has offered Jackie a way of thinking about her difficulties that has allowed her to remain aware of the negative patterns that have developed and to begin to revise them. Through this approach and elements of CBT Jackie managed to free herself from the binge/purge cycle. On the surface it seemed that the goal of Jackie's therapy had been achieved, however, it is emerging that the more difficult work related to Jackie's relationship with herself may only be beginning.

In critique of the work, looking back it seems I had difficulty at times to avoid the role of protector, which I felt drawn to. This may have supported Jackie but did not allow her to develop further understanding of herself, as I was not working in the therapy 'as if in her shoes'. However, the development of the SDR allowed an open discussion of the transference and countertransference both within supervision and the sessions and avoided collusion with the existing reciprocal roles.

At times when I provided Jackie with solutions and new coping strategies, on reflection it would have been beneficial to guide her towards her own solutions. Offering solutions may also have been a result of wanting to help Jackie to progress quicker however allowing the process to emerge may produce sustained change on a more long-term basis.

The therapeutic process for Jackie reflects elements of new understandings and progress alongside difficulties and relapses into old patterns. Jackie's difficulties after combating the symptoms of bulimia are indicative of the profile of bulimia as a

disorder in that the symptoms develop to manage inter and intra-personal difficulties and without the symptoms the underlying difficulties come to the forefront.

As a therapist, throughout my work with Jackie I have furthered my ability to use transference and countertransference within the session, something that I can find difficult at times. Jackie's determination and openness has taught me to trust in her ability to work through her difficulties, which is in turn transferred to my work with other clients.

The progress that has been achieved has also impacted on my confidence as a private therapist. At times, particularly when working with eating disorders, working privately can be very anxiety provoking and also frustrating in that progress can often be minimal. Supervision has allowed me to preserve my sense of competence as a therapist, and continue to enjoy my work with this client group.

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8. Section D – Critical review of the literature
The importance of the family in understanding and
treating adolescent eating disorders – a review

8.1 Introduction

When considering the recent literature on adolescent eating disorders, much attention has been devoted to the role of the family both in the development and the outcome of the eating disorder. This, however, is not a new phenomenon and from the time of the earliest descriptions of anorexia nervosa (AN) in the nineteenth century, the possible influence of the family both as a precipitating and maintaining factor of the eating disorder has been highlighted (Lasegue, 1873; Gull, 1874; Charcot, 1889).

Charcot, 1889, described the influence of the parents as 'particularly pernicious' and the family of the individual with an eating disorder at this time was generally viewed as somewhat pathological and as something that needed to be removed in order for the individual to make a recovery. Charles Lasegue, however, took a slightly more positive stance and stated in 1873 that he always considered the 'preoccupations of the parents side by side with that of the patient'.

Although communicated slightly more sensitively, these views have continued to be reflected in the literature up until the present day, with the family being depicted as both a resource and a hindrance. Eisler et al, (2000) conveyed that the family should be involved in the treatment of the eating disorder as they are part of the solution, whereas Minuchin et al (1978) suggested several negative characteristics as typical of families of anorexia sufferers, including; rigidity, enmeshment, overprotectiveness, conflict avoidance and poor conflict resolution. Although these opinions and theories appear different, it seems that it is the focus that is different in that Eisler et al are more solution focused whereas Minuchin et al are more problem focused but both view the family as an important factor to consider. When considering the different viewpoints, another issue that has raised many questions is the time of onset of family difficulties or traits. It could be argued that they were present before the eating disorder or that the disorder may have influenced the family, distorting dynamics and relationships. (Webster & Palmer, 2000).

When examining the literature, the two main themes in relation to the family that arise are firstly related to the cause/origin of the eating disorder and the family's part in this and secondly the part that the family plays in the treatment of the eating disorder and to what degree this is important or effective. The following review will be structured in respect of these two themes. The literature used was identified using a thorough electronic search of the databases, PsycINFO, MEDLINE and CINAHL with the aim of focusing on articles published after 2000. Studies were selected using the search terms eating disorders, anorexia nervosa, family therapy, family and treatment, interchangeably.

8.2 Family functioning

Family systems formulations of anorexia, pioneered by Minuchin et al. (1978) and Selvini Palazzoli (1978), point to a number of organisational features of families that may predispose youngsters to developing anorexia or maintain the condition once it emerges. Selvini Palazzoli (1978) pinpointed the following features as typical of the anorexic family: an ethic of self-sacrifice, the rejection of personal leadership by the parents, blame-shifting, unclear communication and secret alliances between parent and child which go hand in hand with marital dissatisfaction. Available empirical evidence, however, clearly shows that there is not a single dysfunctional family constellation that causes anorexia and bulimia.

Many of the controlled studies that have been carried out have used self-report measures to compare control groups to eating disordered groups with few observational studies due to the complexities of carrying out such research with families. The review will now cover some of the more recent research in this area to provide an overview of current ideas. The current literature can be split into studies on current family relationships and functioning and familial predisposing factors for the development of an eating disorder, although there is a degree of overlap between the two.

Beginning with studies on current family functioning/relationships, the significance of parental relationships in the development of eating disorders was addressed by Solomon et al. (2003). They investigated perceived relationships between parents and their daughters with AN from both the parent's and the child's perspective. The participants consisted of 31 women with AN, 31 control women, and the parents of both groups. The Parental Environment Questionnaire (PEQ) showed no differences between the eating disorder and control groups, and when there were differences, they were not specific to families with a daughter with AN. These results may have been different however had they been carried out when the individual with the eating disorder was an adolescent rather than a grown woman as your perceived relationship with your parents changes over time.

Also focusing on parents and daughters, Espina (2003), investigated alexithymia (a concept that describes the inability to put emotions into words) among 73 parents of daughters with an eating disorder (AN & BN) as well as the parents of 72 normal female controls. Comparisons were made using the Toronto Alexithymia Scale (TAS-20), the Eysenck Personality Questionnaire (EPQ), the Beck Depression Inventory (BDI) and the Self-Rating Anxiety Scale (SRAS). It was found that parents with a daughter with an eating disorder reported higher scores on the TAS-20, which were associated with neuroticism, anxiety and depression. One could argue however, that the experience of living with a child with an eating disorder could induce all of the aforementioned states due to the pressure it places on family relationships and family living overall and again the question arises of the whether such states are as a response to – rather than generating- the symptoms of an eating disorder?

Also highlighting the level of family dysfunction within eating disordered families, McDermott et al. (2002) compared 80 children and adolescents with AN, BN and eating disorder not otherwise specified (EDNOS) with 'community norms' resulting from the Western Australian Child Health Survey and found that the eating disordered participants had significantly higher scores for in family dysfunction than the norm. McGrane and Carr (2002), identified those specifically at risk from

developing an eating disorder and examined their family functioning as compared to individuals with full-blown cases of the disorder. The 'at risk' group scored significantly higher than the control group for family problems in general functioning as well as roles, affective responsiveness and problem solving. The 'at risk' group also reported that their mothers had more problems with depression, anxiety and sensitivity.

When focusing on the cause and effect process, if difficulties in family functioning were a consequence of having an adolescent with severe anorexia nervosa, one might expect an association between severity of the condition and difficulties in family functioning.

Wisotsky et al (2003) used the Family Adaptability and Cohesion Evaluation Scale II (FACES II: Olson, Portner and Bell, 1982) and the Eating Disorder Inventory 2 (EDI-2: Garner, 1991) to assess the reported level of family functioning (by the patient) and its relationship to the level of eating disorder pathology and diagnosis in a day-patient population. Over the AN, BN and EDNOS groups, there were connections (for example) to 'confusion in recognising emotional states', 'feelings of general inadequacy' and 'lack of control over one's life', all of which appeared to increase as their perceptions of their families indicated less cohesiveness (disengaged) and less adaptability (rigid). Although this study has limited generalisability due to the small and homogenous sample, its results support the earlier idea of Minuchin et al, (1978) that as the family dysfunction increases, the extent of the eating disorder behaviour also increases. This research again supports the proposal that family dysfunction may be a predictor and/or a symptom of eating disorder pathology.

In contrast to this, Gowers and North (1999) have demonstrated that this is not the case. Although agreement between the family members in the study was poor, those with eating disorders tended to be less critical of their families where the condition was more severe. It may then be that families faced with a life threatening condition like AN will tend to avoid conflict regardless of whether or not they tended to do prior to the onset of anorexia.

Despite the inconclusive evidence detailed above, one clear goal of researching family factors associated with eating disorders is to develop criteria from which those at risk for anorexia and bulimia can be identified. Early identification introduces the possibility of preventing eating disorders from even developing by combating specific environmental triggers, which might include family characteristics or functioning. Unfortunately, most of the existing literature is based upon correlational data, and does not yet allow this predictive power. While consistent factors do emerge as significant family characteristics associated with eating disorders, recent literature suggests that these factors, including low cohesion, lack of emotional expression, and high conflict, may simply be characteristics of a distressed family, rather than specifically characteristic of eating disordered families. Although difficult to draw definite conclusions from these occasionally unclear data, all research that can further clarify any aspect of an eating disorder is useful; each piece of information can contribute to a more complete understanding of these difficult disorders, and each potential factor influencing the aetiology of eating disorders is therefore worth investigating.

Moving on to the search for predisposing factors (although it is difficult to separate predisposing and maintaining factors), in an examination of the relationship between parental bonding and the core beliefs of those with eating disorders, Leung, Thomas and Waller (2000), found that overall both anorexic and bulimic women recalled higher levels of unhealthy parental bonding behaviours than the comparison group. For example, both low maternal and paternal care were highly predictive of unhealthy core beliefs in anorexic women, but only weak links were found in bulimic and comparison groups.

In a controlled study focusing on such factors, Shoebridge and Gowers (2000) compared forty consecutive referrals of adolescent girls with DSM-III-R anorexia nervosa with matched controls using obstetric records and maternal interviews. They found that an overprotective or 'high concern' style of parenting is common in

children who subsequently develop anorexia nervosa and that this can in a number of cases be explained by an earlier obstetric tragedy.

Clinical and population studies of women have also consistently demonstrated an increased association between major depression and AN (Strober & Katz, 1988). The findings show depression as being a risk factor for the development of eating disorders in adolescence (Patton et al, 1999) and elevated rates of major depression in first-degree relatives of women with AN. Although it has been suggested that AN and major depression share a common aetiology, it has also been suggested that the risk for AN is distinct from that of any other affective disorders. However, many of the features of depression can also result secondarily from starvation and improve with weight restoration.

A contribution by families to the causation of eating disorders has face validity and is supported by clinical observation and research, yet it is not easily explained in terms of passing through the family generations. General parental factors have been explored, as well as the influence of maternal eating disorders upon offspring. Von Ranson et al. (2003) determined whether maternal eating disorder or parental substance use/misuse was associated with high levels of disordered eating in the children. They found that daughter's disordered eating correlated significantly with maternal eating disorder, but there was no association between eating disorders and substance use disorder across generations. A study by Cooper et al. (2004) examines family environmental factors that may potentially link childhood feeding problems and maternal eating disorder. They found that two environmental variables, 'mealtime disorganisation' and 'maternal strong control and disharmony' were shown to mediate the association between child and maternal disturbance.

Despite the lack of conclusive evidence it is apparent that eating disorders do aggregate in families. Rates of anorexia and bulimia nervosa are higher in the first-degree relatives of index patients (Strober et al, 2000). Genetic factors are suggested to account for up to half of the variance in eating disorders; however more work it is indicted that more work is needed to clarify this indication. Most would agree that environmental and genetic factors, such as contrasting parental

treatment or peer group characteristics, influence the differential expression of eating disorders in siblings (Klump et al, 2002).

A number of authors have argued recently (e.g. Treasure and Schmidt, 2006) that explanatory models which focus primarily on aetiology are less likely to be useful in guiding treatment than models of maintenance of symptoms. Family systems accounts of anorexia nervosa have tended to blur this distinction by implying that the factors that led to the development of the disorder are still operating and are in effect also maintaining the problem. This lack of differentiation has directed the focus of research virtually entirely to the question of 'what is the nature of families with anorexia?' The fact that this research has at best shown that certain family features may be associated with anorexia nervosa but do not provide an explanation of its origin means that it is difficult to argue that such features should be targets for clinical intervention (Eisler, 2005). If the questions of aetiology and maintenance are separated, other types of questions about family functioning arise which are more relevant from a treatment point of view (e.g. are there differences between families of those who recover rapidly and those who remain ill for a long time?; what family features help or hinder the therapeutic process?; do different types of family respond better to different types of treatment?).

8.3 The family and treatment of the eating disorder

The 'family therapy movement' began to gather speed following the pioneering work by Salvador Minuchin and Mara Selvini Palazzoli in the 1970's, who believed that the family's dynamics and/or approach to managing problems needed to be corrected in order for patients to recover from AN. The high level of prestige the observations of these two great practitioners have earned has given great impetus to the application of family therapy (FT) to the treatment of eating disorders.

Initially, the rationale for the use of family interventions was based on the notion of the 'anorexogenic family' but empirical study has failed to support the aetiological role of family dysfunction and the model fuels concern about blaming parents. An approach such as this in practice can create barriers and often leave parents feeling hopeless and disempowered.

Family interventions have thus developed as treatments which mobilise family resources whether delivered as 'conjoint' family therapy, separated FT in which parents and child are seen separately) or 'parental counselling'.

The notion that families or parents of eating disorder patients are characterised by a greater degree of psychopathology than controls is not upheld in the Maudsley family based treatment model (Le Grange et al, 2003)

In line with those who found families essential in the treatment of AN, Christopher Dare and colleagues at the Maudsley Hospital devised a treatment that involves families, but that opposes the tradition of finding families pathological. Instead, Dare takes an 'agnostic' view of the cause of AN and suggests that the family is the most important resource at the therapists disposal to ensure recovery. As a result, the Maudsley approach incorporates elements of a variety of treatment methods, including the use of family meals, specific techniques for family empowerment, a non-authoritarian therapeutic stance and externalising the illness from the patient and family. This treatment does not assume that 'changing family pathology' is a prerequisite for a successful outcome of treatment but that families constitute a vital resource and strength.

In recent years there has also been much interest in working with groups of families systemically. In multiple family therapy, the presence of other families highlights not only similarities but also differences between them, whereby families become curious about how others manage difficulties and new and different perspectives are introduced. Peer support and peer criticism are known to be powerful dynamics that can promote change and feedback from fellow sufferers can be perceived more credible than from staff due to others direct experiences of the difficulties (Asen, 2002). It is likely that its cost effectiveness in times of limited resources may play a part in the popularity of this approach. To date there have

been no randomised control trials to evaluate the effectiveness of this approach as a treatment in its own right but its acceptability and usefulness have been demonstrated through small scale audits and evaluations (Lim, 2000).

Overall, family therapy addresses the eating disorder as a problem of family life affecting all family members. With adolescents, the parents can often be helped to take a very active role to oppose the anorectic eating habits, with a major focus on ensuring the child's food intake is sufficient (Lask, 2000). Therapy usually emphasises the importance of parents working together on a consistent plan of management as well as offering mutual support to each other throughout this process. Parents often require some support doing this, as it is common for couples to be in conflict over the management of their child's eating disorder.

8.4 The effectiveness of family therapy

Despite family therapy being widely known as an effective form of treatment for eating disorders, the evidence base for this knowledge is comparatively small.

However, the clearest and most consistent findings about the effectiveness of family therapy for eating disorders have come from the evaluation of treatments for adolescents. A number of open follow up studies of adolescents with a relatively short history of anorexia nervosa have shown positive response to family therapy (Steinhausen et al, 1993; Strober et al, 1997; Lay et al, 2002).

As was shown by Minuchin, adolescents generally do well when the main treatment offered is family therapy. By the end of treatment between half and two thirds will have resumed a healthy weight. By the time of follow up between 60 and 90% will have fully recovered and no more than between 10 to 15% will be seriously ill. A striking aspect of these studies is the low rates of relapse after successful treatment particularly when compared to inpatient treatment, where 25-

30% relapse rates are typically reported after first admission rising to 55-75% for second and further admissions (Strober et al, 1997; Lay et al., 2002).

To date there have been five controlled treatment studies for adolescent anorexia nervosa involving family therapy.

The first (Russell et al, 1987) compared family therapy with individual therapy in a trial of adolescents and adults whose weight had been restored in a specialist in-patient service. The results from the adolescents within the group show that those with an onset before the age of 18 and a history of the illness being under three years (n = 21) found family therapy significantly more effective than individual therapy. However for those who had been ill for longer than three years, the outcome was generally poor, with inconclusive findings in relation to more effective treatment mode. At five year follow up (Eisler et al, 1997), the short term duration sub group who had received family therapy continued to do well, compared with those who had received individual therapy, who had mostly improved but were less likely to make a full recovery.

Secondly, Robin et al (1994, 1999) compared the effectiveness of Behavioural Family Systems Therapy (BFST) with Ego-Oriented Individual Therapy (EOIT) in 37 adolescents with AN. The comparison individual therapy included weekly therapy for the adolescent and a separate 3-weekly support meeting for the parents. At one year follow up; both therapies were effective with relatively little difference on weight at end of treatment, or on psychological measures. However, over time, the BFST group had a greater change in body mass index (BMI), with 94% resuming menstruation compared with 64% of the EOIT group.

Le Grange, Eisler, Dare and Russell (1992) and Eisler et al (2000), the third and fourth controlled studies, report the results of a randomised treatment trial of conjoint family therapy (CFT) compared with separated family therapy (SFT), in which patients were seen on their own with their parents being seen separately by the same therapist. Overall, when measuring outcome, the two forms of therapy were associated with equivalent end of treatment results. However, for those patients with high levels of maternal criticism towards the patient, the SFT was shown to be superior to the CFT in the Eisler et al. study and overall, the Morgan

Russell Outcome Measure showed that at one year SFT was favoured based on comparison between good vs. intermediate and poor outcomes. The Le Grange et al. trial also found similar results in that there was a trend for the SFT group to do slightly better in terms of weight gain and the Morgan Russell Outcome Measure than the CFT group. The differential effect of maternal criticism in the two treatments suggest that there might be different processes involved in the outcome of therapy in these forms of family intervention.

With these and other previously mentioned studies, caution needs to be taken when interpreting or generalising from the findings as all studies use a fairly small sample (no larger than $n = 50$). Much of the body of literature is also dominated by the same practitioners, which may demonstrate a limited and specific way of working with a similar population. The studies also generally compare two forms of family based intervention, whereby a more marked difference may be demonstrated by entirely different interventions, however with an adolescent group, it does not seem ethical to exclude the family from treatment altogether. It is important to recognize that there has been hardly any research comparing family therapy with other treatments. Cognitive or psychodynamic treatments are described in the literature (Bowers et al., 1996; Jeammet and Chabert, 1998) and are often used in clinical practice, but, with the exception of the final controlled study by Ball and Mitchell (2004), who compared Behavioral Family Therapy with Cognitive Behavioural Therapy, they have not been systematically evaluated with adolescent anorexia nervosa and their relative merits in comparison with family therapy are not known.

When considering how such studies could be further improved it may be interesting and beneficial to measure a baseline rate of family members engagement and motivation throughout treatment so that a relationship could be drawn between this factor and how well the individual progresses. Looking at why particular families do better than other throughout the recovery process may provide more clinically useful results than trying to determine a prototype of the 'eating disordered family'.

The common findings in all studies, is that treatment that encourages parents to take charge of the adolescent's eating are effective in bringing about both symptomatic and psychological change. Involving the parents in a way that is supportive and understanding of their child but that encourages them to step back from trying to influence their eating (EOIT treatment in Robin et al, 1994) appears slightly less effective.

On the basis of the evidence from these studies, several reviewers (e.g. Wilson and Fairburn, 1998; Carr, 2000) have concluded that family therapy, alongside individual therapies such as cognitive behavioural therapy, is the treatment of choice for anorexia nervosa. This is also reflected in the recommendations in the recently published treatment guidelines for eating disorders from the National Institute of Clinical Excellence in the United Kingdom that 'family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa (NICE, 2004, p.65).

8.5 Summary of important findings

Focusing on the role of the impact of family functioning/relationships on the development and maintenance of eating disorders in adolescents, from the studies reviewed it can be stated that family dysfunction is only one example within the aetiology of eating disorders and has limited predictive power (Stice, 2002). It can also be said that although it is not essential for the development of these conditions, it remains a significant factor in a proportion of sufferers. This ties in with the findings that have highlighted differences between the familial experiences of AN and BN sufferers and that of controls (e.g. Shoebridge and Gowers, 2000).

However, a question that remains present throughout this review relates to the direction of causality and whether families are responding to or generating symptoms of eating disorders? A further question relates to whether dysfunctional characteristics that are present are borne out of a distressed family in general rather than being particular to eating disordered families?

These are important questions to raise and draw attention to fundamental flaws with the overall direction of the research at present. By focusing purely on aetiology and not distinguishing between the development and maintenance of symptoms, some of the research has become stuck into trying to determine the nature of families with eating disorders. Also, to be focusing on causal relationships between family functioning and eating disorders seems to moving into trying to develop a model when the basic knowledge of whether there are familial factors that particularly relate to eating disorders is not yet clear.

Despite the inconclusive evidence about family dynamics and pathologies, there is robust evidence for the efficacy of family therapy in eating disorders of early onset and short duration (Eisler et al., 2000). Although there are methodological limitations with the studies measuring the outcomes of family therapies, such as sample size, (e.g. Lay et al., 2002) the results show that the main benefits appear to be in the long term prospects of recovery when involving the family in treatment on a positive and proactive way. The importance of engaging the family, together with the patient, in treatment cannot be overstated, with those involved in conjoint family therapy demonstrating better long term recovery prospects than those receiving separated family therapy. Thus families are an important resource in the recovery of adolescents with eating disorders, while recovery appears to be optimal if patients are treated early in course of their illness, which in turn, provides preliminary support for adolescent interventions as paramount in preventing the development of more chronic and relentless forms of this illness. To conclude and in contrast to the early ideas of Minuchin (1978) of a 'parentectomy', to exclude the family in the treatment of the eating disorder is to lessen the chances of therapeutic gain.

8.6 Future directions

More clinically relevant research may begin to focus on differences between families that progress well through the recovery process and those that don't and what factors help or hinder this process. Studies relating to the motivation of families in the recovery process may also help to determine outcomes of treatment. With regards to the methodological difficulties encountered, it may be useful to consider using data from existing cohort studies following the development of children in the general population to look for factors that those who then develop an eating disorder have in common. Such research may clarify the reported role that family pathology/interaction/dynamics plays in the development of eating disorders

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9. APPENDICES

9.1 APPENDIX 1. – ORIGINAL VERSION OF THE URICA



Cancer Prevention Research Center

Measures

- [About CPRC](#)
 - [Faculty, Staff & Students](#)
 - [Resources & Environment](#)
 - [Survey Center](#)
 - [Job Opportunities](#)
 - [CPRC News](#)
 - [Contact CPRC](#)
- [Transtheoretical Model](#)
- [Publications](#)
- [Measures](#)
 - [Other](#)
 - [URICA \(Long Form\) \(University of Rhode Island Change Assessment\)](#)
- [Interventions](#)

"CPRC - A research organization dedicated to helping people change their behavior for living longer, healthier lives"

Other: URICA (Long Form) (University of Rhode Island Change Assessment)

This questionnaire is to help us improve services. Each statement describes how a person might feel when starting therapy or approaching problems in their lives. 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. For all the statements that refer to your "problem", answer in terms of what you write on the "PROBLEM" line below. And "here" refers to the place of treatment or the program.

There are FIVE possible responses to each of the items in the questionnaire:

1 = Strongly Disagree 2 = Disagree
3 = Undecided 4 = Agree
5 = Strongly Agree

1. As far as I'm concerned, I don't have any problems that need changing. ☐
2. I think I might be ready for some self-improvement. ☐
3. I am doing something about the problems that had been bothering me. ☐
4. It might be worthwhile to work on my problem. ☐
5. I'm not the problem one. It doesn't make much sense for me to be here. ☐
6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help. ☐
7. I am finally doing some work on my problem. ☐
8. I've been thinking that I might want to change something about myself. ☐
9. I have been successful in working on my problem but I'm not sure I can keep up the effort on my own. ☐
10. At times my problem is difficult, but I'm working on it. ☐
11. Being here is pretty much a waste of time for me ☐

- because the problem doesn't have to do with me. ☐
12. I'm hoping this place will help me to better understand myself. ☐
13. I guess I have faults, but there's nothing that I really need to change. ☐
14. I am really working hard to change. ☐
15. I have a problem and I really think I should work at it. ☐
16. I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem. ☐
17. Even though I'm not always successful in changing, I am at least working on my problem. ☐
18. I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it. ☐
19. I wish I had more ideas on how to solve the problem. ☐
20. I have started working on my problems but I would like help. ☐
21. Maybe this place will be able to help me. ☐
22. I may need a boost right now to help me maintain the changes I've already made. ☐
23. I may be part of the problem, but I don't really think I am. ☐
24. I hope that someone here will have some good advice for me. ☐
25. Anyone can talk about changing; I'm actually doing something about it. ☐
26. All this talk about psychology is boring. Why can't people just forget about their problems? ☐
27. I'm here to prevent myself from having a relapse of my problem. ☐
28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved. ☐
29. I have worries but so does the next guy. Why spend time thinking about them? ☐
30. I am actively working on my problem. ☐
31. I would rather cope with my faults than try to change them. ☐

32. After all I had done to try to change my problem, every now and again it comes back to haunt me.



Scoring

Precontemplation items	1, 5, 11, 13, 23, 26, 29, 31
Contemplation items	2, 4, 8, 12, 15, 19, 21, 24
Action items	3, 7, 10, 14, 17, 20, 25, 30
Maintenance items	6, 9, 16, 18, 22, 27, 28, 32

Description

The scale is designed to be a continuous measure. Thus, subjects can score high on more than one of the four stages.

Because the scale is still being validated, it is only available for research purposes. Therefore, to date there have been no cut-off norms established to determine what constitutes high, medium or low on a particular stage. And, again, the stages are considered to be continuous and not discrete.

In one analysis, we have done cluster analyses which have yielded smaller, more homogenous groups of subjects. Stage scores (i.e., means on each set of 8 items for each subject) have been converted to standard score (i.e., T-scores: mean=50, standard deviation=10). The cluster analysis was run on the standard scores of all 155 subjects, producing nine cluster profiles. For your scoring purposes, you could determine subjects' stage score (means, T-scores) and compare those to our nine profiles. Or you could do a cluster analysis and find out what profiles emerge from your sample. If you need a discrete measure of the stages for your research, you would have to use a nominal scale for the particular problem you are assessing. An example of such a discrete measure is reported in our article "Stages and Processes of Self-Change of Smoking: Toward an Integrated Model of Change", *Journal of Consulting and Clinical Psychology* (1983), 51, 390-395.

We would appreciate feedback and would be interested in your findings. We are expecting to have more cut-off scores for each of the stages in the near future.

References

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**9.2 APPENDIX 2. – CITY UNIVERSITY ETHICAL
APPROVAL FORM**

Appendix 4: Ethics Release Form

All students planning to undertake research in the Department of Psychology for degree or other purposes are required to complete this Ethics Release Form and have it signed by their supervisor and one other member of staff **prior to commencing the investigation**. Please note the following:

- An understanding of ethical considerations is central to planning and conducting research.
- The published Code of Ethics of the British Psychological Society (1997) Code of Conduct, Ethical Principles and Guidelines. BPS. Leicester and American Psychological Society (1992) Ethical Principles of Psychologists and Code of Conduct. American Psychologist, 47, no 12, 1597-1611 should be referred to when planning your research.
- Approval to carry out research does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, eg: Hospitals, NHS Trusts, HM Prisons Service, etc.
- Completed and signed ethics release forms must be submitted as an appendix in the final dissertation

Please answer all of the following questions:

- | | | | | | |
|----|---|-----|-------------------------------------|----|-------------------------------------|
| 1. | Has a research proposal been completed and submitted to the supervisor? | Yes | ☒ | No | ☐ |
| 2. | Will the research involve either or both of the following:
<u>2.1</u> A survey of human subjects/participants | Yes | ☒ | No | ☐ |
| | <u>2.2</u> An intervention with a cohort of human subjects/ participants, and/or an evaluation of outcome of an intervention? | Yes | ☐ | No | ☒ |
| 3. | Is there any risk of physical or psychological harm to participants (in either a control or experimental group)? | Yes | ☐ | No | ☒ |
| 4. | Will all participants receive an information sheet describing the aims, procedure and possible risks involved, in easily understood language? (Attach a copy of the participants information sheet) | Yes | ☒ | No | ☐ |
| 5. | Will any person's treatment or care be in any way prejudiced if they choose not to participate in the study? | Yes | ☐ | No | ☒ |
| 6. | Will all participants be required to sign a consent form, stating that they understand the purpose of the study and possible risks ie will informed consent be given? | Yes | ☒ | No | ☐ |
| 7. | Can participants freely withdraw from the study at any stage without risk of harm or prejudice? | Yes | ☒ | No | ☐ |
| 8. | Will the study involve working with or studying minors (ie <16 years)? | Yes | ☒ | No | ☐ |
| | If yes, will signed parental consent be obtained? | Yes | ☒ | No | ☐ |

9. Are any questions or procedures likely to be considered in any way offensive or indecent? Yes ☐ No ☒
10. Will all necessary steps be taken to protect the privacy of participants and the need for anonymity? Yes ☒ No ☐
- Is there provision for the safe-keeping of video/audio recordings of participants? Yes ☒ No ☐
11. If applicable, is there provision for de-briefing participants after the intervention or study? Yes ☒ No ☐
12. If any psychometric instruments are to be employed, will their use be controlled and supervised by a qualified psychologist? Yes ☒ No ☐

If you have placed an X in any of the double boxes further information below:

☒

, please provide

A questionnaire will be submitted to 12-16 yr olds who are involved in a clinical treatment process for their eating disorder.

Both the participants and their parents will be given information sheets and asked to sign consent forms.

The consultants in charge of their care will also be aware of the study and have given consent.

Ethics forms have been submitted to 2 ethics committees (Barret LREC + GOS/ICM Ethics Committee) and 1 are awaiting their approval.

All data will be anonymised and the participant will be aware that their responses will not have any impact on their treatment. To avoid any copying and competition with regard to inpatients, I will administer the questionnaire in small groups.

All details for contacting the researcher following the study are in the information sheet.

Student's Name: Melanie James

Degree Course: 3 yr - Counselling Psychology Programme

Title Of Research Project: Measuring motivation to change in young people with eating disorders: an application and validation of the University of Rhode Island Change Assessment

Supervisor: Stuart Merzies Questionnaire (UK (CA)

Signature of Student:
McJames

Signature of Supervisor:
Stuart A Merzies

Signature of a 2nd Psychology Department member:
John Ransom

Date: 13/11/03

Any further comments:

A completed copy of this form must be included in the appendix of your dissertation.

9.3 APPENDIX 3. – ETHICAL APPROVAL LETTERS

**Great Ormond Street Hospital
for Children NHS Trust / The
Institute of Child Health
Local Research Ethics Committee**

Institute of Child Health
30 Guilford Street
London
WC1N 1EH

Tel: 020 7905 2620
Fax: 020 7905 2201
Email: l.howe@ich.ucl.ac.uk

28th January 2004

Dr D Nicholls
BBSU
ICH

Dear Dr Nicholls,

**Title: Measuring motivation to change in young people
with eating disorders: an application and
validation of the University of Rhode Island
Change Assessment Questionnaire (URICA)**

R&D registration number: 03BS17

Protocol number/version: N/A

Notification of ethical approval

The above research has been given ethical approval after review by the Great Ormond Street Hospital for Children NHS Trust / Institute of Child Health Research Ethics Committee subject to the following conditions.

1. Your research must commence within twelve months of the date of this letter and ethical approval is given for a period of six months from the commencement of the project. If you wish to start the research more than twelve months from the date of this letter or extend the duration of your approval you should seek Chairman's approval.

You must seek Chairman's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature, eg. using the same procedure(s) or medicinal product(s). Each research project is reviewed separately and if there are significant changes to the research protocol, for example in response

to a grant giving body's requirements you should seek confirmation of continued ethical approval.

3. Researchers are reminded that REC approval does not imply approval by the GOS Trust. Researchers should confirm with the R&D office that all necessary permissions have been obtained before proceeding.
4. It is your responsibility to notify the Committee immediately of any information which would raise questions about the safety and continued conduct of the research.
5. On completion of the research, you must submit a report of your findings to the Research Ethics Committee. You may also be required to submit annual reports.
6. Specific conditions pertaining to the approval of this project are:
 - The use of the enclosed standard consent forms for the research. A copy of the signed consent form must be placed in the patient's clinical records and a copy must be kept by you with the research records.

Yours sincerely



Laura Howe
Research Ethics Coordinator

Barnet, Enfield & Haringey Local Research Ethics Committee

Holbrook House,
Cockfosters Road,
Barnet EN4 0DR.
Herts.

Tel: 020 8272 5699

Fax: 020 8272 5691

Email: alison.okane@enfield.nhs.uk

4th December 2003

Ms. M. James,
44 Columbia Road,
London E2 7NN.

Dear Ms. James,

03/124: Motivation to change in eating disorders

Acting under delegated authority I write to acknowledge receipt of your e-mailed message dated 3rd December and the enclosed clarification requested by the LREC in our letter to you dated 1st December. There is now no objection on ethical grounds to the proposed study. I am therefore happy to give you the favourable opinion of the LREC:

Paperwork reviewed

LREC application form

Protocol

Patient Consent form

Patient Information sheet

CV of lead researcher

Finalised questionnaire

Please note that this opinion alone does not entitle you to begin research

The Barnet, Enfield & Haringey LREC considers the ethics of proposed research projects and provides advice to NHS bodies under the auspices of which the research is intended to take place. **It is the NHS body, which has the responsibility to decide whether or not the project should go ahead**, taking into account the ethical advice of the LREC. Where these procedures take place on NHS premises or using NHS patients, the researcher must obtain the agreement of local NHS management who will need to be assured that the researcher holds an appropriate NHS contract and that indemnity issues have been adequately addressed.

The following conditions apply to this project

- The LREC will require a copy of the final report on completion of the project and require details of the progress of the project periodically (i.e. annually for longer projects)
- The committee must receive immediate notification of any adverse or unforeseen circumstances arising out of the project.
- If data is to be stored on a computer in such a way as to make it possible to identify

individuals, then the project must be registered under the Data Act 1998. Please consult your department data protection officer for advice.

- Failure to adhere to these conditions set out above will result in the invalidation of this letter of no objection.

I confirm that LRECs are fully compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH) guidelines as they relate to the responsibilities, composition, function operations and records of an Independent Ethics Committee/Independent Review Board.

Please forward any additional information/amendments regarding your study to the LREC Co-ordinator at the above address.

Your application has been given a unique reference number 03/124, please use it on all correspondence with the LREC.

Yours sincerely



Alison O'Kane
LREC Co-ordinator
Barnet, Enfield & Haringey

9.4 APPENDIX 4. – AMENDMENTS REQUIRED BY ETHICS BOARD.

**Great Ormond Street Hospital
for Children NHS Trust / The
Institute of Child Health
Local Research Ethics Committee**

Institute of Child Health
30 Guilford Street
London
WC1N 1EH

Tel: 020 7905 2620
Fax: 020 7905 2201
Email: l.howe@ich.ucl.ac.uk

10th December 2003

Dr D Nicholls
BBSU
ICH

Dear Dr Nicholls,

03BS17 Measuring motivation to change in young people with eating disorders: an application and validation of the University of Rhode Island Change Assessment Questionnaire (URICA)

Your application was considered by the Research Ethics Committee on Wednesday 3rd December 2003 and will be given approval subject to a satisfactory response to the following points:

- The Committee notes that there was no ethical approval for the pilot, which was conducted at GOSH ✓
- Who carried out the modifications to the questionnaire, and has the questionnaire been validated?
- The Committee felt that the questionnaire was repetitive and also quite long, but accept this may be inevitable within the structure the researchers wish to use
- Information sheets:
 1. The word 'intervention' should be replaced with 'treatment' or 'approach'
 2. In the information sheet for parents, the phrase 'young person' should be replaced with 'your child'
 3. In the participant information sheet, the phrase 'your child' should be replaced with 'you' (in the compensation paragraph)
 4. The address of the Institute of Child Health is Guilford Street, not Guildford
 5. The first sentence in the participant information sheet ('...look at how you feel about you feel...') should be reworded
 6. The indemnity paragraph should be replaced with the following paragraph, since no special compensation arrangements will apply to this project:
'This project has been approved by an independent research ethics committee who believe that it is of minimal risk. However, research can carry unforeseen

risks and we want you to be informed of your rights in the unlikely event that any harm should occur as a result of taking part in this project.

No special compensation arrangements have been made for this project but you have the right to claim damages in a court of law. This would require you to prove fault on the part of the Hospital and/or any manufacturer involved.'

If you have been requested to make any changes to the patient/parent information sheets, please supply copies with your response to this letter, with the changes you have made clearly marked.

Once your response has been seen by the Chairman, or a designated member of the Committee, and is deemed satisfactory, I will issue you with an approval letter.

Please note:

- *if a reply has not been received within **three** months from the date of this letter, the Committee will assume you wish to withdraw your application.*
- *that your project does not have Research Ethics Committee approval until an approval letter has been issued by this office.*

Yours sincerely,



Laura Howe
Research Ethics Coordinator

Barnet, Enfield & Haringey Local Research Ethics Committee

Holbrook House,
Cockfosters Road,
Barnet EN4 0DR,
Herts.

Tel: 020 8272 5699

Fax: 020 8272 5691

Email: alison.okane@enfield.nhs.uk

1st December 2003

Ms. M. James,
44 Columbia Road,
London E2 7NN.

Dear Ms. James,

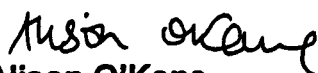
03/124: Motivation to change in eating disorders

Acting under delegated authority I write to inform you that the above study was considered by the LREC at the meeting held on 25th November 2003 and was approved subject to receipt and approval of the following amendments:

- Question 22 – can you please justify the answer. Study should not present non-English speaking participants with significant problems as long as they have an understanding of the questions.
- Consent Form – language used needs to be reviewed. Correct/consistent 'tense' should be used.

The Committee has delegated authority to the Chair to give you approval when it is felt a satisfactory response to the above issues has been received. Your application has been given a unique reference number 03/124, please use it on all correspondence with the LREC.

Yours sincerely



Alison O'Kane
LREC Co-ordinator
Barnet, Enfield & Haringey

9.5 APPENDIX 5. – INTRODUCTORY LETTER TO PARTICIPANTS

RHODES FARM CLINIC

The Ridgeway, London NW7 1RH

Telephone 020 8906 0885 Fax 020 8906 3155

e-mail: rhodesfarm@messages.co.uk

Consultant Psychiatrist:
Dr Gill Stern BSc MBBS MRCPsych

Consultant in Charge:
Dr Linda Zirinsky BSc MBBS MRCPsych

Consultant Clinical Psychologist:
Dr Rachel Bryant-Waugh MSc DPhil

Medical Director:
Dr Dee Dawson BSc MBA MBBS

Residential Consultant:
Dr Andy Price MB ChB MRCPsych

Visiting Consultants :
Dr Malcolm Wiseman MRCPsych
Dr Zaib Davids MRCPsych
Dr Rhea Demetriou MD, MRCPsych

Date as postmarked

Dear Parents

In conjunction with Rhodes Farm Clinic, I am currently researching motivation to change in young people with eating disorders. I am writing to you as I am aware your child is/has been receiving treatment for an eating disorder and I would value their participation in the research.

This would involve your child filling out a questionnaire, which should take about thirty minutes. The results will be used purely for research purposes and will not be passed onto clinicians or affect your child's treatment in any way.

I have enclosed information sheets for both you and your child, which explain the process and consent forms for you to sign.

If you would like feedback on the outcome of the research I would be happy to give you a summary and if you have any further questions about the project please don't hesitate to contact me on 07867971367.

Yours sincerely,



Melanie James
Counselling Psychologist (in training)

Enclosures

9.6 APPENDIX 6. – INFORMATION SHEETS FOR PARENTS

MOTIVATION TO CHANGE IN YOUNG PEOPLE WITH EATING DISORDERS

INFORMATION SHEET FOR PARENTS

We would like to ask for your permission to include your child in our research study.

The aim of the study

The overall aim of this research is to develop a measurement tool that will help us to assess how ready a young person is to change their eating behaviour. By carrying out this study we want to find out if this questionnaire is a good way to measure how young people feel about changing their eating problems.

Why is the study being done?

We know that when a young person has an eating disorder, their ability to acknowledge and their motivation to change their behaviour can be different at different times. Initially they may not acknowledge they have a problem or maybe at a later stage in treatment they may be more ready to start changing their eating behaviour.

Specific measurement tools have been developed to examine a person's stage of change but there is a lack of research related to young people with eating disorders.

Previous research has found that it is beneficial to assess a person's stage of change so that appropriate treatments can be matched to a person's motivation. When there is a mismatch between motivational stage and treatment, e.g. giving advice on calorie intake to a person with anorexia when they are still actively trying to lose weight, resistance can be encountered.

How is the study to be done?

The study involves your child completing a 32-item questionnaire and answering each question on a rating scale, where they state if they agree or disagree with each statement. Some of the questions may seem repetitive but they all ask slightly different things.

The questionnaire measures your child's motivation to change over a series of stages, which describe the progression over the treatment process from not wanting to change to changing your behaviour to maintaining the changes.

The questionnaire should take about thirty minutes to complete overall.

Once completed, the questionnaire should either be returned by hand to the researcher, Melanie James or sent in the stamped addressed envelope provided.

Are there any risks and discomforts?

There are no risks involved in this study.

What are the potential benefits?

In developing a tool that can measure a young person's motivation to change, the hope is that it will then be able to be used as part of the assessment process, thus determining which is the most appropriate treatment. The aim is that it will keep resistance to treatment to a minimum and enhance the overall outcome.

Who will have access to the case/research records?

Only the researchers will have access to the data collected during this study. The use of some types of information is safeguarded by the Data Protection Act 1998 (DPA). The DPA places an obligation on those who record or use personal information, but also gives rights to people about whom information is held. If you have any questions about data protection, contact the Data Protection Officer via the switchboard on 020 7405 9200 extension 5217.

What are the arrangements for compensation?

This project has been approved by an independent research ethics committee who believe that it is of minimal risk. However, research can carry unforeseen risks and we want you and your child to be informed of your rights in the unlikely event that any harm should occur as a result of taking part in this project.

No special compensation arrangements have been made for this project but you have the right to claim damages in a court of law. This would require you to prove fault on the part of the Hospital/Clinic and/or any manufacturer involved.

Do I have to take part in this study?

If you decide, now or at a later stage, that you do not wish your child to participate in this research project, that is entirely your right, and will not in any way prejudice any present or future treatment at this hospital/unit.

Who do I speak to if problems arise?

If you have any complaints about the way this project has been, or is being conducted, please, in the first instance, discuss them with the researcher. If the problems are not resolved, or you wish to comment in any other way, please contact the Chairman of the Research Ethics Committee, by post via the Barnet, Enfield & Haringay Local Research Ethics Committee, Holbrook House, Cockfosters Road, Barnet, EN4 0DR, or if urgent, by telephone on 020 8272 5699, and the Committee administration will put you in contact with them.

The researcher who will have contact with your family is; Melanie James. Dr. Dasha Nicholls has overall responsibility for the project. You are welcome to contact either of them if you wish to discuss the study further.

Details of how to contact the researchers

You can contact Melanie James by ringing 07867971367. If you want to write with your concerns or for further information, please write to: Dr. Dasha Nicholls, Department of Psychological Medicine, Eating Disorders Team, Great Ormond Street Hospital, London, WC1N 3JH.

**9.7 APPENDIX 7. – INFORMATION SHEETS FOR YOUNG
PERSON/PARTICIPANT**

MOTIVATION TO CHANGE IN YOUNG PEOPLE WITH EATING DISORDERS

INFORMATION SHEET FOR PARTICIPANTS

We would like to ask you if you would help us with our research project.

The aim of the study

The aim of this research is to develop a questionnaire that will help us to look at your attitudes towards changing your eating behaviour. We want to know if this questionnaire is a good way to measure how you feel about changing your eating.

Why is the study being done?

We know that when a young person has an eating disorder, their feelings and thoughts about changing their behaviour can be different at different times. To start with, they may not think they have a problem or maybe at a later stage in treatment they may be more ready to start changing their eating behaviour.

Specific questionnaires have been developed to examine a person's thoughts and feelings about change but most of these studies have been done in adults and there are not many studies related to young people with eating disorders. Previous research has found that there are benefits to looking at a person's thoughts about changing their behaviour so that the most helpful treatments can be matched to a person's motivation to change. When there is a mismatch between a person's thoughts about change and their type of treatment, they may be less likely to begin to get better.

How is the study to be done?

The study involves you completing a 32-item questionnaire and answering each question on a rating scale, where you state if you agree or disagree with each statement. Some of the questions may seem repetitive but they all ask slightly different things. Depending on how you feel about change at the moment you will agree or disagree with certain statements.

The questionnaire should take about thirty minutes to complete overall. Once completed, the questionnaire should either be returned by hand to the researcher, Melanie James, or sent in the stamped addressed envelope provided.

Are there any risks and discomforts?

There are no risks involved in this study.

What are the potential benefits?

In developing a questionnaire that can measure a young person's motivation to change, the hope is that it will then be able to be used as part of the assessment process to help us use the most appropriate treatment. The aim is that because the treatment will match how the young person is feeling about change at the time they will be more likely to get better.

Who will have access to the case/research records?

Only the researchers will have access to the data collected during this study.

What are the arrangements for compensation?

This project has been approved by an independent research committee who believe that it is of minimal risk. However, research can carry unforeseen risks and we want you to be informed of your rights in the unlikely event that any harm should occur as a result of taking part in this project. No special compensation arrangements have been made for this project but you would have the right to claim damages in a court of law. This would require you to prove fault on the part of the hospital/unit and/or any manufacturer involved.

Do I have to take part in this study?

If you decide now or at a later date that you do not wish to take part in this research project, that is entirely your right and will not in any way effect any present or future treatment at this hospital/unit.

Who do I speak to if problems arise?

If you have any complaints about the way this project has been, or is being conducted, please, in the first instance, discuss them with the researcher. If the problems are not resolved, or you wish to comment in any other way please contact the Chairman of the Research Ethics Committee, by post via the Barnet, Enfield & Haringay Local research Ethics Committee, Holbrook House, Cockfosters Road, Barnet, EN4 0DR, or if urgent, by telephone on 020 8272 5699, and the Committee administration will put you in contact with them.

The researcher who will have contact with you is: Melanie James.

Dr. Dasha Nicholls has overall responsibility for the project. You are welcome to contact either of them if you wish to discuss the study further.

Details of how to contact the researchers

You can contact Melanie James by ringing 07867971367. If you want to write with your concerns or for further information, please write to: Dr. Dasha Nicholls, Department of Psychological Medicine, Eating Disorders Team, Great Ormond Street Hospital, London, WC1N 3JH.

9.8 APPENDIX 8. – CONSENT FORMS

RHODES FARM CLINIC
The Ridgeway, London NW7 1RH
Telephone 020 8906 0885 Fax 020 8906 3155
e-mail: rhodesfarm@messages.co.uk

Consultant Psychiatrist:
Dr Gill Stern BSc MBBS MRCPsych

Consultant in Charge:
Dr Linda Zirinsky BSc MBBS MRCPsych

Consultant Clinical Psychologist:
Dr Rachel Bryant-Waugh MSc DPhil

Medical Director:
Dr Dee Dawson BSc MBA MBBS

Residential Consultant:
Dr Andy Price MB ChB MRCPsych

Visiting Consultants :
Dr Malcolm Wiseman MRCPsych
Dr Zaib Davids MRCPsych
Dr Rhea Demetriou MD, MRCPsych

Study Number: 03/124

Patient Information number for this trial:

CONSENT FORM FOR PARTICIPANT

Title of project: **Measuring motivation to change in young people with eating disorders: an application and validation of the University of Rhode Island Change Assessment Questionnaire (URICA).**

Name of researcher: **Melanie James**

Please initial the box next to each statement and sign below.

1.	I confirm that I have read and understood the information sheets provided about the above study.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without my medical care or legal rights being affected.	
3.	I agree to take part in the above study.	

Name of participant

Date

(block capitals)

Signature

I have explained the nature, demands and foreseeable risks of the above research project to the parent and their child (participant).

Name of researcher

Date

(block capitals)

Signature

RHODES FARM CLINIC
The Ridgeway, London NW7 1RH
Telephone 020 8906 0885 Fax 020 8906 3155
e-mail: rhodesfarm@messages.co.uk

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Visiting Consultants :
Dr Malcolm Wiseman MRCPsych
Dr Zaib Davids MRCPsych
Dr Rhea Demetriou MD, MRCPsych

Study Number: 03/124

Patient Information number for this trial:

CONSENT FORM FOR PARENTS

Title of project: **Measuring motivation to change in young people with eating disorders: an application and validation of the University of Rhode Island Change Assessment Questionnaire (URICA).**

Name of researcher: **Melanie James**

Please initial the box next to each statement and sign below.

1.	I confirm that I have read and understood the information sheets provided about the above study.	
2.	I understand that my child's participation is voluntary and that I am free to withdraw them at any time without their medical care or legal rights being affected.	
3.	I agree for my child to take part in the above study.	

Name of child (block capitals)

Name of parent (block capitals)

Date

Signature

I have explained the nature, demands and foreseeable risks of the above research project to the parent and their child (participant).

Name of researcher
(block capitals)

Date

Signature

Great Ormond Street Hospital for Children NHS Trust and Institute of Child Health Research Ethics Committee

Consent Form for PARENTS OR GUARDIANS of Children Participating in Research Studies

Title: Measuring motivation to change in young people with eating disorders: an application and validation of the University of Rhode Island Change Assessment Questionnaire (URICA)

NOTES FOR PARENTS OR GUARDIANS

1. Your child has been asked to take part in a research study. The person organising that study is responsible for explaining the project to you before you give consent.
2. Please ask the researcher any questions you may have about this project, before you decide whether you wish to participate.
3. If you decide, now or at any other stage, that you do not wish your child to participate in the research project, that is entirely your right, and if your child is a patient it will not in any way prejudice any present or future treatment.
4. You will be given an information sheet which describes the research project. This information sheet is for you to keep and refer to. *Please read it carefully.*
5. If you have any complaints about the way in which this research project has been or is being conducted, please, in the first instance, discuss them with the researcher. If the problems are not resolved, or you wish to comment in any other way, please contact the Chairman of the Research Ethics Committee, by post via The Research and Development Office, Institute of Child Health, 30 Guilford Street, London WC1N 1EH or if urgent, by telephone on 020 7905 2620 and the committee administration will put you in contact with him.

CONSENT

I/We _____, being the parent(s)/guardian(s) of
_____ agree that the Research Project named above has been
explained to me to my/our satisfaction, and I/We give permission for our child to take part
in this study. I/We have read both the notes written above and the Information Sheet
provided, and understand what the research study involves.

SIGNED (Parent (s)/Guardian (s)) PRINTED

DATE

SIGNED (Researcher)

PRINTED

DATE

Great Ormond Street Hospital for Children NHS Trust and Institute of
Child Health Research Ethics Committee

Assent Form for CHILDREN Participating in Research Studies

Title: Measuring motivation to change in young people with eating disorders: an application and validation of the University of Rhode Island Change Assessment Questionnaire (URICA)

NOTES FOR CHILDREN

- 1. You have been asked to take part in some research. The person organising that study must explain the project to you before you agree to take part.
- 2. Please ask the researcher any questions you like about this project, before you decide whether to join in.
- 3. If you decide, now or at any other time, that you do not wish to be involved in the research project, just tell us and we will stop the research. If you are a patient your treatment will carry on as it would normally.
- 4. You will be given an information sheet which describes the research. This information is for you to keep and refer to at any time. *Please read it carefully.*
- 5. If you have any complaints about the research project, discuss them with the researcher. If the problems are not resolved, or you wish to comment in any other way, please contact the Chairman of the Research Ethics Committee, by post via The Research and Development Office, Institute of Child Health, 30 Guilford Street, London WC1N 1EH or if urgent, by telephone on 020 7905 2620 and the committee administration will put you in contact with him.

ASSENT

I _____ agree that the Research Project named above has been explained to me to my satisfaction, and I agree to take part in this study.
I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

SIGNED	PRINTED	DATE
-----	-----	-----
SIGNED (Researcher)	PRINTED	DATE
-----	-----	-----

9.9 APPENDIX 9. – AMENDED VERSION OF THE URICA

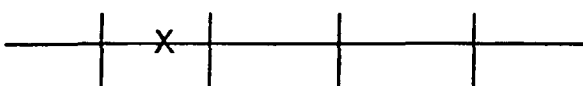
STAGES OF CHANGE QUESTIONNAIRE

You are/have been receiving treatment for problems with your eating and this questionnaire will ask you about how you feel about those problems.

Please complete the following questionnaire by marking a cross on the line as to how much you agree or disagree with the statement above it.

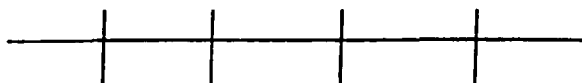
For example:

1. I do not think I have any eating problems that need changing.

Agree  Disagree

If you don't think the statement applies to you at all then mark it as a disagree.

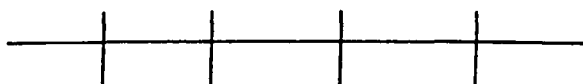
1. My eating is not the problem. I don't know why I am here.

Agree  Disagree

2. I might change the way I eat.

Agree  Disagree

3. I have been doing something about the eating problems that have been worrying me.

Agree  Disagree

4. It could help to talk about my eating problem.

Agree  Disagree

5. I don't think I have any eating problems that need changing.

Agree  Disagree

6. I am worried that my eating problem might come back so I have come here for someone to help me.

Agree  Disagree

7. I am trying to change my eating patterns at last.

Agree  Disagree

8. There is something about my eating problem that I might want to change.

Agree  Disagree

9. I have done well on working on my eating problem but I am not sure I can keep doing well without help from others.

Agree  Disagree

10. Sometimes my eating problem is difficult for me but I am trying to change it.

Agree  Disagree

11. It is a waste of time being here. It's not me who has the problem.

Agree  Disagree

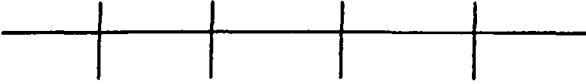
12. I hope someone can help me change the way I eat.

Agree  Disagree

13. I may not be perfect, but I don't think I need to change the way I eat.

Agree  Disagree

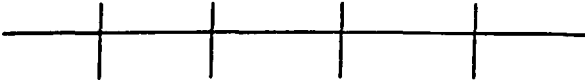
14. I am really working hard to change my eating problem.

Agree  Disagree

15. I have an eating problem and I think I should change it.

Agree  Disagree

16. It is difficult to keep to the changes I have made to my eating habits as well as I had hoped.

Agree  Disagree

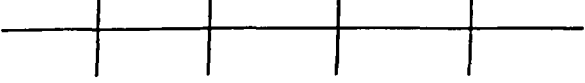
17. Although I don't always do well in trying to change my eating pattern, I am at least working on it.

Agree  Disagree

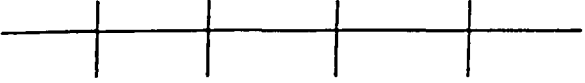
18. I thought that once I had got over my eating problem it would have gone away but sometimes I still find it difficult.

Agree  Disagree

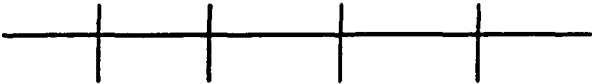
19. I don't know how to change the way I eat, but I would like to try.

Agree  Disagree

20. I have started working on my eating problems but I would like some help with them.

Agree  Disagree

21. Maybe this place might help me.

Agree  Disagree

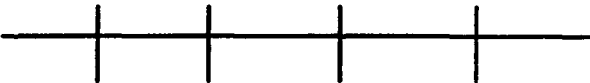
22. I may need some extra help at the moment to keep to the changes I have made to my eating patterns.

Agree  Disagree

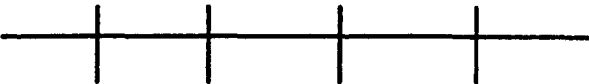
23. As it is, I don't think my eating is really part of the problem.

Agree  Disagree

24. I hope someone knows how to help me.

Agree  Disagree

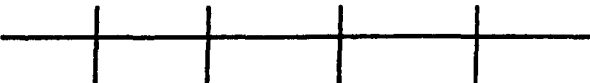
25. I am not just talking about my problem anymore.

Agree  Disagree

26. Talking about eating problems is boring. Why can't people forget about their problems.

Agree  Disagree

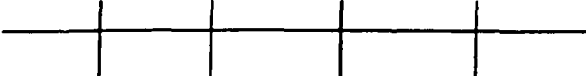
27. I am here to stop my eating problems from coming back.

Agree  Disagree

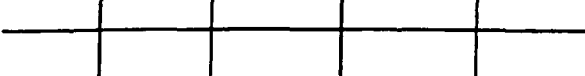
28. My eating problem had gone away, I would hate to admit it might be coming back.

Agree  Disagree

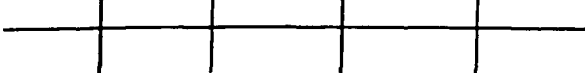
29. I have the same sort of worries that other young people have. I don't see the point in talking about them.

Agree  Disagree

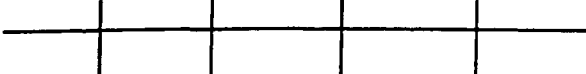
30. I am doing something about my eating problem now.

Agree  Disagree

31. Things are fine as they are. I don't need to change.

Agree  Disagree

32. After everything I have done to get rid of my eating problem, it still haunts me every now and then.

Agree  Disagree

9.10 APPENDIX 10. – LETTER TO G.P.

Dear Dr.,

I would like to inform you that your patient, ..., has agreed to take part in a study exploring motivation to change in young people with eating disorders. The study involves the completion of a 30 minute questionnaire, the results of which will be used purely for research purposes.

The study has been given ethical approval by Barnet, Enfield and Haringey Local Research Ethics Committee.

Please do not hesitate to contact me should you have any queries.

Yours sincerely,

Melanie James
Counselling Psychologist (in training)

9.11 APPENDIX 11. – FOLLOW UP LETTER

RHODES FARM CLINIC

The Ridgeway, London NW7 1RH

Telephone 020 8906 0885 Fax 020 8906 3155

e-mail: rhodesfarm@messages.co.uk

Consultant Psychiatrist:

Dr Gill Stern BSc MBBS MRCPsych

Consultant in Charge:

Dr Linda Zirinsky BSc MBBS MRCPsych

Consultant Clinical Psychologist:

Dr Rachel Bryant-Waugh MSc DPhil

Medical Director:

Dr Dee Dawson BSc MBA MBBS

Residential Consultant:

Dr Andy Price MB ChB MRCPsych

Visiting Consultants :

Dr Malcolm Wiseman MRCPsych

Dr Zaib Davids MRCPsych

Dr Rhea Demetriou MD, MRCPsych

25th March 2004

Dear Parent,

I have recently sent a pack to you containing a questionnaire for your child to fill out.

If they wish to take part in my research study I would really appreciate it if the completed questionnaire and consent forms could be returned to me within the next 7 days.

Please don't hesitate to contact me on 07867971367 should you have any queries.

Many thanks.

Yours sincerely,

Melanie James

Counselling Psychologist (in training)

9.12 APPENDIX 12. – RAW DATA

code	gender	DOB	status	pc1	pc2	pc3	pc4	pc5	pc6	pc7	pc8	pctotal	c1	c2	c3	c4	c5	c6	c7	c8	ctotal	a1	a2
rtc21	Male	17.03.91	Discharged	4	4	2	4	4	5	3	4	30	1	1	2	1	1	1	1	1	9	1	1
rtc42	Female	25.03.87	Discharged	4	4	4	4	4	4	5	4	33	3	1	3	3	2	2	2	3	18	3	1
rtc28	Female	27.01.91	Discharged	1	1	1	2	2	5	5	3	21	5	5	1	5	1	1	1	1	20	4	2
rtc36	Female	07.01.93	Discharged	5	1	4	3	5	5	5	5	29	1	2	5	3	3	5	3	5	25	5	2
rtc15	Female	13.05.87	Discharged	1	1	1	5	5	2	5	3	5	27	1	5	1	1	1	1	1	3	14	1
rtc19	Female	13.07.88	Discharged	2	4	5	1	3	3	5	3	24	5	1	1	1	1	1	2	1	13	2	1
rtc29	Female	15.05.89	Discharged	2	1	1	3	2	2	2	4	3	17	3	5	3	5	3	5	5	32	5	1
rtc3	Male	07.05.88	In-patient	1	2	1	2	5	2	2	1	16	4	4	1	4	3	4	2	5	4	30	5
rtc41	Female	28.09.89	Discharged	2	4	2	3	4	5	5	5	30	4	4	2	2	2	3	1	3	19	2	3
rtc25	Female	25.08.89	Discharged	1	3	4	3	3	3	3	3	22	3	3	1	3	3	3	2	3	21	2	2
rtc17	Female	30.04.91	Discharged	2	3	5	3	3	5	1	1	23	1	1	3	3	4	4	5	5	22	3	3
rtc47	Female	04.07.91	Discharged	1	5	1	1	1	5	1	1	16	5	1	1	1	5	1	1	5	24	1	5
rtc25	Male	27.02.89	Discharged	2	2	2	2	1	2	4	2	3	18	3	4	4	3	4	3	5	4	30	4
rtc17	Female	14.11.88	Discharged	1	3	1	3	3	3	3	5	2	21	4	3	4	3	3	3	1	3	24	4
rtc47	Female	25.10.89	Discharged	1	5	3	5	5	3	4	5	31	1	1	2	3	1	5	3	5	1	21	5
rtc9	Female	02.01.90	In-patient	3	3	3	3	3	2	3	3	24	3	3	3	3	3	2	2	2	2	21	2
rtc31	Female	27.07.87	Discharged	3	5	3	5	3	5	4	5	33	2	2	2	1	1	1	1	1	3	12	2
rtc49	Female	22.09.89	In-patient	1	1	1	1	1	1	1	1	8	5	4	5	5	5	4	5	5	37	3	3
gos18	Female	12.02.90	Outpatient	1	2	1	4	1	2	1	3	17	3	3	4	4	3	3	3	4	3	27	3
gos6	Female	30.04.90	Outpatient	2	1	1	1	1	3	2	2	12	3	4	5	5	5	5	5	5	37	4	3
gos14	Female	17.02.88	Outpatient	1	1	3	3	3	2	5	4	21	3	5	5	5	5	5	5	5	38	3	3
gos3	Male	25.10.89	Outpatient	1	1	1	1	1	1	3	1	10	4	2	2	5	5	5	5	5	36	1	2
gos15	Male	02.06.87	Outpatient	1	2	2	3	1	3	3	3	19	3	2	1	2	2	2	1	1	13	1	1
gos29	Female	25.09.91	Outpatient	1	1	2	1	1	1	5	5	21	1	1	3	1	1	1	1	1	11	1	1
gos27	Female	23.06.90	Outpatient	1	1	2	1	1	1	2	1	10	5	4	4	5	5	5	3	5	37	5	5
gos30	Male	20.12.90	Outpatient	1	1	1	1	1	1	2	2	1	10	3	3	3	5	5	5	4	5	35	3
gos13	Female	26.03.89	Outpatient	2	4	4	4	4	5	1	1	28	1	1	1	1	1	1	1	1	2	9	1
gos8	Female	13.06.90	Outpatient	1	1	2	5	2	5	1	1	5	22	1	1	1	1	1	1	2	10	5	1
gos9	Male	30.09.90	Outpatient	1	1	1	1	1	1	1	1	8	1	5	4	5	5	5	5	4	4	37	3
em1	Female	02.10.88	Outpatient	1	1	1	1	1	2	1	2	1	10	4	5	5	5	5	5	4	4	37	5
em2	Female	27.09.89	Outpatient	1	1	2	1	1	1	1	5	1	13	4	5	5	5	3	5	4	5	3	5
em3	Female	01.09.88	Outpatient	2	2	2	2	2	3	2	3	2	18	5	5	5	5	5	4	4	5	4	4
em4	Female	14.02.90	Discharged	4	3	3	1	3	1	5	4	3	24	3	3	4	3	5	4	4	5	37	4
em5	Female	12.06.91	Discharged	1	4	1	1	1	3	4	3	20	5	5	5	1	1	3	3	1	4	27	5
em6	Male	25.03.91	In-patient	2	2	1	1	1	3	3	3	16	3	5	5	5	5	5	4	5	39	5	5
em7	Female	06.06.89	Outpatient	1	1	1	1	1	1	1	1	10	5	5	5	5	2	5	1	1	3	27	5
em9	Female	01.03.89	Discharged	1	4	1	3	3	2	1	1	18	3	3	2	4	2	2	3	1	1	18	3
em10	Female	16.12.90	In-patient	1	1	1	1	1	2	3	1	11	4	5	5	5	5	5	5	5	39	4	4
em11	Female	25.11.90	Outpatient	1	1	1	1	4	2	1	1	13	5	5	5	5	2	5	1	1	3	27	5
Total				65	88	81	95	93	112	113	103	750	129	121	133	119	133	107	115	131	988	129	108
Means				2	2	2	2	2	2	3	3	19	3	3	3	3	3	3	3	3	25	3	3

Key:
pc - precontemplation
c - contemplation
a - action
m - maintenance
t - T-score

a3	a4	a5	a6	a7	a8	atotal	m1	m2	m3	m4	m5	m6	m7	m8	mtotal	pcmean	cmean	amean	mmean	pct	ct	at	mt	
1	5	1	3	1	3	4	17	1	1	1	1	1	4	1	11	3.75	1.13	2.13	1.38	64.9	33.1	38.4	42.7	
4	2	3	3	3	3	3	22	1	4	3	3	4	1	1	3	20	4.13	2.25	2.75	2.5	69	42.4	45	48.9
4	3	4	1	4	4	3	25	1	1	5	4	1	2	1	5	20	2.63	2.5	3.13	2.5	52.4	44.5	48.9	52.7
5	5	1	3	5	5	5	31	2	5	2	3	1	5	5	3	26	3.63	3.13	3.88	3.25	63.5	49.7	56.7	60.2
1	3	4	1	3	1	3	15	5	5	5	5	4	1	1	4	30	3.38	1.75	1.88	3.75	60.7	38.3	35.8	40.2
4	3	3	1	1	3	18	1	4	3	5	1	2	3	5	24	3	1.63	2.25	3	56.6	37.2	39.7	43.9	
2	1	3	5	1	5	1	18	1	2	3	3	3	1	2	16	2.13	4	2.25	2	46.9	56.9	39.7	43.9	
5	4	2	4	5	3	33	3	2	2	2	3	4	5	2	4	25	2	3.75	4.13	3.13	45.5	54.8	59.4	62.7
4	2	4	2	1	3	21	1	2	2	4	1	4	3	5	22	3.75	2.38	2.63	2.75	64.9	43.5	43.7	47.7	
3	3	3	1	2	3	19	1	2	3	1	2	2	2	4	17	2.75	2.63	2.38	2.13	53.8	45.5	41	45.2	
3	4	3	4	3	3	26	3	4	4	4	1	5	1	1	20	2.88	2.75	3.25	2.5	55.2	46.6	50.2	53.9	
1	5	5	1	5	5	28	1	1	1	1	1	1	5	5	16	2	3	3.5	2	45.5	48.6	52.8	56.5	
4	5	4	2	2	2	25	2	4	5	5	5	5	3	4	33	2.25	3.75	3.13	4.13	48.3	54.8	48.9	52.7	
4	2	3	3	3	3	25	1	3	4	4	2	1	1	2	3	20	2.63	3	3.13	2.5	52.4	48.6	48.9	52.7
5	5	4	1	4	5	32	1	1	1	2	1	5	3	1	15	3.88	2.63	4	1.88	66.3	45.5	58	61.5	
3	2	4	3	2	3	22	2	4	4	5	3	3	3	5	29	3	2.63	2.75	3.63	56.6	45.5	45	48.9	
1	2	2	1	4	2	15	1	3	2	3	1	1	1	1	17	4.13	1.5	1.88	2.13	69	36.2	35.8	40.2	
3	4	5	3	5	3	31	1	5	3	3	4	5	1	3	25	1	4.63	3.88	3.13	34.5	62.1	56.7	60.2	
4	3	4	2	4	4	27	4	2	3	5	2	4	5	5	30	2.13	3.38	3.38	3.75	46.9	51.7	51.5	55.2	
5	3	4	5	3	4	32	5	5	4	5	5	5	3	1	3	31	1.5	4.63	4	3.88	40	62.1	58	61.5
5	3	3	5	5	5	30	4	5	4	5	5	5	5	5	38	2.63	4.75	3.75	4.75	52.4	63.1	55.4	59	
5	5	5	5	5	5	33	1	1	1	2	1	3	1	1	11	1.25	4.5	4.13	1.38	37.3	61	59.4	62.7	
1	1	1	1	1	1	8	1	2	1	1	1	1	4	1	12	2.38	1.83	1	1.5	49.7	37.2	26.6	31.4	
1	1	2	1	3	1	11	2	4	4	3	1	1	1	3	19	2.63	1.38	1.38	2.38	52.4	35.2	30.6	35.2	
5	5	5	5	5	5	40	4	5	5	5	5	5	4	5	38	1.25	4.63	5	4.75	37.3	62.1	68.5	71.5	
5	3	4	4	4	3	4	29	1	3	1	1	1	1	1	10	1.25	4.38	3.63	1.25	37.3	60	54.1	57.7	
1	1	1	1	5	1	12	1	1	1	1	1	1	1	1	8	3.25	1.13	1.5	1	59.4	33.1	31.9	36.4	
1	2	1	3	5	3	19	1	1	1	2	1	1	4	1	12	2.75	1.25	2.38	1.5	53.8	34.1	41	45.2	
5	5	5	5	5	5	38	1	4	5	1	1	1	5	1	5	23	1	4.63	4.75	2.88	34.5	62.1	65.9	69
4	2	5	3	4	3	29	3	5	5	5	4	3	2	5	32	1.25	4.5	3.63	4	37.3	61	54.1	57.7	
4	4	5	4	5	5	35	3	4	5	4	4	4	3	4	32	1.63	4.25	4.38	4	41.4	59	62	65.2	
3	4	4	4	4	4	31	3	3	3	3	4	2	2	3	23	2.25	4.63	3.88	2.88	48.3	62.1	56.7	60.2	
4	4	3	3	4	3	28	1	3	5	5	4	1	4	5	28	3	3.38	3.5	3.5	56.6	51.7	52.8	56.5	
5	5	5	1	5	5	32	4	3	5	5	5	4	5	1	32	2.5	2.75	4	4	51.1	46.6	58	61.5	
4	5	4	4	4	1	33	2	4	4	5	3	5	1	5	29	2	4.88	4.13	3.63	45.5	64.1	59.4	62.7	
5	4	3	3	1	4	30	1	5	4	4	5	4	1	4	5	29	1.25	3.38	3.75	3.63	37.3	51.7	55.4	59
4	4	5	1	1	1	4	26	3	1	3	5	4	1	2	5	24	2	2.25	3.25	3	45.5	42.4	50.2	53.9
5	3	5	5	5	1	5	32	1	1	5	1	4	1	1	15	1.38	4.88	4	1.88	38.6	64.1	58	61.5	
5	4	3	3	3	1	4	30	1	5	4	5	4	1	4	5	29	1.63	3.38	3.75	3.63	41.4	51.7	55.4	59
138	131	133	106	126	137	1008	76	120	127	129	109	109	89	132	891	93.83	123.61	126.1	111.46	1950	1949.9	1949.5	2086.7	
4	3	3	3	3	4	26	2	3	3	3	3	3	3	2	3	2	2	3	3	50	50	50	54	

Key:
pc - precontemplation
c - contemplation
a - action
m - maintenance
t - T-score

9.13 APPENDIX 13. – SPSS SCRIPTS

- MEAN TABLES
- CRONBACH'S ALPHA
- PEARSON PRODUCT-MOMENT CORRELATION BETWEEN THE STAGES.
- PEARSON PRODUCT MOMENT CORRELATION WITHIN THE STAGES.
- PRINICIPAL COMPONENTS ANALYSIS FOR EACH STAGE OF CHANGE.

Total scores for each stage – mean table

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
PCTOTAL	39	8	33	19.23	7.242
ctotal	39	9	39	25.33	9.669
ATOTAL	39	8	40	25.85	7.635
MTOTAL	39	8	38	22.85	7.975
Valid N (listwise)	39				

Mean scores for each stage – Mean table

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
pcmean	39	1.00	4.13	2.4038	.90524
cmean	39	1.13	4.88	3.1667	1.20864
amean	39	1.00	5.00	3.2308	.95436
mmean	39	1.00	4.75	2.8558	.99693
Valid N (listwise)	39				

Sum of total scores

Descriptive Statistics

	N	Range	Sum
PCTOTAL	39	25	750
ctotal	39	30	988
ATOTAL	39	32	1008
MTOTAL	39	30	891
Valid N (listwise)	39		

Correlations between the four stages of change

Correlations

		pcmean	cmean	amean	mmean
pcmean	Pearson Correlation	1	-.728**	-.576**	-.242
	Sig. (2-tailed)	.	.000	.000	.137
	N	39	39	39	39
cmean	Pearson Correlation	-.728**	1	.813**	.436**
	Sig. (2-tailed)	.000	.	.000	.005
	N	39	39	39	39
amean	Pearson Correlation	-.576**	.813**	1	.481**
	Sig. (2-tailed)	.000	.000	.	.002
	N	39	39	39	39
mmean	Pearson Correlation	-.242	.436**	.481**	1
	Sig. (2-tailed)	.137	.005	.002	.
	N	39	39	39	39

** . Correlation is significant at the 0.01 level (2-tailed).

Reliability for Precontemplation stage

***** Method 1 (space saver) will be used for this analysis *****

RELIABILITY ANALYSIS - SCALE (ALPHA)

Reliability Coefficients

N of Cases = 39.0 N of Items = 8

Alpha = .7996

Reliability for Contemplation stage

***** Method 1 (space saver) will be used for this analysis *****

RELIABILITY ANALYSIS - SCALE (ALPHA)

Reliability Coefficients

N of Cases = 39.0 N of Items = 8

Alpha = .8955

Reliability for Action stage

***** Method 1 (space saver) will be used for this analysis *****

RELIABILITY ANALYSIS - SCALE (ALPHA)

Reliability Coefficients

N of Cases = 39.0

N of Items = 8

Alpha = .8168

Reliability for Maintenance stage

***** Method 1 (space saver) will be used for this analysis *****

RELIABILITY ANALYSIS - SCALE (ALPHA)

Reliability Coefficients

N of Cases = 39.0 N of Items = 8

Alpha = .8014

Precontemplation – Pearson's Correlations

Correlations

		PC1	PC2	PC3	PC4	PC5	PC6	PC7	PC8
PC1	Pearson Correlation	1	.306	.342*	.293	.381*	.461**	.334*	.166
	Sig. (2-tailed)	.	.059	.033	.070	.017	.003	.038	.313
	N	39	39	39	39	39	39	39	39
PC2	Pearson Correlation	.306	1	.289	.366*	.643**	.163	.171	.381*
	Sig. (2-tailed)	.059	.	.074	.022	.000	.322	.299	.017
	N	39	39	39	39	39	39	39	39
PC3	Pearson Correlation	.342*	.289	1	.439**	.395*	.415**	.280	.327*
	Sig. (2-tailed)	.033	.074	.	.005	.013	.009	.085	.042
	N	39	39	39	39	39	39	39	39
PC4	Pearson Correlation	.293	.366*	.439**	1	.388*	.357*	.155	.701*
	Sig. (2-tailed)	.070	.022	.005	.	.015	.026	.347	.000
	N	39	39	39	39	39	39	39	39
PC5	Pearson Correlation	.381*	.643**	.395*	.388*	1	.150	.157	.216
	Sig. (2-tailed)	.017	.000	.013	.015	.	.361	.340	.187
	N	39	39	39	39	39	39	39	39
PC6	Pearson Correlation	.461**	.163	.415**	.357*	.150	1	.388*	.448*
	Sig. (2-tailed)	.003	.322	.009	.026	.361	.	.015	.004
	N	39	39	39	39	39	39	39	39
PC7	Pearson Correlation	.334*	.171	.280	.155	.157	.388*	1	.339*
	Sig. (2-tailed)	.038	.299	.085	.347	.340	.015	.	.035
	N	39	39	39	39	39	39	39	39
PC8	Pearson Correlation	.166	.381*	.327*	.701**	.216	.448**	.339*	1
	Sig. (2-tailed)	.313	.017	.042	.000	.187	.004	.035	.
	N	39	39	39	39	39	39	39	39

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Contemplation – Pearson's Correlations

Correlations

		C1	C2	C3	C4	C5	C6	C7	C8
C1	Pearson Correlation	1	.366*	.444**	.446**	.408**	.275	.159	.391*
	Sig. (2-tailed)	.	.022	.005	.004	.010	.090	.333	.014
	N	39	39	39	39	39	39	39	39
C2	Pearson Correlation	.366*	1	.476**	.469**	.454**	.454**	.229	.572*
	Sig. (2-tailed)	.022	.	.002	.003	.004	.004	.162	.000
	N	39	39	39	39	39	39	39	39
C3	Pearson Correlation	.444**	.476**	1	.661**	.869**	.628**	.443**	.567*
	Sig. (2-tailed)	.005	.002	.	.000	.000	.000	.005	.000
	N	39	39	39	39	39	39	39	39
C4	Pearson Correlation	.446**	.469**	.661**	1	.564**	.758**	.716**	.842*
	Sig. (2-tailed)	.004	.003	.000	.	.000	.000	.000	.000
	N	39	39	39	39	39	39	39	39
C5	Pearson Correlation	.408**	.454**	.869**	.564**	1	.586**	.470**	.513*
	Sig. (2-tailed)	.010	.004	.000	.000	.	.000	.003	.001
	N	39	39	39	39	39	39	39	39
C6	Pearson Correlation	.275	.454**	.628**	.758**	.586**	1	.581**	.546*
	Sig. (2-tailed)	.090	.004	.000	.000	.000	.	.000	.000
	N	39	39	39	39	39	39	39	39
C7	Pearson Correlation	.159	.229	.443**	.716**	.470**	.581**	1	.585*
	Sig. (2-tailed)	.333	.162	.005	.000	.003	.000	.	.000
	N	39	39	39	39	39	39	39	39
C8	Pearson Correlation	.391*	.572**	.567**	.842**	.513**	.546**	.585**	1
	Sig. (2-tailed)	.014	.000	.000	.000	.001	.000	.000	.
	N	39	39	39	39	39	39	39	39

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Action – Pearson's Correlations

Correlations

		A1	A2	A3	A4	A5	A6	A7	A8
A1	Pearson Correlation	1	.385*	.583**	.289	.104	.334*	.086	.395*
	Sig. (2-tailed)	.	.016	.000	.075	.528	.038	.601	.013
	N	39	39	39	39	39	39	39	39
A2	Pearson Correlation	.385*	1	.527**	.479**	.522**	.574**	-.048	.549*
	Sig. (2-tailed)	.016	.	.001	.002	.001	.000	.772	.000
	N	39	39	39	39	39	39	39	39
A3	Pearson Correlation	.583**	.527**	1	.468**	.491**	.596**	.014	.528*
	Sig. (2-tailed)	.000	.001	.	.003	.002	.000	.934	.001
	N	39	39	39	39	39	39	39	39
A4	Pearson Correlation	.289	.479**	.468**	1	.452**	.305	.171	.710**
	Sig. (2-tailed)	.075	.002	.003	.	.004	.059	.297	.000
	N	39	39	39	39	39	39	39	39
A5	Pearson Correlation	.104	.522**	.491**	.452**	1	.389*	.017	.515*
	Sig. (2-tailed)	.528	.001	.002	.004	.	.014	.918	.001
	N	39	39	39	39	39	39	39	39
A6	Pearson Correlation	.334*	.574**	.596**	.305	.389*	1	.155	.426*
	Sig. (2-tailed)	.038	.000	.000	.059	.014	.	.346	.007
	N	39	39	39	39	39	39	39	39
A7	Pearson Correlation	.086	-.048	.014	.171	.017	.155	1	.125
	Sig. (2-tailed)	.601	.772	.934	.297	.918	.346	.	.448
	N	39	39	39	39	39	39	39	39
A8	Pearson Correlation	.395*	.549**	.528**	.710**	.515**	.426**	.125	1
	Sig. (2-tailed)	.013	.000	.001	.000	.001	.007	.448	.
	N	39	39	39	39	39	39	39	39

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Maintenance – Pearson's Correlations

Correlations

		M1	M2	M3	M4	M5	M6	M7	M8
M1	Pearson Correlation	1	.411**	.421**	.510**	.583**	.190	.176	.323*
	Sig. (2-tailed)	.	.009	.008	.001	.000	.246	.283	.045
	N	39	39	39	39	39	39	39	39
M2	Pearson Correlation	.411**	1	.545**	.542**	.493**	.058	.275	.456*
	Sig. (2-tailed)	.009	.	.000	.000	.001	.726	.091	.003
	N	39	39	39	39	39	39	39	39
M3	Pearson Correlation	.421**	.545**	1	.587**	.614**	-.118	.114	.587*
	Sig. (2-tailed)	.008	.000	.	.000	.000	.474	.490	.000
	N	39	39	39	39	39	39	39	39
M4	Pearson Correlation	.510**	.542**	.587**	1	.483**	.052	.400*	.782*
	Sig. (2-tailed)	.001	.000	.000	.	.002	.754	.012	.000
	N	39	39	39	39	39	39	39	39
M5	Pearson Correlation	.583**	.493**	.614**	.483**	1	-.067	.096	.320*
	Sig. (2-tailed)	.000	.001	.000	.002	.	.685	.561	.047
	N	39	39	39	39	39	39	39	39
M6	Pearson Correlation	.190	.058	-.118	.052	-.067	1	.257	.128
	Sig. (2-tailed)	.246	.726	.474	.754	.685	.	.114	.437
	N	39	39	39	39	39	39	39	39
M7	Pearson Correlation	.176	.275	.114	.400*	.096	.257	1	.343*
	Sig. (2-tailed)	.283	.091	.490	.012	.561	.114	.	.032
	N	39	39	39	39	39	39	39	39
M8	Pearson Correlation	.323*	.456**	.587**	.782**	.320*	.128	.343*	1
	Sig. (2-tailed)	.045	.003	.000	.000	.047	.437	.032	.
	N	39	39	39	39	39	39	39	39

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).


```
RELIABILITY
/VARIABLES=VAR00001 VAR00002 VAR00003 VAR00004 VAR00005 VAR00006 VAR00007
VAR00008
/SCALE('ALL VARIABLES') ALL/MODEL=ALPHA
/SUMMARY=TOTAL .
```

Reliability for Precontemplation

[DataSet0] C:\Program Files\SPSS\Mel's data.sav

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	39	100.0
	Excluded ^a	0	.0
	Total	39	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.800	8

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
VAR00001	17.5641	44.358	.493	.782
VAR00002	16.9744	41.447	.497	.779
VAR00003	17.1538	41.607	.542	.773
VAR00004	16.7949	39.746	.602	.763
VAR00005	16.8462	41.870	.491	.780
VAR00006	16.3590	40.184	.514	.777
VAR00007	16.3333	42.386	.385	.798
VAR00008	16.5897	38.827	.582	.765

```
RELIABILITY
/VARIABLES=VAR00010 VAR00011 VAR00012 VAR00013 VAR00014 VAR00015 VAR00016
VAR00017
/SCALE('ALL VARIABLES') ALL/MODEL=ALPHA
/SUMMARY=TOTAL .
```

Reliability for Contemplation

[DataSet0] C:\Program Files\SPSS\Mel's data.sav

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	39	100.0
	Excluded ^a	0	.0
	Total	39	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.895	8

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
VAR00010	22.0256	79.815	.445	.902
VAR00011	22.2308	76.077	.546	.894
VAR00012	21.9231	69.704	.774	.873
VAR00013	22.2821	67.682	.858	.864
VAR00014	21.9231	71.231	.729	.877
VAR00015	22.5897	72.459	.725	.878
VAR00016	22.3846	72.559	.587	.892
VAR00017	21.9744	71.657	.763	.874

RELIABILITY

```

/VARIABLES=VAR00019 VAR00020 VAR00021 VAR00022 VAR00023 VAR00024 VAR00025
VAR00026
/SCALE('ALL VARIABLES') ALL/MODEL=ALPHA
/SUMMARY=TOTAL .

```

Reliability for Action

[DataSet0] C:\Program Files\SPSS\Mel's data.sav

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	39	100.0
	Excluded ^a	0	.0
	Total	39	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.817	8

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
VAR00019	22.5385	46.729	.459	.807
VAR00020	23.0769	43.704	.646	.780
VAR00021	22.3077	42.271	.705	.770
VAR00022	22.4872	45.572	.611	.786
VAR00023	22.4359	46.621	.523	.798
VAR00024	23.1282	43.536	.601	.786
VAR00025	22.6154	53.927	.101	.854
VAR00026	22.3333	44.018	.705	.773

RELIABILITY

```

/VARIABLES=VAR00028 VAR00029 VAR00030 VAR00031 VAR00032 VAR00033 VAR00034
VAR00035
/SCALE('ALL VARIABLES') ALL/MODEL=ALPHA
/SUMMARY=TOTAL .

```

Reliability for Maintenance

[DataSet0] C:\Program Files\SPSS\Mel's data.sav

Scale: ALL VARIABLES

Case Processing Summary

	N	%
Cases Valid	39	100.0
Excluded ^a	0	.0
Total	39	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.801	8

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
VAR00028	20.8974	51.516	.571	.773
VAR00029	19.7692	48.498	.609	.764
VAR00030	19.5897	49.248	.605	.766
VAR00031	19.5385	44.255	.763	.737
VAR00032	20.0513	49.682	.531	.776
VAR00033	20.0513	58.260	.097	.843
VAR00034	20.5641	53.726	.359	.801
VAR00035	19.4615	45.466	.659	.754

9.14 – APPENDIX 14. ORIGINAL RESEARCH PROPOSAL

RESEARCH PROPOSAL

MELANIE JAMES

3-YEAR COUNSELLING PSYCHOLOGY PROGRAMME – YEAR 2

Working title:

Measuring motivation to change in young people with eating disorders: an application and validation of the University of Rhode Island Change Assessment Questionnaire (URICA).

Summary:

This study will examine the measurement of motivation to change in young people (12-16 years) with eating disorders, who have become/been involved in the clinical treatment process to some degree. The participants will be recruited from Tier three or four specialist eating disorder services and will be asked to complete an adapted version of the URICA questionnaire. The questionnaire measures the young person's current stage of change (according to Prochaska and DiClemente's Transtheoretical Model of Change) using a likert scale for each of the 32 questions.

The aim of determining their stage of change is then to increase awareness around matching an appropriate treatment to the young person's motivation, to maximize outcome.

Aims:

The primary aim of this study is to explore, in a sample of young people with eating disorders, the psychometric properties of a questionnaire measure of motivation, the URICA which we have adapted to measure motivation to change eating behaviour. It will also ascertain if the sample fall into predicted subgroups as previously found in other studies. In addition to validation of the questionnaire, this study will also aim to identify key constructs in the URICA, so that it can be abbreviated for ease of use with younger patients. Measures of motivation can be used to match treatments in line with motivational stage.

Hypotheses to be tested:

Hypothesis 1:

The sample's mean raw scores and standard deviations from the URICA will be similar to those reported in previous literature.

Hypothesis 2:

The URICA scales/stages will be internally consistent.

Hypothesis 3:

The theoretically predicted simplex pattern of adjacent stages (e.g. Contemplation and Action) that are highly correlated would be evident in the sample in this study.

Hypothesis 4:

After conducting a cluster analysis, the resulting stage profiles should organize participants into groups representing various degrees of overall involvement in change.

Literature Review:

In the early 1980's, Prochaska and DiClemente, described a Transtheoretical Model of Change (Prochaska et al, 1992). The model identifies different stages of motivational change that a person goes through, when receiving psychotherapeutic care. The five stages originally described were Precontemplation, Contemplation, Preparation (now omitted), Action, and Maintenance.

The model was mainly applied to problem/addictive behaviours such as smoking, alcohol, and drug abuse.

The early studies were based initially on smokers. Stage of change determined was found to be predictive of smoking cessation at 6month follow up (DiClemente et al, 1991).

The University of Rhode Island Change Assessment Questionnaire (URICA) (McConaughy, Prochaska and Velicer, 1983) was developed to measure the stages of change described above. It consists of 32 items on a Likert scale and yields continuous data for each of the four scales. The URICA item generation was based on behavioural criteria for the five stages of change (Precontemplation, Contemplation, Preparation, Action and Maintenance). Reliability and factor analyses generated four scales (Precontemplation, Contemplation, Action and Maintenance) with eight separate items loading on each of the scales (McConaughy et al., 1983).

The URICA has been found to be reliable for adult psychotherapy participants (McConaughy et al., 1983, McConaughy, DiClemente, Prochaska and Velicer, 1989). Greenstein, Franklin, and McGuffin (1999) have examined the URICA in relation to an adolescent sample and found their participants responded similarly to adults and clustered into clinically meaningful groups, concordant with the model of change. They also found the questionnaire to be psychometrically sound and to reflect the results of the original research on the URICA and it's replication (McConaughy et al. 1989). Overall the URICA has been proven to provide reliable results on three replications (2 with adults, 1 with adolescents). In the field of eating disorders, the transtheoretical model of change began to be applied, primarily to the adult clinical population, where early results suggested it might be useful in assessing ambivalence about change. Treasure et al. (1999) in a study of bulimic outpatients, found that those classified as being in the action stage at the start of treatment showed greater improvement in bingeing than those in contemplation, although there was no reduction of compensatory behaviours. R. Levy (1997) also applied the model to bulimic patients and found that the stages and processes progressed through were consistent with the transtheoretical model.

The limitations when applying this measure to eating disorders are found in the complex nature of eating disorder symptoms and the difficulty of separating them out on a uni-dimensional questionnaire, e.g. bulimics

motivated to reduce binges may be reluctant to change weight control behaviour (Treasure et al., 1999).

Despite these limitations, the benefits of determining stages of change are evident in the literature on motivational interviewing. Rollnick et al. (1993) found that when there was a mismatch between motivational stage and treatment intervention, they encountered resistance. An example of this would be giving advice to an anorexic patient on increasing calorie intake when they are still actively trying to lose weight.

There have been assessment tools developed (for use with adults) to fit the more complex patterns of eating disorders such as the Readiness and Motivation Interview (Geller and Drab, 1999). This measure provides symptom specific information about readiness to change and motivation in eating disorder patients. The tool was developed to assist in setting stages for treatment planning.

When considering the use of such a tool with a young person with an eating disorder, the RMI is a lengthy assessment tool not best suited to assessment of younger patients. There are existing studies exploring young peoples attitudes to their eating disorder (L. Serpell et al. 2003) but there still remains a need for a reliable measure of motivation to change eating behaviour that is suitable for use with adolescents suffering from eating disorders. Increasingly clinical management is based on the young person's motivation to address their eating difficulties, making the need for development of such an instrument a pressing issue. Our study uses a measure of motivation to change that has been previously validated in an adolescent sample, adapting it to be specific to change in eating behaviours.

References:

DiClemente, C. C., Prochaska, J. O., Fairhurst, S. K., Velicer, W. F., Velasques, M. M., & Rossi, J. S. (1991). The process of smoking cessation: An analysis of precontemplation, contemplation, and preparation stages of change.

Journal of Consulting and Clinical Psychology, 59, 295-304.

Geller, J., & Drab, D.L., (1999). The Readiness and Motivation Interview: A Symptom-Specific Measure of Readiness for Change in the Eating Disorders.

European Eating Disorders Review, 7 (4), 259-278.

Greenstein, D.K., Franklin, M. E., & McGuffin, P. (1999). Measuring Motivation to Change: An Examination of the University of Rhode Island Change Assessment Questionnaire (URICA) in an Adolescent Sample.

Psychotherapy, 36 (1), 47-55.

Levy, R. K. (1997). The Transtheoretical Model of Change: An Application to Bulimia Nervosa. **Psychotherapy, 34 (3) 278-285.**

McConaughy, E. A., DiClemente, C. C., Prochaska, J. O., & Velicer, W. F. (1989). Stages of change in psychotherapy: a follow-up report. **Psychotherapy, 26 (4), 494-503.**

McConaughy, E. A., Prochaska, J. O., & Velicer, W. F. (1983). Stages of change in psychotherapy: measurement and sample profiles. **Psychotherapy: Theory, Research and Practice, 20 (3), 368-375.**

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change. **American Psychologist, 47, 1102-1114.**

Rollnick, S., Kinnnersley, P. & Stott, N. (1993). Methods of helping patients with behaviour change. **British Medical Journal, 307, 188-190.**

Serpell, L., Neiderman, M., Haworth, E., Emmanueli, F., & Lask, B. (2003). The use of the Pros and Cons of Anorexia Nervosa (P-CAN) Scale with children and adolescents. **Journal of Psychosomatic Research, 54 (6), 567-571.**

Treasure, J. L., Katzman, M., Schmidt, U., Todd, G., & de Silva, P. (1999). Engagement and outcome in the treatment of bulimia nervosa: first phase of a sequential design combining motivation enhancement therapy and cognitive behavioural therapy. **Behaviour Research and Therapy, 37, 405-418.**

Research Design

Sample:

All those patients aged 12-16 years, currently involved or recently (within past year) discharged from clinical treatment process at the following specialist eating disorder services:

- Great Ormond Street Eating Disorders Service
- Rhodes Farm Clinic
- Ellern Mede

The term eating disorders will include those with Anorexia Nervosa, Bulimia Nervosa, Eating Disorder Not Otherwise Specified.

Sample size:

The sample size will be made up of number of inpatients, outpatients and recently discharged patients from each location.

Great Ormond Street –	Open cases = 20 Recently discharged = 20
Ellern Mede -	Inpatients = 17 Outpatients = 20 Inpatients that have become outpatients = 13 Recently discharged = 10
Rhodes Farm -	Inpatients = 23 Recently discharged = 20
Total -	133

Pilot study:

A small pilot study was carried out by administering the questionnaire to four in-patients at Great Ormond Street Hospital. The main purpose of this study was to assess whether the target population could understand the rephrased version of the questionnaire. The rephrasing of the items involved using language appropriate for 12-16 year olds without changing the original meaning.

The participants were asked to complete the questionnaires and then asked if they had any difficulty understanding the directions or the questions. None of these adolescents reported difficulties with understanding but two found that some of the questions were repetitive and became confused at times. This issue will be addressed in the following study, as one of the aims is to abbreviate the questionnaire, by collapsing some of the items into one.

Procedure:

Participants and their parents will be given written and verbal information regarding the study and will be asked to sign a consent form, if they agree to take part.

Once consent has been given, the young person will be asked to complete the questionnaire, which should take approximately 30 minutes.

Measure:

The URICA consists of 32 items answered on a Likert scale ranging from strongly agree to strongly disagree (copy attached).

Statistical Analysis

Scoring:

A total score of each of the scales is obtained by adding the responses to the items that load on each particular stage/scale. A participant's raw score on any of the four stages/scales can range from eight to forty. This total score is then divided by eight, producing the mean raw score. Mean raw scores are then converted to T-scores, which have a mean of 50 and a standard deviation of 10 for each stage/scale. T-scores are recommended by McConnaughy et al. (1989) to ease interpretation of scores.

Internal Consistency:

To assess the inter-item reliability of the questionnaire, the study will calculate the coefficients using Cronbach's alpha for each stage/scale. Cronbach's alpha is the standard index of the reliability of the pooled observations, i.e. overall score across items.

A Pearson Product-Moment Correlation:

This will be used to measure the level of relatedness between the stages. Previous studies have shown that, consistent with the transtheoretical model, precontemplation was negatively correlated with all other stages, whereas correlations among the contemplation, action, and maintenance stages were all positive.

Cluster Analyses:

Using the Ward method available in the Statistical Package for Social Sciences (SPSS) for Windows, a hierarchical agglomerative cluster analysis will be conducted to classify the entire sample into smaller groups with homogenous stage profiles. The hierarchical agglomerative clustering procedure was chosen to maintain consistency with Greenstein et al. (1999), McConnaughy et al. (1989) and McConnaughy et al. (1983).

Ethics:

I do not anticipate any ethical problems that may affect my research and am currently awaiting ethical approval from the GOS/ICH Research Ethics Committee and Barnet LREC.

Timetable:

Week	Month	Action
24	October	Design research proposal and preliminary questionnaire.
23		Pilot study
22		Analyse pilot results
21	November	Meet supervisor – refine proposal
20		Submit ethics forms
19		Break
18	December	In-depth literature review
17		" " "
16		Begin photocopying and preparing questionnaire packs
15	January	Begin data collection
14		" " "
13		" " "
12	February	Finish data collection
11		Collate results
10		" "
9		Analyse results
8	March	" "
7		" "
6		Write up
5		" "
4	April	" "
3		" "
2		" "
1		Proof reading/production
0	May	Hand in dissertation

9.15 – APPENDIX 15 – COREC APPROVAL LETTER

Camden & Islington Community Local Research Ethics Committee

Room 3/14
Third Floor, West Wing
St Pancras Hospital
4 St Pancras Way
London
NW1 0PE

Telephone: 020 7530 3799
Facsimile: 020 7530 3931

30 September 2005

Dr. Dasha Nicholls
Consultant Psychiatrist
Great Ormond Street Hospital
Great Ormond Street
London
WC1N 3JH

Dear Dr. Nicholls

Full title of study: Factors influencing motivation in adolescent eating disorders: a systemic perspective.
REC reference number: 05/Q0511/89

Thank you for your email of 28 September 2005, responding to the Committee's request for further information on the above research. The further information was considered by a Sub-Committee of the REC including the Chair and Dr Carl Walker.

Confirmation of ethical opinion

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

Ethical review of research sites

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

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully. In addition, the Committee require the following change to be made to the letters of invitation to parents, participants, and their sibling/friend:

"I have enclosed information sheets for you (and your child) that explain the process, and I will be contacting you within the next two days to arrange an initial interview".

Should be amended to:

"I have enclosed information sheets for you (and your child) that explain the process. If you are agreeable, I will be contacting you within the next two days to discuss the possibility of arranging an initial interview. If you would prefer not to be involved please contact my office on ...".

Please submit revised copies of the documents to the Committee Administrator (by email is acceptable). You will be notified that the documents have been received but there is no need to wait for further correspondence from the Committee.

Approved documents

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

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	2	12 July 2005
Investigator CV		11 July 2005
Protocol	1	11 July 2005
Covering Letter		11 July 2005
Interview Schedules/Topic Guides	1 - Patients	11 July 2005
Interview Schedules/Topic Guides	1 - Parent/Sibling/Friend/Professional	11 July 2005
Questionnaire	Chilo Global Assessment of Severity (CGAS)	
Questionnaire	2 - Stages of Change Questionnaire	28 August 2005
Questionnaire	EDE-Q5.2	
Letter of invitation to participant	1 - For 16+ (current service users)	28 August 2005
Letter of invitation to participant	1 - For Parents (current service users)	28 August 2005
Letter of invitation to participant	1 - For 16+ (former service users)	28 August 2005
Letter of invitation to participant	1 - Sibling/Friend	28 August 2005
Letter of invitation to participant	2 - For Parents (former service user)	28 August 2005
GP/Consultant Information Sheets	2 (letter)	28 August 2005
Participant Information Sheet	2 - For Parents	28 August 2005
Participant Information Sheet	1 - For Sibling/Friend	28 August 2005
Participant Information Sheet	2 - For Participants	28 August 2005
Participant Consent Form	2 - For Parents	28 August 2005
Participant Consent Form	2 - For Participant	28 August 2005
Participant Consent Form	1 - For Participant 16+	28 August 2005
Response to Request for Further Information		28 September 2005
Response to Request for Further Information		06 September 2005
R&D Registration Form		
Article - Passi, Bryson & Lock		05 August 2002

Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Statement of compliance

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

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

Yours sincerely

Stephanie Ellis
Chair

Email: kathryn.simpson@camdenpct.nhs.uk

Enclosures: *Standard approval conditions*
 Site approval form

Copy to: **Miss Emma Pendleton**
 Great Ormond Street Hospital for Children NHS Trust
 Research and Development Office
 Grest Ormond Street
 London
 WC1N 3JH

Camden & Islington Community Local Research Ethics Committee				
LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION				
For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.				
REC reference number:	05/Q0511/89	Issue number:	1	Date of issue:
Chief Investigator:	Dr. Dasha Nicholls			
Full title of study:	Factors influencing motivation in adolescent eating disorders: a systemic perspective.			
This study was given a favourable ethical opinion by Camden & Islington Community Local Research Ethics Committee on 29 September 2005. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.				
Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site
Dr. Dasha Nicholls	Consultant Psychiatrist	Great Ormond Street Hospital NHS Trust	Institute of Child Health/Great Ormond Street Hospital Research Ethics Committee	29/09/2005
Notes ⁽¹⁾				
Approved by the Chair on behalf of the REC:				
..... (delete as applicable) (Signature of Chair/Administrator) (Name)				

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

9.16 – APPENDIX 16 – DPSYCH RESEARCH PROPOSAL

DPsych Counselling Psychology – City University

Research Proposal

Melanie James

Factors influencing motivation in adolescent eating disorders: a systemic perspective.

Summary/Aims:

This study will examine the attitudes towards change of young people with Anorexia Nervosa and explore the views of family and professionals about factors that might influence the young persons motivation or ability to change (recover) by conducting in depth interviews, combined with questionnaires. This information will then provide the basis of the development of a model of change that fits this particular sample population. The current predominant model that conceptualises the change process is The Transtheoretical Model of Change (Prochaska et al, 1992). However there have been some difficulties in applying this model both to young people and the eating disorders field and it seems there may be a need to review this model. By adopting a grounded theory approach, it is hoped that various themes will emerge from the semi-structured interviews that will allow a new model to be developed and conceptualize the change process more accurately. A secondary aim will be to compare the experiences of both parent/carers and child and use the differences and similarities to inform services about what family interventions could be clinically useful.

Principal research question:

To develop a model to understand the contextual and relationship factors influencing motivation to change/recover in adolescents with eating disorders.

Secondary research questions/objectives:

- 1) To explore the relationship between the young person's attitude to change and their engagement in treatment.
- 2) To explore the young person's relationship to help and their stage of change.
- 3) To explore key figures (parents, therapists, sibling or friend) perceive the adolescent ED sufferers attitude to change
- 4) To explore the significance of discrepancies in perceived motivation to change in different contexts

Scientific justification for research

Why people change and why they do not change is a question that therapists have asked for many years and more recently, techniques have been developed to enhance an individual's change process, e.g. motivational interviewing (Miller & Rollnick, 1991). For almost two decades, one model of change has stood as the standard bearer for conceptualizing the stages of change in therapy.

Prochaska and DiClemente developed this predominant framework that focused on the notion of an individual's readiness to change in the 1980's. It is described as the Transtheoretical Model of Change (TTM) (Prochaska et al, 1992). The model identifies different stages of motivational change that a person goes through, when receiving psychotherapeutic care. Stages of change represent a collection of intentions and behaviours through which individuals pass as they move from having a problem to doing something to resolve it (Prochaska & Norcross, 1994). The five stages originally described were Precontemplation (being unaware of or unwilling to change symptoms), Contemplation (thinking about change but not ready to make commitment), Preparation (intending to change in the near future) (now omitted), Action (actively involved in the process if change), and Maintenance (working to maintain changes made)

The model was mainly applied to problem/addictive behaviours such as smoking, alcohol, and drug abuse. In the field of eating disorders, the transtheoretical model of change began to be applied, primarily to the adult clinical population, where early results suggested it might be useful in assessing ambivalence about change. Treasure et al. (1999) in a study of bulimic outpatients, found that those classified as being in the action stage at the start of treatment showed greater improvement in bingeing than those in contemplation, although there was no reduction of compensatory behaviours. R. Levy (1997) also applied the model to bulimic patients and found that the stages and processes progressed through were consistent with the transtheoretical model.

The limitations when applying this measure to eating disorders are found in the complex nature of eating disorder symptoms and the difficulty of separating them out on a uni-dimensional questionnaire (the University of Rhode Island Change Assessment Questionnaire), e.g. bulimics motivated to reduce binges may be reluctant to change weight control behaviour (Treasure et al., 1999).

In a previous study (James & Nicholls, 2004) we found, although the TTM was broadly applicable to adolescents, there was a complex and dynamic relationship with change suggesting attitude to change was in constant flux. The correlations between the four stages reveal that the Precontemplation stage is negatively correlated with all the other stages, making the position of not considering change, distinctively different from undertaking a serious consideration for or against change. However, for those contemplating change, young people endorsed statements from multiple stages.

Previous researchers concluded that because the other adjacent stages tended to be highly correlated, the stages of change could be conceptualized as invariant and additive (McConaughy et al., 1989; McConaughy et al., 1983).

However, it could also be viewed that as Contemplation, Action and Maintenance have a high correlation (particularly Contemplation and Action at .81), they could be merged into a stage, which would have elements of each of the latter three stages, included in one. Thus, moving towards a shorted version of The Transtheoretical Model of Change.

With particular reference to adolescents, Bauman et al. (2001), also question the model in its entirety. After carrying out a validation of a measure of motivation to change in substance abusers, they began to reconsider the TTM. They only found profiles similar to those of precontemplators and contemplators, with the remaining stage profiles not presenting in this particular sample. Cady et al. (1996), also only identified three groups when researching motivation to change as a predictor of treatment outcome of adolescent substance abusers. They named their groups/stages, Contemplation, Contemplation/Preparation and Preparation. Neither of the above named studies found evidence of the action and maintenance stages as theorized by Prochaska and Norcross (1994). These findings are consistent with ours and led us to question factors influencing change once the decision to change has been taken.

With particular reference to working with young people, the concept of motivation is particularly significant as it is rarely their decision to enter the treatment process; usually the decision to seek treatment is made by significant adults in their life, leaving them angry and resentful (Miller & Rollnick, 2002). Much of the completed research has focused on the individual and their attitudes, whereas with this particular client group there is a definite need to examine environmental influences on an individual's motivation such as family, peers and other role models. From our previous study, responses received from parents suggest that understanding motivation to change in adolescents requires an understanding of the views of the parents and the impact of the eating disorder on the family as a whole.

Consequently, it is very important to consider the different sets of views to enable the bigger picture to be explored. In using a more exploratory approach such as that used by Serpell et al (2003), a richer form of data will be obtained with the aim of enhancing our understanding of such an under researched client group, in the expectation that improving understanding of the factors influencing motivation may be helpful in aligning parental and child attitude and motivation to change throughout the treatment process.

References:

- Bauman, S., Merta, R.J., & Steiner, R. (2001). The Development of a Measure of Motivation to change in Adolescent Substance Users: Preliminary Findings. *Journal of Child and Adolescent Substance Abuse*, 11 (2), 19-40.
- Cady, M. E., Winters, K. C., Jordon, D. A., Solberg, K. B., & Stinchfield, R. D. (1996). Motivation for change as a predictor of outcome for adolescent substance abusers. *Journal of Child & Adolescent Substance Abuse*, 5, 73-81.

DiClemente, C. C., Prochaska, J. O., Fairhurst, S. K., Velicer, W. F., Velasques, M. M., & Rossi, J. S. (1991) The process of smoking cessation: An analysis of precontemplation, contemplation, and preparation stages of change. *Journal of Consulting and Clinical Psychology*, 59, 295-304.

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McConaughy, E. A., Prochaska, J. O., & Velicer, W. F. (1983) Stages of change in psychotherapy: measurement and sample profiles. *Psychotherapy: Theory, Research and Practice*, 20 (3), 368-375.

McConaughy, E. A., DiClemente, C. C., Prochaska, J. O., & Velicer, W.F. (1989) Stages of change in psychotherapy: a follow up report. *Psychotherapy*, 26 (4), 494-503.

Miller, W. M., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change*. New York: The Guildford Press.

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Treasure, J., Schmidt, U., Todd, G., Katzman, M., Troop, M., & de Silva, P. (1999) Engagement and outcome in the treatment of bulimia nervosa: first phase of a sequential design combining motivation enhancement therapy and cognitive behavioural therapy. *Behaviour Research and Therapy*, 37, 405-418.

Sample:

Inclusion criteria

Being aged between 12 and 16 and being treating for an eating disorder, including Anorexia Nervosa, and Eating Disorder not Otherwise Specified.

Exclusion criteria

If the child or parents do not have an understanding of the English language. The reason for this is that a thematic analysis of discourse from the interviews will be difficult on translated material because the meaning may be changed.

Approximately 15 main participants will be recruited but interviews will also be carried out with the participant's parent, sibling/friend and individual worker involved in their treatment. There will be no control group.

Methods:

Semi structured interviews will be carried out to establish issues related to the young person's motivation to change their eating disorder. Interviews will be with

the young person with an eating disorder, a parent/carer, a sibling/friend and an individual worker involved in their treatment.

They will also complete the adapted version of the University of Rhode Island Change Questionnaire (URICA), a measure of motivation adapted to assess motivation to change eating behaviour and validated in terms of its psychometric properties.

Interviews will be supported by baseline measures of illness severity such as EDE-Q (Eating Disorders Examination Questionnaire), CGAS (Child Global Assessment of Severity) and BMI centile.

The interviews will be analysed using a grounded theory approach. The results of the baseline measures and the assessment of motivation will then be correlated with the main themes.

Procedure:

Participants and their parents will be written to or preferably approached in person giving them information about the research project and inviting them to take part in the study. After 24 hours, participants will then be contacted by phone regarding their consent to take part. Once consent has been given, arrangements will then be made to carry out the interviews, which will be recorded on audiotape and take place either at the participants home or their treatment centre. A list of questions (see appendix) will be devised to ask during the interviews but the structure will be flexible with room for further exploration and expansion. At this point the young person will also be required to fill out 3 baseline questionnaires.

Analysis:

Grounded Theory:

What differentiates grounded theory from much other research is that it is explicitly emergent. It does not test a hypothesis. It sets out to find what theory accounts for the research situation as it is. In this respect it is like action research: the aim is to understand the research situation. The aim as Glaser (1992) in particular states, is to discover the theory implicit in the data.

The basic process involving identifying categories from the discourse of the interviews at a low level of abstraction and then building up to more abstract theoretical concepts. The end point is often one or more core categories, which capture the essence of what is being explored. By working 'from the ground up', the aim is to discover concepts relating to the process of change that are particular to the individuals experiences. These experiences can then be compared to see if patterns emerge.

By working towards developing a new model, the hope is that this can then be used within clinical practice to conceptualise and tailor individuals' and their families' treatment programmes.

Analyses will also be performed on the scores from the baseline measure questionnaires. The scores from the motivation questionnaire will be correlated with the baseline measures to explore any relationships between severity of illness and motivation to change. Any other emerging relationships will also be explored.

Glaser, B, G. (1992) Basics of grounded theory analysis: emergence vs. forcing. Mill Valley, Ca: Sociology Press.

Application of findings:

As there is currently no evident literature into the systemic influences on motivation to change in this sample we hope to develop the understanding into the particular processes with relation to adolescents with eating disorders.

When looking at the clinical application of this it is hoped that the results will enable a forum to increase awareness of the need to assess motivation from a systemic perspective – considering all the influential factors with the aim of maximising engagement with treatment.

Appendix

Questions for semi-structured interviews (patients):

- 1. How did you come to be in treatment for your eating difficulties disorder?**
- 2. Probe: When was the last time you remember thinking about wanting to get better?**
 - a. What was it that made you think about wanting things to change?**
 - b. Did anything happen/how did it come about?**
- 3. Probe: Can you tell me about a time when you have found it really difficult to think about getting better?**
 - a. What was it that made you feel like this?**
 - b. Did anything happen/how did it come about?**
- 4. When you are at home, are there things that make it more or less likely for you to feel like getting better? [Note: Is this most likely to come about from within the individual or through interaction with others?]
What about when you are at the hospital, are there things that make it more or less likely for you to feel like getting better?**
- 5. How do you feel at the moment about getting better and the changes you have made or plan to make?**
- 6. When you have been doing well have you noticed things that can set you back?**
- 7. Looking ahead, what are the things that might get in the way of getting better?**
- 8. Who/what has helped the most since your eating difficulties began?**

9.17 – APPENDIX 17 – INTRODUCTORY LETTER TO PARTICIPANTS

Dear

In conjunction with Ellern Mede/GOS/Rhodes Farm, I am currently researching motivation to change in young people with eating disorders. I am writing to you as I am aware your child is/has been receiving treatment and I would value their and your participation in the research. The aim of the research is to gain an understanding of how young people go about changing their eating behaviour and what sorts of things may have an influence on their decisions.

The study would involve you, your child, their sibling/friend and their individual worker being interviewed individually for approximately an hour and also filling out 3 questionnaires, which should take about half an hour. The results will be used purely for research purposes and will not affect their treatment.

I have enclosed information sheets for you and your child that explain the process. If you are agreeable, I will be contacting you within the next two days to discuss the possibility of arranging an initial interview. If you would prefer not to be involved please contact me on the number below.

If you would like feedback on the outcome of the research I will be presenting a summary when the research is complete and if you have any further questions about the project please don't hesitate to contact me on 07867971367.

Yours sincerely,

**Melanie James
Counselling Psychologist (in training)**

9.18 – APPENDIX 18 – INFORMATION SHEETS FOR PARTICIPANTS AND PARENTS

MOTIVATION TO CHANGE IN YOUNG PEOPLE WITH EATING DISORDERS

INFORMATION SHEET FOR PARENTS

We would like to ask for your permission to include both yourself and your child in our research study.

The aim of the study

The aim of this research is to gain an understanding of how young people go about changing their eating behaviour and what sorts of things may have an influence on their decisions.

Why is the study being done?

We know that when a young person has an eating disorder, their feelings and thoughts about changing their behaviour can be different at different times. To start with, they may not think they have a problem or maybe at a later stage in treatment they may be more ready to start changing their eating behaviour.

It is also known that often, young people may begin changing their behaviour for many different reasons. We believe it is important to understand their experience further as there are often many parts involved in their treatment that may or may not have an impact on their attitudes to change.

Previous research has found that there are benefits to looking at a person's thoughts about changing their behaviour so that the most helpful treatments can be matched to a person's motivation to change. When there is a mismatch between a person's thoughts about change and their type of treatment, they may be less likely to begin to get better.

How is the study to be done?

The study involves your child, yourself, your child's sibling/friend and their individual worker (involved in their treatment) taking part in individual interviews lasting about an hour. The questions that will be asked will be based around how your child feels about changing at different times and what are the factors that may be influencing these shifts in attitude. The study also involves everyone completing 3 questionnaires, 1 based on their motivation to change and 2 to assess the severity of their eating disorder. These questionnaires should take about half an hour to complete.

Once all interviews are complete, a group feedback session will take place to give everyone a chance to discuss anything that came up and ask questions. The interviews will be audio taped and your GP will be informed of your child's participation but all the information you give will only be used for research purposes and will not affect their treatment

Are there any risks and discomforts?

There are no risks involved in this study.

What are the potential benefits?

In developing an understanding of how a young person goes about changing their eating behaviour, the hope is that we will then be able to use the information to help us develop our assessments and to use the most appropriate treatments.

Who will have access to the case/research records?

Only the researchers will have access to the data collected during this study.

What are the arrangements for compensation?

This project has been approved by an independent research ethics committee who believe that it is of minimal risk. However, research can carry unforeseen risks and we want you and your child to be informed of your rights in the unlikely event that any harm should occur as a result of taking part in this project.

No special compensation arrangements have been made for this project but you have the right to claim damages in a court of law. This would require you to prove fault on the part of the Hospital/Clinic and/or any manufacturer involved.

Do I have to take part in this study?

If you decide, now or at a later stage, that you do not wish your child or yourself to participate in this research project, that is entirely your right, and will not in any way prejudice any present or future treatment at this hospital/unit.

Who do I speak to if problems arise?

If you have any complaints about the way this project has been, or is being conducted, please, in the first instance, discuss them with the researcher. If the problems are not resolved, or you wish to comment in any other way, please contact the Chairman of the Research Ethics Committee, by post via the Research and Development Office, Institute of Child Health, 30 Guildford Street, London, WC1N 1EH, or if urgent, by telephone on 020 7242 9789 ext 2620, and the Committee administration will put you in contact with them.

The researcher who will have contact with your family is; Melanie James. Dr. Dasha Nicholls has overall responsibility for the project. You are welcome to contact either of them if you wish to discuss the study further.

Details of how to contact the researchers

You can contact Melanie James by ringing 07867971367. If you want to write with your concerns or for further information, please write to: Dr. Dasha Nicholls, Department of Psychological Medicine, Eating Disorders Team, Great Ormond Street Hospital, London, WC1N 3JH.

MOTIVATION TO CHANGE IN YOUNG PEOPLE WITH EATING DISORDERS

INFORMATION SHEET FOR PARTICIPANTS

We would like to ask you if you would help us with our research project.

The aim of the study

The aim of this research is to gain an understanding of how young people go about changing their eating behaviour and what sorts of things may have an influence on their decisions.

Why is the study being done?

We know that when a young person has an eating disorder, their feelings and thoughts about changing their behaviour can be different at different times.

To start with, they may not think they have a problem or maybe at a later stage in treatment they may be more ready to start changing their eating behaviour.

It is also known that often, young people may begin changing their behaviour for many different reasons. We believe it is important to understand your experience further as there are often many parts involved in your treatment that may or may not have an impact on your attitudes to change.

Previous research has found that there are benefits to looking at a person's thoughts about changing their behaviour so that the most helpful treatments can be matched to a person's motivation to change. When there is a mismatch between a person's thoughts about change and their type of treatment, they may be less likely to begin to get better.

How is the study to be done?

The study involves you, one of your parents, your brother/sister or friend and your individual worker (involved in your treatment) taking part in individual interviews lasting about an hour. The questions that will be asked will be based around how you may have changed your eating behaviour at different times and what sorts of decisions you may have made about change. The study also involves everyone completing 3 questionnaires, 1 based on your motivation to change and 2 focusing on your eating disorder. These questionnaires should take about half an hour to complete.

Once all interviews are complete, a group feedback session will take place to give everyone a chance to discuss anything that came up and ask questions. The interviews will be audio taped and your GP will be informed of your participation but all the information you give will only be used for research purposes and will not affect your treatment.

Are there any risks and discomforts?

There are no risks involved in this study.

What are the potential benefits?

In developing an understanding of how a young person goes about changing their eating behaviour, the hope is that we will then be able to use the information to help us develop our assessments and to use the most appropriate treatments.

Who will have access to the case/research records?

Only the researchers will have access to the data collected during this study.

What are the arrangements for compensation?

This project has been approved by an independent research ethics committee who believe that it is of minimal risk. However, research can carry unforeseen risks and we want you to be informed of your rights in the unlikely event that any harm should occur as a result of taking part in this project.

No special compensation arrangements have been made for this project but you have the right to claim damages in a court of law. This would require you to prove fault on the part of the Hospital/unit and/or any manufacturer involved.

Do I have to take part in this study?

If you decide, now or at a later stage, that you do not wish to participate in this research project, that is entirely your right, and will not in any way prejudice any present or future treatment at this hospital/unit.

Who do I speak to if problems arise?

If you have any complaints about the way this project has been, or is being conducted, please, in the first instance, discuss them with the researcher. If the problems are not resolved, or you wish to comment in any other way, please contact the Chairman of the Research Ethics Committee, by post via the Research and Development Office, Institute of Child Health, 30 Guildford Street, London, WC1N 1EH, or if urgent, by telephone on 020 7242 9789 ext 2620, and the Committee administration will put you in contact with them.

The researcher who will have contact with your family is: Melanie James. Dr. Dasha Nicholls has overall responsibility for the project. You are welcome to contact either of them if you wish to discuss the study further.

Details of how to contact the researchers

You can contact Melanie James by ringing 07867971367. If you want to write with your concerns or for further information, please write to: Dr. Dasha Nicholls, Department of Psychological Medicine, Eating Disorders Team, Great Ormond Street Hospital, London, WC1N 3JH.

9.19 – APPENDIX 19 – CONSENT FORMS

Study Number:

Patient Information number for this trial:

CONSENT FORM FOR PARTICIPANT

Title of project: Factors influencing motivation to change in adolescent eating disorders: a systemic perspective.

Name of researcher: Melanie James

Please initial the box next to each statement and sign below.

1.	I confirm that I have read and understood the information sheets provided about the above study.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without my medical care or legal rights being affected.	
3.	I agree to take part in the above study.	
4.	I agree for the interviews to be audio taped.	
5.	I agree to my GP being informed that I am taking part in the above study.	
6.	I give permission for my friend/sibling to be approached to take part in the above study.	

Name of participant
(block capitals)

Date

Signature

I have explained the nature, demands and foreseeable risks of the above research project to the parent and their child (participant).

Name of researcher
(block capitals)

Date

Signature

Study Number:

Patient Information number for this trial:

CONSENT FORM FOR PARENTS

Title of project: Factors influencing motivation to change in adolescent eating disorders: a systemic perspective.

Name of researcher: Melanie James

Please initial the box next to each statement and sign below.

1.	I confirm that I have read and understood the information sheets provided about the above study.	
2.	I understand that my child's participation is voluntary and that I am free to withdraw them at any time without their medical care or legal rights being affected.	
3.	I agree for my child to take part in the above study.	
4.	I agree to take part in the above study.	
5.	I agree for the interviews to be audio taped.	
6.	I agree to my child's GP being informed that my child is taking part in the above study.	

Name of child (block capitals)

Name of parent (block capitals) Date Signature

I have explained the nature, demands and foreseeable risks of the above research project to the parent and their child (participant).

Name of researcher Date Signature
(block capitals)

9.20 – APPENDIX 20 – LETTER TO SIBLING/FRIEND

Dear.....,

With the agreement of Ellern Mede/GOS/Rhodes Farm, I am currently researching motivation to change in young people with eating disorders and "X" has nominated you to take part in this research study with them (please see their consent form attached).

The study would involve you, X, their parents and their individual worker being interviewed individually for approximately an hour and also filling out 3 questionnaires, which should take about half an hour. The results will be used purely for research purposes and will not affect their treatment.

I have enclosed information sheets for you that explain the process and I will be contacting you within the next two days to arrange an initial interview.

If you would like feedback on the outcome of the research I will be presenting a summary when the research is complete and if you have any further questions about the project please don't hesitate to contact me on 07867971367.

Yours sincerely,

Melanie James
Counselling Psychologist (in training)

9.21 – APPENDIX 21 – ADAPTED CHILD VERSION OF URICA

Hospital/Clinic Code:

No:

STAGES OF CHANGE QUESTIONNAIRE

You are/have been receiving treatment for problems with your eating and this questionnaire will ask you about how you feel about those problems.

Please complete the following questionnaire by marking a cross on the line as to how much you agree or disagree with the statement above it.

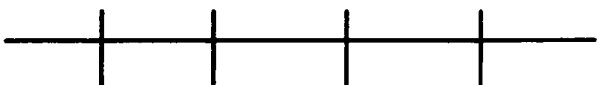
For example:

1. I do not think I have any eating problems that need changing.

Agree  Disagree

If you don't think the statement applies to you at all then mark it as a disagree.

1. My eating is not the problem. I don't know why I am here.

Agree  Disagree

2. I might change the way I eat.

Agree  Disagree

3. I have been doing something about the eating problems that have been worrying me.

Agree  Disagree

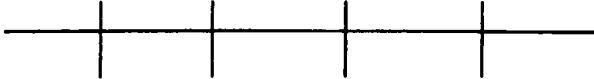
4. It could help to talk about my eating problem.

Agree  Disagree

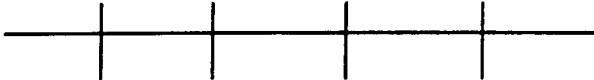
5. I don't think I have any eating problems that need changing.

Agree  Disagree

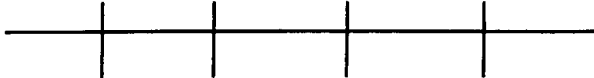
6. I am worried that my eating problem might come back so I have come here for someone to help me.

Agree  Disagree

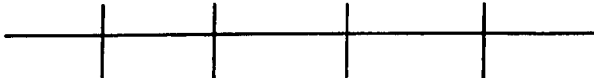
7. I am trying to change my eating patterns at last.

Agree  Disagree

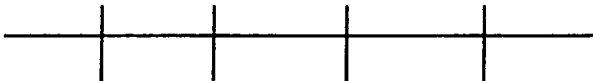
8. There is something about my eating problem that I might want to change.

Agree  Disagree

9. I have done well on working on my eating problem but I am not sure I can keep doing well without help from others.

Agree  Disagree

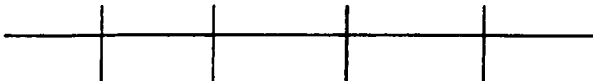
10. Sometimes my eating problem is difficult for me but I am trying to change it.

Agree  Disagree

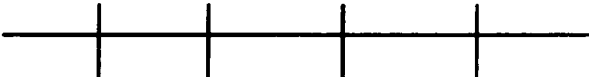
11. It is a waste of time being here. It's not me who has the problem.

Agree  Disagree

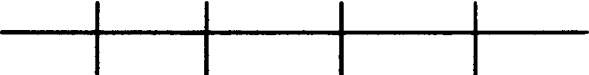
12. I hope someone can help me change the way I eat.

Agree  Disagree

13. I may not be perfect, but I don't think I need to change the way I eat.

Agree  Disagree

14. I am really working hard to change my eating problem.

Agree  Disagree

15. I have an eating problem and I think I should change it.

Agree  Disagree

16. It is difficult to keep to the changes I have made to my eating habits as well as I had hoped.

Agree  Disagree

17. Although I don't always do well in trying to change my eating pattern, I am at least working on it.

Agree  Disagree

18. I thought that once I had got over my eating problem it would have gone away but sometimes I still find it difficult.

Agree  Disagree

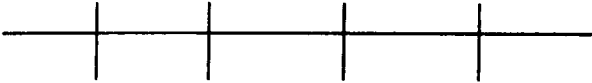
19. I don't know how to change the way I eat, but I would like to try.

Agree  Disagree

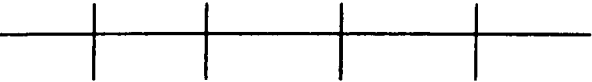
20. I have started working on my eating problems but I would like some help with them.

Agree  Disagree

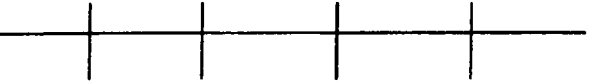
21. Maybe this place might help me.

Agree  Disagree

22. I may need some extra help at the moment to keep to the changes I have made to my eating patterns.

Agree  Disagree

23. As it is, I don't think my eating is *really* part of the problem.

Agree  Disagree

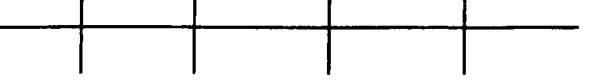
24. I hope someone knows how to help me.

Agree  Disagree

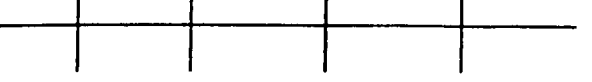
25. I am not just talking about my problem anymore.

Agree  Disagree

26. Talking about eating problems is boring. Why can't people forget about their problems.

Agree  Disagree

27. I am here to stop my eating problems from coming back.

Agree  Disagree

28. My eating problem had gone away, I would hate to admit it might be coming back.

Agree  Disagree

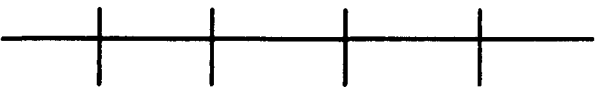
29. I have the same sort of worries that other young people have. I don't see the point in talking about them.

Agree  Disagree

30. I am doing something about my eating problem now.

Agree  Disagree

31. Things are fine as they are. I don't need to change.

Agree  Disagree

32. After everything I have done to get rid of my eating problem, it still haunts me every now and then.

Agree  Disagree

9.22 – APPENDIX 22 – EDE-Q

EATING QUESTIONNAIRE

Instructions: The following questions are concerned with the past four weeks (28 days) only. Please read each question carefully. Please answer all of the questions. Thank you.

Questions 1 to 12: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days) only.

On how many of the past 28 days	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
1 Have you been deliberately <u>trying</u> to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
2 Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight?	0	1	2	3	4	5	6
3 Have you <u>tried</u> to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
4 Have you <u>tried</u> to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
5 Have you had a definite desire to have an <u>empty</u> stomach with the aim of influencing your shape or weight?	0	1	2	3	4	5	6
6 Have you had a definite desire to have a <u>totally flat</u> stomach?	0	1	2	3	4	5	6
7 Has thinking about <u>food, eating or calories</u> made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
8 Has thinking about <u>shape or weight</u> made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
9 Have you had a definite fear of losing control over eating?	0	1	2	3	4	5	6
10 Have you had a definite fear that you might gain weight?	0	1	2	3	4	5	6
11 Have you felt fat?	0	1	2	3	4	5	6
12 Have you had a strong desire to lose weight?	0	1	2	3	4	5	6

Questions 13-18: Please fill in the appropriate number in the boxes on the right. Remember that the questions only refer to the past four weeks (28 days).

Over the past four weeks (28 days)

13 Over the past 28 days, how many <u>times</u> have you eaten what other people would regard as an <u>unusually large amount of food</u> (given the circumstances)?	
14 On how many of these times did you have a sense of having lost control over your eating (at the time that you were eating)?	
15 Over the past 28 days, on how many DAYS have such episodes of overeating occurred (i.e., you have eaten an unusually large amount of food <u>and</u> have had a sense of loss of control at the time)?	
16 Over the past 28 days, how many <u>times</u> have you made yourself sick (vomit) as a means of controlling your shape or weight?	
17 Over the past 28 days, how many <u>times</u> have you taken laxatives as a means of controlling your shape or weight?	
18 Over the past 28 days, how many <u>times</u> have you exercised in a "driven" or "compulsive" way as a means of controlling your weight, shape or amount of fat, or to burn off calories?	

Questions 19 to 21: Please circle the appropriate number. Please note that for these questions the term "binge eating" means eating what others would regard as an unusually large amount of food for the circumstances, accompanied by a sense of having lost control over eating.

19 Over the past 28 days, on how many days have you eaten in secret (ie, furtively)? Do not count episodes of binge eating	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
	0	1	2	3	4	5	6
20 On what proportion of the times that you have eaten have you felt guilty (felt that you've done wrong) because of its effect on your shape or weight? Do not count episodes of binge eating	None of the times	A few of the times	Less than half	Half of the times	More than half	Most of the time	Every time
	0	1	2	3	4	5	6
21 Over the past 28 days, how concerned have you been about other people seeing you eat? Do not count episodes of binge eating	Not at all		Slightly		Moderately		Markedly
	0	1	2	3	4	5	6

Questions 22 to 28: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days).

Over the past 28 days	Not at all		Slightly		Moderate -ly		Markedly
22 Has your <u>weight</u> influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
23 Has your <u>shape</u> influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
24 How much would it have upset you if you had been asked to weigh yourself once a week (no more, or less, often) for the next four weeks?	0	1	2	3	4	5	6
25 How dissatisfied have you been with your <u>weight</u> ?	0	1	2	3	4	5	6
26 How dissatisfied have you been with your <u>shape</u> ?	0	1	2	3	4	5	6
27 How uncomfortable have you felt seeing your body (for example, seeing your shape in the mirror, in a shop window reflection, while undressing or taking a bath or shower)?	0	1	2	3	4	5	6
28 How uncomfortable have you felt about <u>others</u> seeing your shape or figure (for example, in communal changing rooms, when swimming, or wearing tight clothes)?	0	1	2	3	4	5	6

What is your weight at present? (Please give your best estimate.)

What is your height? (Please give your best estimate.)

If female: Over the past three-to-four months have you missed any menstrual periods?

If so, how many?
Have you been taking the "pill"?

THANK YOU

9.23 – APPENDIX 23 - CGAS

Children's Global Assessment of Functioning (GAF) Scale

Rate the subject's most impaired level of general functioning for the specified time period by selecting the lowest level which describes his/her functioning on a hypothetical Continuum of health-illness. Use intermediary levels (e.g. 35, 58, 62). Rate actual functioning regardless of treatment or prognosis. The examples of behavior provided are only illustrative and are not required for a particular rating.

Specified Time Period: 1 month

91-100

Superior functioning in all areas (at home, at school, and with peers); involved in a wide range of activities and has many interests (e.g. has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc): likeable, confident; "everyday" worries never get out of hand; doing well in school; no symptoms

81-90

Good functioning in all areas; secure in family, school, and with peers; there may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g. mild anxiety associated with an important exam. occasionally "blowups" with siblings parents, or peers)

71-80

No more than slight impairment in functioning at home, at school; or with peers; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g. parental separations, deaths, birth of a sib), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them

61-70

Some difficulty in a single area, but generally functioning pretty well (e.g. sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern

51-60

Variable functioning with sporadic difficulties or symptoms in several but not all

social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings

41-50

Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships

31-40

Major impairment in functioning in several areas and unable to function in one of these areas, e.g. disturbed at home, at school, with peers or in society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent: such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not a sufficient criterion for inclusion in this category)

21-30

Unable to function in almost all areas, e.g., stays at home, in ward, or in bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate)

11-20

Needs considerable supervision to prevent hurting others or self (e.g. frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication, e.g. severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

0-10

Needs Constant supervision (24-hr care) due to severely aggressive or destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene

Children's Global Assessment Scale was adapted from the Global Assessment Scale for Adults

Children's Global Assessment Scale- Shaffer et al 1229

9.24 – APPENDIX 24 – ADAPTED PARENT VERSION OF URICA

Patient Name:

Hospital Number:

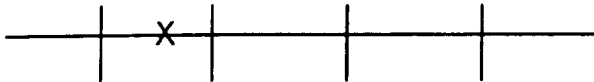
Code: P.....

STAGES OF CHANGE QUESTIONNAIRE

Please complete the following questionnaire by marking a cross on the line as to how much you agree or disagree with the statement above it.

For example:

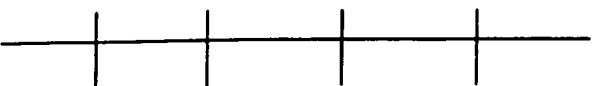
1. My/our child does not think they have any eating problems that need changing.

Agree  Disagree

1. My/our child does not think they have any eating problems that need changing.

Agree  Disagree

2. My/our child might change the way they eat.

Agree  Disagree

3. My/our child is doing something about the eating problems that have been worrying them.

Agree  Disagree

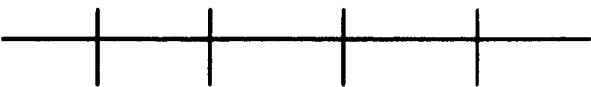
4. It could help for my/our child to talk about their eating problem.

Agree  Disagree

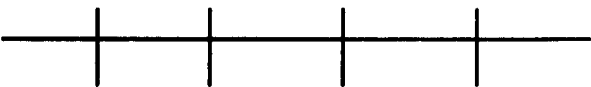
5. My/our child thinks eating is not the problem. They don't know why they are here.

Agree  Disagree

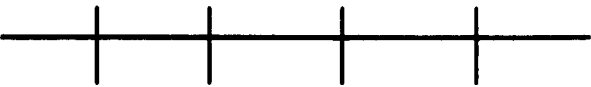
6. My/our child is worried that their eating problem might come back so they have come here for someone to help them.

Agree  Disagree

7. My/our child is trying to change their eating patterns at last.

Agree  Disagree

8. There is something about my/our child's eating problem that they might want to change.

Agree  Disagree

9. My/our child thinks they have done well on working on their eating problem but they are not sure they can keep doing well without help from others.

Agree  Disagree

10. Sometimes my/our child's eating problem is difficult for them but they are trying to change it.

Agree  Disagree

11. My/our child thinks it is a waste of time being here. They don't think it is them who has the problem.

Agree  Disagree

12. My/our child hopes someone could help change the way they eat.

Agree  Disagree

13. My/our child may not think they are perfect, but they don't think they need to change the way they eat.

Agree

Disagree

14. My/our child is really working hard to change their eating problem.

Agree

Disagree

15. My/our child has an eating problem and they think they should change it.

Agree

Disagree

16. My/our child is finding it difficult to keep to the changes they have made to their eating habits as well as they had hoped.

Agree

Disagree

17. Although my/our child does not always do well in trying to change their eating pattern, they are at least working on it.

Agree

Disagree

18. My/our child thought that once they had got over their eating problem it would have gone away but sometimes they still find it difficult.

Agree

Disagree

19. My/our child does not know how to change the way they eat, but they would like to try.

Agree

Disagree

20. My/our child has started working on their eating problems but they would like some help with them.

Agree  Disagree

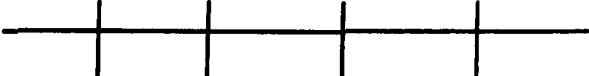
21. My child thinks maybe this place might help them.

Agree  Disagree

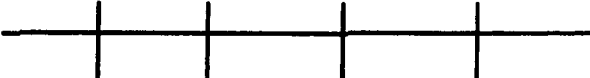
22. My/our child may need some extra help at the moment to keep to the changes they have made to their eating patterns.

Agree  Disagree

23. As it is, my/our child does not think their eating is really part of the problem.

Agree  Disagree

24. My/our child hopes someone knows how to help them.

Agree  Disagree

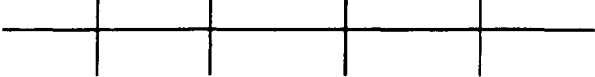
25. My/our child is not just talking about their problem anymore.

Agree  Disagree

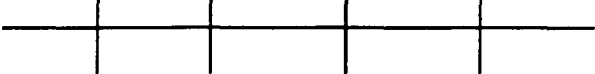
26. My/our child thinks talking about eating problems is boring. They don't know why people can't forget about their problems.

Agree  Disagree

27. My/our child is here to stop their eating problems from coming back.

Agree  Disagree

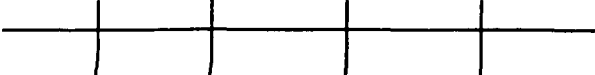
28. My/our child thought their eating problem had gone away but they would hate to admit it might be coming back.

Agree  Disagree

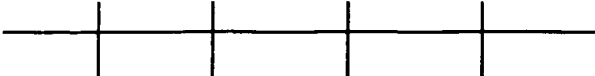
29. My/our child thinks they have the same sort of worries that other young people have. They don't see the point in talking about them.

Agree  Disagree

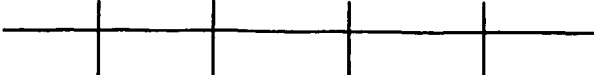
30. My/our child is doing something about their eating problem now.

Agree  Disagree

31. My/our child thinks things are fine as they are. They think they don't need to change.

Agree  Disagree

32. After everything my/our child has done to get rid of their eating problem, it still haunts them every now and then.

Agree  Disagree

9.25 – APPENDIX 25 – FULL LIST OF CATEGORY QUOTES

Results quotes

What does getting better mean?

"It depends what you mean by wanting to get better, I think getting better for her is getting to a point where people don't consider her eating disorder to be a serious risk. She can only consider herself better when she can accept the way she looks and without eating what everybody wants her to eat. So her idea of getting better is not the same as everybody else's."

"Well, I'm trying and I don't really think of it as getting better I think of it as trying to get better and I don't really know if I can sometimes as it's not really working. Getting better means not worrying about what I'm eating and eat normally, like I haven't eaten sweets or chocolate or chips or anything like that for three years. So eating normally, maybe having a MacDonald's or something once or twice a week and not worrying how much I've got like one day I might have a big lunch and then the next day I'll have a small lunch so that would be better. Not look at myself in the mirror and see a fat person."

"To me it means going back to what I was before and I don't want to be like that"

"I don't really know what getting better involves so I don't really know what I might have to give up or do. Because of that it makes it difficult to know whether I want it or not. Can't really prepare myself because I don't really know."

".....so if she could be at home, in school, without having to eat and without having to have these horrible feelings then that would be okay and that's where we differ I suppose."

"I think it means being able to come home, being able to go back to school and being able to mix with her friends again but still being able to be slim, that's how she would see it, still have some control over her eating so that she doesn't get, I wouldn't say fat but she doesn't want to be average, she always wants to be slim. for S it's I get to this weight and then I'm better rather than the weight is really irrelevant it's how she's thinking and being able to cope with her life."

"Getting better for H is – if someone says to her oh you're looking better she sees that as oh you're looking fatter but whereas I would think that was good. So that's where I think she still wants the illness and doesn't want to look better and doesn't like people telling her that she looks better."

Being an inpatient

"...obviously there are disadvantages to having everybody with anorexia and there probably are advantages too, recently somebody's come to this clinic and they're very very unwell and I think it really scared S, she's very obsessive about this young person who's very ill and I think in a strange kind of way I think it's motivated her to want to get better, being able to see outside herself and see the sadness to the illness. But basically I think she would find it easier not being with other children with eating disorders."

"The not wanting to get better is probably when new admissions come in and it throws everybody off because everyone starts thinking oh I came in that low and things like that.. "

"Sometimes when you see other people here struggling you think I wish I was like that but then you were there and you think I don't want to get back like that so that can make a difference to how you're feeling about things"

"...there's something about being very ill and there's a kind of jealousy about that and that it's not good to be getting better so sometimes she doesn't want to show it."

"She finds it difficult being one of the old ones here because all the new ones are small and thin and she hates it when new ones come in and are tiny, she feels a frump."

"One of the things is like peer pressure within the unit and there are people that cheat the system and you think well should I be doing that, does that mean I'm just fine now, maybe I should be doing it.....I think that's the biggest thing that can make you slip up, thinking people have got away with doing it so maybe I should be doing it."

"There's another patient who's suddenly making a lot of changes who's L's quite close to so she's got motivation from him so that's making it easier.."

"She saw people that couldn't get better and she'd be like I've got to get better to get out because I don't want this to control my life and other days when she was with a group of people like her friends in there and they all talked about it and they all clubbed together and it was like it was their thing and she felt like she was part of something and in a way she quite liked being part of that group."

"Well, when there was like L and E (other anorexic patients) there, it kind of, I don't know if it made me think about getting better but they helped me

think about getting better, or like that, well E helped me start eating again, then I was like E to L, because I helped L start eating again."

"I think at one point she thought, why's this happening to me and nobody else and I think seeing children in the same situation and seeing them get better helped her."

"That's why all her motivations are wrong wanting to come back here, it's not about wanting to get better. But I do think she does want to get better, something's changed within her, in that life outside is more tempting than staying in because it wasn't tempting for a long time."

"I don't think she's ever expressed a wish to get better except to get out of here."

"I think although here I still don't want to change my eating patterns at all, I do want to go home so in that sense I do want to get better"

"...thoughts of wanting to get home and contact from friends at home, time on the internet and drums, things like that motivate her really well."

"I've missed out on so much, I've missed out on two holidays, I was meant to be in two shows at one of my theatres and I was devastated. I couldn't sing because there's nowhere to sing in here. I couldn't act, I couldn't do any of the things I love doing. Whereas if I'm out I can still be doing them and just coping with it (the anorexia) being there."

"I think she is motivated by being sick of being in an inpatient setting and not being able to see her friends. She's very sociable and has very good social skills, so not wanting to be here."

"I'm scared of getting better although I've accepted that that's what needs to happen. And going home is also quite scary because I've been used to being in hospital."

"Well sometimes I think it would be better if I could just stay ill because it's safer here but then out of here seems a bit safer sometimes."

"I find it really difficult because I'm not here by choice, they forced me to come. I don't want to change by choice but I've got to because if I don't change when I get out I'll have to come back and I don't want to so I may as well do it while I'm here."

"I've probably had the thoughts of getting better when being questioned about being put on a section and wondering if I could do anything to stop this happening."

"....you don't have a choice so you were just kind of eating and trying not to worry about it. It wasn't really me wanting to but I just wanted to get home and didn't want to be tube fed."

"So she's been pretty deskilled really in terms of choices but she's had to be really to get her to eat. She's got to relearn now how to make informed choices. The food is almost like a side issue now, she can't refuse food here or at home, that bit's cured now but it's more about becoming a mini adult."

Normal life

"The fact that we're surrounded by each other all the time, it's like calorie, calorie, food, exercise, just all about food, food, food. That's not normal and I don't think anyone can start to recover from it until they're out of here and start living a normal life.....until you get out into the real world and experience real world experiences, you're not going to get better."

"I really want to get better and be normal, no plans, in a way I'm hoping other people will help, I try to get better myself but nobody's really helped that much either."

"She is genuinely trying at the moment and just wants to be a normal teenage girl, buy teenage clothes and shoes."

DEVELOPMENT

Having periods/children

"Umm, I don't know. It could have been possibly when she started her period again which was a few weeks back now, because she so badly wanted her periods back and that was a sort of a target for her to get to that point. Then she knew and we knew that she was getting better and almost the right weight and I think she might have possibly thought that she wanted to get better."

"And I do want to have children and I'd have to sort it out then because I wouldn't want my child or whatever to get it and they say you're much more likely to get it if you're parent had it or whatever so I wouldn't want them to get it."

"She says little things like her periods have come back, I'm pleased that my periods have come back, well why, well it means I can have children if I want to. Well it's also to do with them lowering her target weight, the majority being about the target weight. But for me that's encouraging because the tiny bit can become better."

"She wants to have children so she wants that part to get back to normal."

"I know when she had her first weekend that really helped. When she got her target lowered because she got her periods that influenced her and it didn't seem too bad."

Changing body shape

"Fear of change, I really think it boils down to fear of change, fear of developing umm not so much fear of independence but fear of maturation so changing body and weight."

"Another thing I think is de-motivating for her is seeing her friends and thinking they've got fat. Obviously they've gone through puberty and are just normally developed but she is scared that if she goes through puberty she'll end up fat like them."

"We say to her that as you get older your body will change and she can't seem to understand or can't see or doesn't want to see that difference."

She was quite squeamish about any kind of physical development. When we talked to her about the effects of her being underweight for a long time, her main preoccupation was that she wanted to be taller; she certainly didn't want to be anymore physically developed as a young women.

Growing

"Growing is what I'm looking forward to most."

FRIENDS

"I want to get better but I don't want it to take a long time because I want to see my friends."

"Friends has come up recently, we're doing a trip on Sunday to the cinema for the first time in ages and that's reminding her of times she's been to the cinema with her being able to do that and she's thinking about that but wanting to do it without going home I think but it's early stages."

"....she's got one very good friend who's been very loyal to her and sees her nearly every weekend she comes home and I think that's helped her a lot. Having that friendship, a lot of children with anorexia, their friends just disappear after a while but this particular friend has been unbelievable for

a 12/13 year old girl to be as amazingly supportive to S, so I think that's helped a lot.

"But I just think it's healthier now because she will come and say can I go round and see one of her friends, I'll be back by a certain time. A lot of them are the old friends and where they couldn't deal with the situation when it all first happened they sort of lost contact with her and they're now slowly coming back again."

"I'd say her friends are just as important to her and seeing other young people do and can make changes.."

"..she has 2 girlfriends that have been writing to her and she's been writing back a lot and I know she's been putting in her letters the same sort of things she's been talking to us about and neither of them have judged her."

"A lot of it revolves around friendship patterns and the inability to cope with all the dynamics of what was going on."

"...the fact that she's doing something now and she's made friends, good friends, is pushing her along."

"..sometimes I talk to my friends on the phone and we arrange days we can meet. I didn't usually see my friends a lot, only in school but now I go round theirs or they come round mine."

"I think it's going to be really hard, going to make new friends who don't know about it because I'd have to tell them."

"Friends and being around people, I know the minute she feels a bit lonely or is hurt by a friend or gets into the wrong crowd, that will knock her back again."

"Friends that she's met, that has helped her along."

"When I'm here, talking to my friends makes me want to get better.."

"I think seeing people back in Leicester did help, not that I was able to make improvements but I was more able to think about things."

"I don't think her friends help her that much, she's got a few friends who are ok but some of her friends say things to her like oh you look fine, you look fine at the weight you are, which is really the worst thing she could hear."

"Her friends have been motivating for her in some ways, supporting her"

"..it's really disappointing and it would be nice to be with your friends and not worry about eating stuff..."

ACTIVITIES

Music (singing, playing drums, CD's)

"When I go home for the weekends I do a lot of singing and acting, that's my passion, I just love it. I did some singing for three and a half hours with a guy that I perform with but I hadn't done for about 5 months and it felt so good. I loved it and I really wanted to do that so I guess that's in the right direction for wanting to do other things because before when I was really underweight I didn't want to."

"Music has helped her, M, H and M love music, dissect it and each week she has another CD she gets into heavily and that's helped her with her work and music has been a big part of her recovery."

"...she loves playing the drums, she's good at that and she's very good if you give her goals to reach, she's good at motivating herself to reach them.."

Watching TV or DVD's

"I think the things that help are , I don't know, just doing something really, something like watching a DVD or TV or something like that."

General hobbies

"I thought of stuff that I wanted to do and I knew that I couldn't do it if I've got anorexia. Like hobbies and things when I'm older and stuff like that.'

(What helps?) "Going places, having fun."

Walking, playing badminton

"Go walking or play badminton as a family, she has fun despite herself, she has fun. She is laughing now and it's a long time since we've seen her laugh.'

Having a pet

"The thing that's made a huge difference is getting her a rabbit, now that might sound silly but once we got the rabbit she totally started to change and so she had something to care for, something to live for, responsibility.....But once we got the rabbit she was out in the garden, she involved us with the rabbit and things moved on from there."

"We bought a dog now, we bought a puppy because we always agreed that when she was 16 she could get a dog and it coincided with her discharge so we've got a puppy at home and that belongs to Sarah, so that has given her some motivation to come home because up to a few weeks ago she didn't even want to come home."

"All the time, there are flashes now when she can think about taking the puppy to obedience classes which is something she can look forward to which is a new thing."

SCHOOL

As a distraction

"Well hopefully it's starting some normal activities, getting back to school, she's not going back to her old school, she's going to a new school and starting a work placement in a nursery organised by the school."

"We're getting towards exam time and she wants to be back at school, back with friends so that's going to be a motivation..."

"When she's motivated and on track is when there's school because I think she finds it very difficult being in a clinic with lots of other children with the same kind of illness as her and it's difficult to be motivated when there's others that are much more motivated and some that are thinner and worse than yourself."

"Things that distract her like school work, when she's doing things and when we had half term I'm really pleased I get a week off but for her she's here and they didn't get a week off and she was really happy about that because she gets bored."

"....she hates half terms and holidays because there's no school and she doesn't find she's distracted enough."

"When I'm at school and I'm talking to people, it's like if there's 12345 things in my head say, it's like the second thing instead of the first, it's usually the first but not always and I'll still like even when sometimes I'm very withdrawn when I'm talking to people but probably when I'm talking to people or when there's a lesson or something but I'm getting quite withdrawn in class at the moment but it's probably better when there's something to do."

Pressure of school environment and to achieve

"I think my concern is when she's back at school, at the moment she's motivated and trying but that won't last and we'll revert to well she's not having lunch."

"The worry of anticipating going back to school, she would say I'll eat tomorrow or I'll eat when I go back."

"School and the pressure she goes to quite a high performing school and she feels that's too much, that might not help because the school don't seem to have a very good understanding of eating disorders at the moment so the teachers have got quite a lot of work to do there to take the pressure off a bit."

"Well she's starting a different school in September so that could be difficult because she's up to community college. She's looking forward to it but you just don't know until she gets there, because she looks forward to things and then they come and they're not as she wishes they would be."

"I can imagine that if she doesn't settle at school or has problems at school or problems with friends might make her lose her footing again."

Choice and control

An aspect that arose as a motivational factor solely for the young person was the degree of choice or level of control that the individual has within their treatment programme. This feature is particularly important with the age group of this sample as their parents still hold the ultimate control and can make decisions on their behalf should it be deemed beneficial for them

Choice of food

"Well I can deal with it by thinking I can be at home and lose weight but then again I would have to come back here and eat all the crap, like chocolate, cheese and chips and nobody's illness in their right mind would choose to eat that. That would be motivating me, the food I'd have to eat if I came back here because it's just junk. Whereas if I was at home I could eat the things I want to eat, be sensible about it but make the most of the fact of eating healthy. Once you come to terms with the fact that you have to eat, you may as well eat what you want to eat, so I'll eat pasta and vegetables and fruit and I'll eat meat. I think that will be motivating."

Choice to eat/control over eating

"I just feel rough all the time, I've just had to accept that I don't have a choice, I accept that I've got to be this weight, I don't have a choice."

"I can't imagine myself without it being there, I just can't. Yeah it's like there's two parts to the illness, there's the psychological part, the body image the eating problem and then there's weight loss, the physical change and when you come in here that part is taken away from you and suddenly you can't be underweight anymore you can't lose weight, you've got no control over it at all. The psychological part is automatically going to take over, so before I came in here I was eating, I wasn't eating much whereas now if I had a choice I wouldn't touch a thing."

"....you don't have a choice so you were just kind of eating and trying not to worry about it. It wasn't really me wanting to but I just wanted to get home and didn't want to be tube fed."

Choice to be treated

"I find it really difficult because I'm not here by choice, they forced me to come. I don't want to change by choice but I've got to because if I don't change when I get out I'll have to come back and I don't want to so I may as well do it while I'm here."

'I've probably had the thoughts of getting better when being questioned about being put on a section and wondering if I could do anything to stop this happening.'

Control over life

As one parent describes it below, it's like a necessary process that has to happen to enable someone to think and behave more healthily.

"So she's been pretty deskilled really in terms of choices but she's had to be really to get her to eat. She's got to relearn now how to make informed choices. The food is almost like a side issue now, she can't refuse food here or at home, that bit's cured now but it's more about becoming a mini adult."

EMOTIONS

"I think it's easier in one way that she can move forward as things are so much more structured here and there aren't the emotions involved that there are at home and they can move on to planning phase and they're likely to meet resistance by adhering to the plan but they're more likely to stick at it and get E to think through and stick at it so it's easier from that point of view although but I guess what I'm trying to say is that it will be easier to achieve here without the emotional attachment of home. I think what's difficult for E is easy to achieve."

Worry/feeling nervous

"If I get upset or told off or something I get worried about doing badly and I do do badly and if I am doing well I get worried that I can't keep it up and I'll do badly and people will be disappointed and I'll be disappointed."

"It's hard to imagine being better but I still want to get better it's harder when it's really bad. Sometimes it's because I'm worried about something but sometimes it's anything."

"Just if anything big happens it can be quite hard to cope with like if you got nervous or something I feel really sick and find it hard to eat."

"As I said I think it's going to be quite tough, when she does get quite overwhelmed or if there are going to be problems in school, as there always will be or problems at home as there always will be, that her first response is maybe to go back to exercising."

"...she was always someone who was able to think very well but so worried and anxious what certain people thought of her or thought of her ideas so that was hard for her sometimes and she found it very difficult to communicate her feelings and whenever she felt overwhelmed or was experiencing a lot of feelings she always put it into having too much energy so she started to develop a way of being able to communicate or even recognise what she was feeling and put words to it. That was when

her activity began to drop off, as she wasn't using it as a means of communication."

"We always know that if you have to tell C off about something or she's upset then it's almost impossible and the danger with C is that once she gets in a bad place she spirals downwards and it's very difficult to get out of that spiral."

Feeling annoyed

"So when I'm annoyed or angry I don't really think about getting better, like nothing's better and all that. But when I'm feeling like sad but it's just a normal day like now, I feel sad but like everyday it's sad but sometimes it's different like you can feel more sad or more annoyed. It's kind of hard then. It depends what's going on around you."

Anger

"Well on MCU when people were having difficulty not just with eating but with say anger, it was kind of hard then because there was loads of stuff going on outside and loads of stuff going on inside and you didn't know what to do."

"I think anger is a huge thing with S, she finds it difficult to express her distress and it tends to come out in anger about the system and about the nurses, about the doctors and I mean everybody here is horrible, obviously."

SUPPORT/UNDERSTANDING

From parents/family

"My parents probably because they haven't given up, they kind of, they do accept me for who I am and feel uncomfortable saying you look better but people here have told them to say that, tell the truth and I respect that. They do try really hard and will do anything and they kind of like have been through a bit of a rough year and are still ok about it. So my parents probably."

"she has become very close to my husband which is lovely for me to see and he does seem to be able to say the right things, He has been an absolute rock for her."

"I think Mum and Dad, they've been amazing because however hard it's been they've taken so much from her, they've taken so much grief and I think it's helped her to realise how serious it is."

"She says that clinics don't help but obviously they have helped a lot. I don't know her family, I mean all of her family have been really supportive of her so that has helped her a bit."(S.8)

"I think her sister has also been very supportive and I think sometimes it's easier for a young person to talk to their sibling rather than their parents because they're of a similar age and she doesn't take any rubbish."

"So I think people just generally taking an interest and I think she's grown a really closer bond with her parents and they've grown together because of it."

From individual therapist/nurse and staff

"From my point of view I think the staff here have worked wonders because she's no longer harming herself, she's no longer talking about suicide and killing herself, all the stuff she was talking about before she came here. So from my point of view just being here has transformed things enormously but I don't think she sees that and she will probably say nothing has helped."

"I think her individual work helped as well and you know the way she copes, she's been taught how to cope."

"Probably her therapist here and her therapist at home, both of whom are quite motherly people and I do think that gives her a lot without feeling judged and she's starting to do this work as there's something she's never told anybody before and that does seem to be working and she seems more confident in herself and more able to be herself."

"While she was in Leicester she had therapy with a psychiatric nurse looking at the thought processes that go along with anorexia and she found those quite helpful and while she's been here a similar support worker has helped her and has used the support well to talk over her problems."

"Sometimes staff can help you think about things."

"She's found the individual therapist very helpful, she's found that very motivating. She also had a course of CBT to help her with some of her rituals and she found that very helpful but that's finished now,"

"..her key nurse and the school has really helped, the teachers here have helped her to believe in herself and helped her to cut off from her illness which has been very successful. I think it's so terribly important and by believing in her it's given her a sense of self-confidence."

"The hospital definitely, when she was in hospital it was good how, we were informed how things were so we could act the same way so we weren't going in different directions and things because that was so important because she'd play anybody off."

"She would actually say that no-one helped her get better, only herself and being on MCU didn't make any difference but it did, but she won't admit to that. Just by getting us to eat together, we couldn't even sit at the table together at one point and on MCU we were able to do that."

From other patients

"Well E helped me quite a lot because she kind of, well she was the same as me but different, cos everyone's different but like probably E because I was going to have to have a tube on MCU she helped me eat something so I wouldn't have to have the tube. Well I should say my Mum but I don't think she's helped that much because sometimes in family therapy she listens to her and not to me so she has helped me a bit but not a lot, not as much as E I don't think."

"It's the one thing that like distances her from us, she's rather talk to people that have had it and understand than us."

Feeling understood and kept in mind

"Her individual therapist, Paul Flower, she felt, her and her family felt really understood her and I think he played a major part in her recovery. And that she was being held in mind by people, certainly for her esteem."

"Certainly, (therapist) when he came to visit S in hospital and actually understood her thought pattern and made a connection."(P.9)

STRUCTURE

"The structure, the structure of not being able to get away with anything."

Plans

"It's all when she's better she's going to have another dog and it's all planning ahead but it's not dealing with issues now."

"She can't think of now, all the time she's planning, looking on the internet what job's she's going to do when she's older, what she's going to do when she's sixteen, she's going to get a flat one minute, she's going to be a soldier the next."

"I think if things don't go according to plan, she likes everything planned. E went on holiday last week and it didn't go according to plan because there wasn't a children's club for E, the weather was bad and it was supposed to be hot. You know it's things like that, she stopped eating twice last week but we managed to catch it up but as soon as she's thrown, she struggles and then to get herself back on track she has to give herself an incentive."

"We literally live day to day, the only plan we actually do is like she's already saying what we doing at the weekend, are we out Saturday night, she seems to need pre warning if anything's going on and then she can get herself sorted out in her own mind, what she's got to do but we don't actually plan ahead. She's nowhere near ready to take that responsibility I don't think."

Goals

"Definitely having goals, having something to work towards"

"If things are going E's way it's easier, if she's got something to look forward to it's easier. But I think she's, definitely if there's something to look forward she's, it's seems sometimes she's able to eat and be fine if she's got something that she knows she's going to go and do but if she's got nothing to look forward to I think it really throws her."

Firmness

"Her parents being really firm with her has helped and them if there's two of them being consistent and providing a united front. So you have to be really firm with her, I mean that helps her. What doesn't help her, umm, is when Mum feels unsupported or tired or she's had enough."

"So it's just structure and being really firm, if she thinks she can get away with something, she will try really hard and be manipulative and will use behaviours to push her parents buttons and scare them and drain them down so they give in and it's really difficult not to."

"I would have said some of the staff as well, because with J, you have to be firm with her, if you gave her an inch, she took two and once the staff established that, right this is what's happening Jade, no negotiation. Firmness but in the nicest way, obviously, that worked and we obviously learnt to do that at home eventually, that made a big difference."

Expectations

"To be honest I think that people expect too much, they expect me to be completely back to normal like what I was before but I know that I can't do that."

"I do want to get better but I'm not sure about doing things that that might involve, kind of in the middle."

"I don't really know what getting better involves so I don't really know what I might have to give up or do."

CHANGE

"I think the fact that she never thought her life would change and actually feel a bit happier and she does now and she's starting to accept it and not feel so bad about it."

Being a different person

"It was a bit later than Christmas because she came back so it would have been around February time that she decided she wanted to be seen differently because she saw herself as or her parents referred to her as someone who exercises and that's how she built up her personality and that was her only interest so she wanted to be seen differently and responded to differently. She was going to be starting a new school and thought it would be a fresh start, so she thought it would enable her to be a different person as there was a lot about her that she wanted to change."

"She'd been here a long time and she'd seen a lot of people come and go and umm some of the time was quite envious of their position really, I think there was always a desire to change so when thinking of that, what

set her back was a real sense of whether she was able to, just a fear I suppose."

Moving home

"I found it really difficult when I was at home because I was upset with my parents because I didn't believe they would go back again, go back to England and I wanted to stay in Beijing."

Changes in relationships/getting a boyfriend

"So yeah, I suppose that was the position she'd taken up in her family as well and she would often refer to her siblings as being quite different from her. She worried about whether they would be able to relate to her as this new person when she made all these changes. It was almost like she had this role in the family and how well would they be able to function if she took up a different role so that was quite difficult for her."

"Relationships, boyfriend, that will be a huge change for Sarah, she's lost all her confidence. She's had a few fleeting relationships but they've been bad choices and she knows that, she's just attracted to challenges."

Fear of change/growing up

"She seems to have a problem with changes. She doesn't like changes, she'd be quite happy to revert back to when she was about years old when it was just me and her, she's often said that."

"...so she'd probably say that she's really keen to move forward and in a lot of areas she's very thoughtful and she will think about those things but when it actually comes to physically making the changes it just becomes too overwhelming for her and it's just too big."

*"..you can't stop change it's there but I think she wants to change it back to when she was younger but she can't.
She doesn't like changes at all, she doesn't want to grow up, that's one of the main things, she'd prefer to be a little toddler when everything's done for her and she doesn't have to worry about anything I mean we could all feel like that but."*

ANOREXIA AS A GOD

Provides comfort

"I can picture myself going out and doing all the things I love but just coping with it being there. It's like a comfort and that's why I don't want to get better."

"It's almost like the whole thing is a contradiction, what sort of comfort makes you upset and makes you cry all the time and makes you ill. But actually it does actually feel like a guidance, it's guiding you in the right direction, like a god."

"When she's alone she said the anorexia is like her only friend and the anorexia is there with her, so she'll cry and she'll think about it but when she's doing something it's taking a back seat."

"So probably actually, I know it's really strange but the illness is, when it's there, it is a comfort."

Helping body to function, like an organ

"I like to feel it as a part of me, like an organ and without it I wouldn't be able to function properly, I wouldn't be able to think properly or do things the right way."

Gives life a purpose

"When I think about it properly it's really difficult because it's not something I really want to do but at the same time I don't want to be in here. It's difficult because it's not something I want to give up, anorexia gives me a purpose and it helps me make sense of my life and I feel if it wasn't there, there would just be a void and I'm not sure what there would be to fill it."

"Not because of anything is wrong there she's working on some difficulties in therapy and we're not quite sure what they are at the moment but it does seem to be something to do with her personality and she's worried about how her parents deal with that and it's something that she has had for a long time even before coming ill and having anorexia has completely taken that out of her life so she's worried that if she gives up

anorexia that and this thing comes back then her parents won't like her so to her it's easier to stay here and be anorexic."

Provides guidance

"Now she's at her target weight and she's happy about that but I don't think she wants to move on from the anorexia, it's still there. She's still afraid about seeing people that she knows, she wants to move on and she wants to come out but she still wants the illness with her."

Addiction

"it seems that anorexia is like an addiction Sarah is now saying that she doesn't want to be ruled by the anorexia, she wants to rule the anorexia."

BODY/SELF IMAGE

Looking at/comparing with other people's shape/size

"Looking at other people does affect me, people I want to look like. "

"If someone came in now and said oh I'm so fat, if they think that then I should think I'm fatter and if they're fat then I'm even bigger because they're thinner."

"...and it's harder when other people talk about their shape and they're like oh I'm so fat when they're really skinny. Do you know what I mean, like people at school sometimes, not a lot but sometimes say I'm so fat, when they're not. That makes me think about myself more because as a skinny person to me, I think of myself as big cos like if you're next to a small person then you feel fat so it's worse then."

"The pressure too in the media of being thin and being perfect."

"It's just like seeing really skinny people, like celebrities on TV or whatever, also like when my Mum or my sister, like because they're normal people and they go on diets or whatever, that can be really hard. I have to eat everything, which I really hate and if they don't want to, they don't have to."

Looking in the mirror

(What sets you back?) "Just err, when like you look in the mirror and you don't look nice and you feel rubbishy."

"Well it's like if I look in the mirror and I see I've got a spot or something then that will completely throw me off because I've got a spot and I'm spotty and horrible."

"The way she looks I think is a big thing with her, I think it's how she looks in the mirror, if she thinks she looks bigger than she was then she doesn't like it so that's when she has a tough time."

Confidence

"Her increasing confidence has helped too and she has realised that she can be herself, she doesn't have to be a low weight to get friends or anything."

"I think it will be difficult with the singing because I'm not confident about myself and I really want that back. I used to wear skimpy clothes and not care whereas now I just cover up which I hate because I want to feel confident, look in the mirror and say yeah I look good today and go out and face the world but I can't. "

Distorted perceptions

"If I don't feel like big then I feel alright but sometimes I just feel like down and stuff and I think if I didn't have anorexia then I might get big because if I haven't got it then I might put on weight."

"We've got some family but she finds it difficult to see anybody that knew her when she was at her lowest weight because if they see her now she thinks they'll see a fat Sarah. The way she copes with that is she puts loads of layers of clothes on, she calls it a space suit and just hides her shape completely."

Body changes

"Sarah's never been this weight ever and I think it's going to be challenge for her going out into society being the size she is now, she's got a completely different image than she had when she was growing up. But it's not so much about size with Sarah, it's about body shape, Sarah's a very curvy girl, she's got a big backside and a nice bust so she's got an hourglass figure and she hates that,"

"Most of the time, she says she actually doesn't want to get better but she knows she has to, I don't think she can think about getting completely better, getting past 6 and a half seven stone, she can't think about. I think it's mostly the self-image thing that she can't countenance looking any bigger than she does now. She has a terror of not wanting to look any different than she does now."

FOOD

"I think at the moment she doesn't want to put on any more weight and I think she'll be telling people she wants to get better but there have been times when she does genuinely want to get better and move on and not have to think about food all the time."

Counting calories

"I don't want to get to a point in a few years when I can't get in my jeans or when I'm 17 or 18 and I've still got to count all my calories, it's just pathetic and it's never gonna go away as soon as you've been in here it scars you for life, for the rest of my life I know I'm gonna have to be all pathetic and counting my calories."

"I think if she didn't have to worry so much about food and calories and about being fat, then we might be able to move on to the next stage, I think that's her main worry at the moment on how she's going to get better if she still thinks about all these different issues."

"I think maybe going out with friends and meeting people and anything related with food and her just getting on with her life normally. We just have breakfast, lunch, dinner and snack or whatever and I think she'll still

be counting calories. Just the whole food thing will get in the way of her trying to move on with it."

Meal times/meal plan

"At home we recognise that as long as it's nothing to do with food she's probably back to her normal self except that she's quite distractible. I can't imagine she's be able to sit down and do a lot of homework, she hasn't got a huge amount of concentration span, And sort of about 20 minutes before each meal she gets quite depressed and anxious because of the worry about eating."

"If they increase her calories she will find it really hard and she gets upset."

"We said the only way you can come out of hospital is by sticking to your meal plan and showing them that you're able to do it so that's what she was able to do and show us that she wanted to get better."

"Sometimes nearer, than others it just depends how I manage my meal plan and we were going to go fortnightly but I'm not sure now. I want to be discharged by next year."

"When they increase my calories too much it's too hard and I can't eat it all and want to eat less."

Type of food

"Well I can deal with it by thinking I can be at home and lose weight but then again I would have to come back here and eat all the crap, like chocolate, cheese and chips and nobody's illness in their right mind would choose to eat that. That would be motivating me, the food I'd have to eat if I came back here because it's just junk. Whereas if I was at home I could eat the things I want to eat, be sensible about it but make the most of the fact of eating healthy. Once you come to terms with the fact that you have to eat, you may as well eat what you want to eat, so I'll eat pasta and vegetables and fruit and I'll eat meat. I think that will be motivating."

"If I have to eat food that I don't really like it's hard or going out to places to eat is difficult."

"Well sometimes Mum and Dad talk about going out for dinner and that's, I find that hard, and I can't do that yet, so I like have my own meal before I go, I don't have restaurant food, that's kind of a thing."

WEIGHT

Being weighed

"I think she did have better days when at home but they were days when she wasn't being pressured to eat more or being weighed. I think she always used to feel better when she got weighed and it had gone down. When she was weighed and the weight had gone up then they were not good days."

Getting better = putting on weight

"She doesn't like coming to terms with putting on weight and that's when she has bad days when she thinks she's put on weight or she's not done anything to try and prevent putting on weight."

"Umm well she wants to get better now but she finds it hard. I think she just finds it hard because she can't take in that she has to eat to get better, she wants to try and find another way. Stay thin and get better."

"She occasionally comes out with stuff though when she's talking about wanting to come home and that she's desperate to leave and then she says she can't bear putting on anymore weight and you realise it's not all peachy."

"I can say I didn't want to get better in that I didn't want to put on weight but I knew that I needed to in order to be healthy but I didn't really care about that. I don't know. I've never wanted to become better in my head because, I can see why people think I need to be better in my head but I don't think I do because that's how I've always thought. (The getting bit is getting to a healthy weight) but I don't really want to do that, I'm not happy about that."

Preoccupation with weight

"Some days she wants to get over it and other days she wants to stay her target weight, she doesn't want to go over, she wants to be thin all the time."

"Changes in my meal plan, putting on weight, not being fixed on weight."

Putting on/Losing weight

"I think when she thinks about oh I'm eating things and I don't want to put on weight so I better do something or say something, I don't know just to say something to take your mind off it or do something to lose the weight or try and lose the weight."

"She doesn't want to get better, even though she's been given a target weight of 52.5 she doesn't want to be 52.5 she wants to be lower."

"Gaining the weight for her is what she sees as the obstacle to getting better."

9.26 – APPENDIX 26 – CAT GLOSSARY

Glossary (taken from Ryle & Kerr, 2002)

1. Core pain – The “Hot’ emotional issues of clients early life eg: rejection, abandonment, abuse.
2. Dilemma – A problem procedure: the evident restriction of possible acts/roles etc. to polar opposites, described as ‘*either...or*’, or as ‘*if...then*’.
3. Procedure/procedural sequence – The basic CAT unit of description required to understand the persistence and possible revision of problematic behaviours and experiences. Combines mental, behavioural and external events and other people in a sequence.
4. RRP’s Reciprocal Role Procedures – patterns of relating with significant others, that are based on our earliest ways of relating.
5. Reformulation – Prose description of presenting problem and painful issues: includes: relevant biographic history, TPP’s maintaining TP’s and summary of therapy aims/focus.
6. SDR – Sequential Diagrammatic Reformulation – a pictorial representation of central conflict, RRP’s and TPP’s and procedures emanating from core pain.
7. Snag – A form of problem procedure in which legitimate and appropriate goals are abandoned or undone either because of the assumed attitudes of others or because of irrational guilt.
8. TP’s – Target Problems – the problem defined as the focus for change.
9. TPP’s – Target Problem Procedures – the maladaptive behaviours that maintain the TP’s.
10. Trap – A problem procedural pattern: self-reinforcing patterns of thought and behaviour. Basically, a negative belief generates a form of action, which produces consequences that are seen to confirm the belief.
11. Zone of proximal development (ZPD) – A Vygotskian term. Defined as the gap between current performance and the level, which could be achieved with the assistance of a more competent other.
12. Zone of proximal personality development (ZPPD) – A proposed extension of the ZPD to apply to the development of self processes.

9.27 – APPENDIX 27 – PSYCHOTHERAPY FILE

An aid to understanding ourselves better.

We have all had just one life and what has happened to us, and the sense we made of this, colours the way we see ourselves and others. How we see things is for us, how things are, and how we go about our lives seems 'obvious and right'. Sometimes, however, our familiar ways of understanding and acting can be the source of our problems. In order to solve our difficulties we may need to learn to recognise how what we do makes things worse. We can then work out new ways of thinking and acting.

These pages are intended to suggest ways of thinking about what you do; recognising your particular patterns is the first step in learning to gain more control and happiness in your life.

Keeping a diary of your moods and behaviour.

Symptoms, bad moods, unwanted thoughts or behaviours that come and go can be better understood and controlled if you learn to notice when they happen and what starts them off.

If you have a particular symptom or problem of this sort, start keeping a diary. The diary should be focussed on a particular mood, symptom or behaviour, and should be kept every day if possible. Try to record this sequence:

1. How you were feeling about yourself and others and the world before the problem came on.
2. Any external event, or any thought or image in your mind that was going on when the trouble started, or what seemed to start it off.
3. Once the trouble started, what were the thoughts, images or feelings you experienced.

By noticing and writing down in this way what you do and think at these times, you will learn to recognise and eventually have more control over how you act and think at the time. It is often the case that bad feelings like resentment, depression or physical symptoms are the result of ways of thinking and acting that are unhelpful. Diary keeping in this way gives you the chance to learn better ways of dealing with things.

It is helpful to keep a daily record for 1-2 weeks, then to discuss what you have recorded with your therapist or counsellor.

PATTERNS THAT DO NOT WORK, BUT ARE HARD TO BREAK

There are certain ways of thinking and acting that do not achieve what we want, but which are hard to change. Read through the lists on the following pages and mark how far you think they apply to you.

Applies strongly ++ Applies + Does not apply -

1. TRAPS

Traps are things we cannot escape from. Certain kinds of thinking and acting result in a 'vicious circle' when, however hard we try, things seem to get worse instead of better. Trying to deal with feeling bad about ourselves, we think and act in ways that tend to confirm our badness.

Examples of Traps

1. Fear of hurting others Trap

Feeling fearful of hurting others* we keep our feelings inside, or put our own needs aside. This tends to allow other people to ignore or abuse us in various ways, which then leads to our feeling, or being, childishly angry. When we see ourselves behaving like this, it confirms our belief that we shouldn't be aggressive and reinforces our avoidance of standing up for our rights.

++	+	0
✓		

* People often get trapped in this way because they mix up aggression and assertion. Mostly, being assertive -asking for our rights- is perfectly acceptable. People who do not respect our rights as human beings must either be stood up to or avoided.

2. Depressed thinking Trap

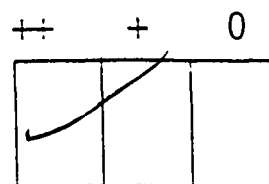
Feeling depressed, we are sure we will manage a task or social situation badly. Being depressed, we are probably not as effective as we can be, and the depression leads us to exaggerate how badly we handled things. This makes us feel more depressed about ourselves.

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3. Trying to please Trap:

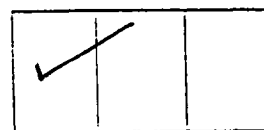
Feeling uncertain about ourselves and anxious not to upset others, we try to please people by doing what they seem to want. As a result:

- (1) we end up being taken advantage of by others which makes us angry, depressed or guilty, from which our uncertainty about ourselves is confirmed;
- or (2) sometimes we feel out of control because of the need to please, and start hiding away, putting things off, letting people down, which makes other people angry with us and increases our uncertainty.



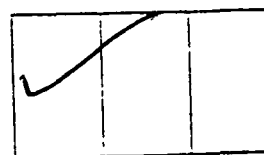
4. Avoidance Trap:

We feel ineffective and anxious about certain situations, such as crowded streets, open spaces, social gatherings. We try to go back into these situations, but feel even more anxiety. Avoiding them makes us feel better, so we stop trying. However, by constantly avoiding situations our lives are limited and we come to feel increasingly ineffective and anxious.



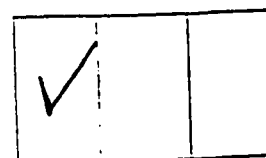
5. Social isolation Trap:

Feeling under-confident about ourselves and anxious not to upset others, we worry that others will find us boring or stupid, so we don't look at people or respond to friendliness. People then see us as unfriendly, so we become more isolated from which we are convinced we are boring and stupid- and become more underconfident .



6. Low self-esteem Trap:

Feeling worthless we feel that we cannot get what we want because 1) we will be punished, 2) that others will reject or abandon us, or 3) as if anything good we get is bound to go away or turn sour. 4) Sometimes it feels as if we must punish ourselves for being weak. From this we feel that everything is hopeless so we give up trying to do anything which confirms and increases our sense of worthlessness.



Do you act as if any of the following false choices rule your life? Recognising them is the first step to changing them.

1. Either I keep feelings bottled up or I risk being rejected, hurting others, or making a mess.
2. Either I feel I spoil myself and am greedy or I deny myself things and punish myself and feel miserable.
3. If I try to be perfect, I feel depressed and angry; If I don't try to be perfect, I feel guilty, angry and dis-satisfied.
4. If I must then I won't; it is as if when faced with a task I must either 1) ~~ang~~ gloomily submit or 2) passively resist. Other people's wishes, or even my own feel too demanding, so I put things off, avoid them.
5. If I must not then I will; it is as if the only proof of my existence is my resistance. Other people's rules, or even my own feel too restricting, so I break rules and do things which are harmful to me.
6. If other people aren't expecting me to do things for them or look after them, then I feel anxious, lonely and out of control.
7. If I get what I want I feel childish and guilty; if I don't get what I want, I feel frustrated, angry and depressed.
8. Either I keep things (feelings, plans) in perfect order, or I fear a terrible mess.

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1. Either I'm involved with someone and likely to get hurt or I don't get involved and stay in charge, but remain lonely.
2. Either I stick up for myself and nobody likes me, or I give in and get put on by others and feel cross and hurt.
3. Either I'm a brute or a martyr (secretly blaming the other).
- 4 a. With others either I'm safely wrapped up in bliss or in combat;
b. If in combat then I'm either a bully or a victim.
5. Either I look down on other people, or I feel they look down on me.
- 6a. Either I'm sustained by the admiration of others whom I admire or I feel exposed
b. If exposed then I feel either contemptuous of others or I feel contemptible.
7. Either I'm involved with others and feel engulfed, taken over or smothered, or I stay safe and uninvolved but feel lonely and isolated.
8. When I'm involved with someone whom I care about then either I have to give in or they have to give in.
9. When I'm involved with someone whom I depend on then either I have to give in or they have to give in.
10. As a woman either I have to do what others want or I stand up for my rights and get rejected.
10. As a man either I can't have any feelings or I am an emotional mess.

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DIFFERENT STATES

Everybody experiences changes in how they feel about themselves and the world. But for some people these changes are extreme; sometimes sudden and confusing. In such cases there are often a number of states which recur, and learning to recognise them and shifts between them can be very helpful. Below are a number of descriptions of such states. Identify those which you experience by ringing the number. You can delete or add words to the descriptions. and there is space to add any not listed.

1. Zombie. Cut off from feelings, cut off from others, disconnected.
2. Feeling bad but soldiering on, coping.
3. Out of control rage.
4. Extra special. Looking down on others.
5. In control of self, of life, of other people.
6. Cheated by life, by others. Untrusting.
7. Provoking, teasing, seducing, winding-up others.
8. ~~Clinging, fearing abandonment.~~
9. Frenetically active. Too busy to think or feel.
10. Agitated, confused, anxious.
11. Feeling perfectly cared for, blissfully close to another.
12. Misunderstood, rejected, abandoned.
13. Contemptuously dismissive of myself.
14. Vulnerable, ~~needy, passively helpless,~~ waiting for rescue.
15. Envious, wanting to harm others, put them down, pull them down.
16. Protective, respecting of myself, of others.
17. Hurting myself, hurting others.
18. Resentfully submitting to demands.
19. Hurt, humiliated by others.
20. Secure in myself, able to be close to others.
21. Intensely critical of self, ~~of others.~~
22. Frightened of others.
- 23.

9.28 – APPENDIX 28 – REFORMULATION LETTER

10th March 2006

Dear Jackie,

Here is the letter that I promised you, it is my attempt to understand your past life and how it has affected you now. We will discuss it and you will be able to alter any aspects that are wrong or do not make sense.

You have come to therapy as you feel that you need some support to move on from the last bits of your bulimia and you can feel yourself slipping back into old habits when you are on your own. Over the last few weeks we have discussed your history and how you are feeling now and I will summarise what I have understood from you in this letter.

From a very young age you have been very independent, both as a result of feeling that your Mum didn't like you and your Dad refusing to deal with you due to the difficulties between you and your Mum. It seems from what you have said that your independence had grown more because you felt you had to be but what you really wanted was more love and affection.

It seems that from this time and maybe because you had not felt good enough to be loved that you have found it difficult to maintain relationships and often drift between different groups of people. Both growing up and currently it seems that you are anxious to fit in with others and often try and please everyone to do so, putting your own needs aside. You describe being in 'your own little bubble', which seems a protected space that you may have created to stop getting hurt or to stop people getting close fearing that you may not be enough for them.

Another area that seems to have had a big impact on your adult life was not having your opinions validated or encouraged, often being told that you were stupid. As you confirmed in the Psychotherapy File you seem to isolate yourself from social situations as you feel under-confident and are always 'second guessing' yourself. The anxiety around this seems to paralyse you at times, which may then come across to others that you are not interested so you become more isolated and convinced that you are not worth talking to.

After receiving a further blow to your confidence at 17 when your boyfriend broke up with you it seemed that you found something in food that enabled you to feel more in control but also may have given you a sense of achievement and a way of coping with feelings that you had stored up, not feeling able to deal with on your own.

This coping mechanism seems to have continued into your adult life and seems to have become a friend to you, something that you share things with that you feel unable to do with anyone else for fear that you may upset them or that they may not want to be around you.

Recently, when feeling more confident after therapy you took a risk on trusting someone again, opening up to them only to be hurt and manipulated, further confirming your need to be in your own little bubble. You may have also felt maybe guilty that it was your fault as he had led you believe, similarly when feeling guilty about the abuse that you and your Mum received as it seemed that it wasn't around before you were born.

You recognised in the File how, feeling uncertain of your worth or your rights, you try to do what others want and as a result feel used and resentful and still more uncertain about yourself. It also seems that you Mum's seeming indifference to your emotional needs left you with the belief that you must either be totally self sufficient or emotionally involved and doomed to be abandoned. Having managed your life without deep involvements, intimate relationships in your adult life seemed to confirm the above dilemma and reinforced your relationship with the bulimia. I also wonder how much you believe you have brought about the trouble that has occurred throughout your life and as a result believe that good things can't last, always sabotaging them with a 'but' or a 'whatever'.

During therapy we will work on recognising and controlling these negative patterns as they recur in daily life. We will also need to be alert to how they may arise in your relationship with me. For example, you may feel you need to please me to be accepted and hence you may feel angry with yourself and me because of that. You may also feel that being exposed and vulnerable is too dangerous to risk and we will try and face and resolve these feelings as they arise.

No therapy or relationship can make up for the losses you experienced as a child but I believe that working together for the next few months will give you enough support for you to revise the damaging ways you have relied upon up until now. It can give you new understandings and a manageable loss and by building on your strengths can free you to find the good that is available in yourself and others.

Yours sincerely,

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