A PORTFOLIO OF STUDY, PRACTICE AND RESEARCH

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Comprising Academic, Clinical and Research Dossiers

RESEARCH TITLE:

The Relatedness of Superstition, Anxiety and Locus of Control in Men and Women Suffering Obsessive Compulsive Disorder: A Gender Comparison.

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Introduction to the Portfolio

This portfolio is comprised of two volumes that has been produced in fulfilment of the criteria for the Psych.D in Clinical Psychology and presents the academic work that was completed over three years. The portfolio is organised chronologically to demonstrate the acquisition and development of academic, clinical and research skills throughout training.

Volume one is divided into three sections: academic, clinical and research. The academic section contains four essays which examine subject areas associated with the four core placements: Adult Mental Health; Learning Disabilities; Child and Family and finally, Older people. The clinical section contains summaries of the four core clinical placements, one specialist clinical case report and summaries of each of the clinical placements. The research section contains the Service Related Research Project from year one, the Qualitative Research Projects completed in year two, the Major Research Project completed in year three, and a research log which details research skills, knowledge and experience gained throughout the three years of training.

Volume two of the portfolio comprises the confidential dossier, which details the experience gained on the clinical placements. It contains: the placement contracts; clinical placement evaluation forms; logbooks of clinical activity for the four core clinical placements and the two specialist clinical placements; the five case reports for the four core clinical placements and one specialist placement. Due to the confidential nature of volume two, it is retained by the Department of Clinical Psychology at the University of Surrey.

Dedications

This volume is dedicated to my children,
Daniel, Laura and Thomas
and in memory of
my husband Michael.

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Adult Mental Health Essay

Critically discuss two therapeutic interventions for major recurrent depressive episode

Word Count 4959

Introduction

This essay will seek to evaluate two interventions for Major Recurrent Depressive Disorder (MRDD). The theory and process of cognitive behavioural therapy (CBT) and psychoanalysis is outlined within their historical and clinical perspectives and outcome evidence for their application and efficacy is reviewed accordingly. The diverse nature of these two approaches is discussed and the philosophical and theoretical difficulties encountered in developing and applying effective treatments within publicly funded health services are considered.

Definition of Major Recurrent Depressive Disorder (MRDD)

According to the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-TR, 2000) the essential feature of MRDD is that it is *cyclical* in nature ie. the individual should experience recurrent Major Depressive Episodes (see definition below) that are at least two months apart. During that two month period there should be either full or partial remission of symptoms such that they no longer meet the criteria for diagnosis of a Major Depressive Episode (MDE).

Given the above, the occurrence of each MDE[1] is characterised by social withdrawal and depressed mood or loss of interest or pleasure (anhedonia) in almost all of the person's activities that were previously considered enjoyable. The person may describe themselves as feeling sad, discouraged and hopeless (DSM-IV-TR, 2000). It is distinct from the extreme sadness one may feel when bereaved. In each MDE there are disturbances in appetite (which if severe are evidenced by either a significant loss or gain in weight) and sleeping pattern. The person may wake either in the middle of the night or early morning and have difficulty returning to sleep. There may be a decrease in sexual desire and activity. The person may experience extreme lethargy, feelings of worthlessness and guilt often through focussing on very negative evaluations of the self based on a mis-interpretation of neutral and adverse events. Huge effort may be needed to approach minor tasks, taking much longer than usual to

[1] Throughout this essay the term 'Major Depressive Episode' is always referred to within the context of its occurrence in MRDD.

accomplish. Psychomotor agitation in the form of hand-wringing, pacing or scratching and pulling of the skin may be present. The person may show a slowness and poverty in their speech and movement. Impairment in thinking, concentrating and memory capacity is common, with associated difficulties in reasoning and making decisions. There may be a preoccupation with death evidenced by attempting or planning suicide, with the belief that others would be better off without them. The individual's presentation and facial expressions may reflect their depressed mood. Alternatively, they may demonstrate a heightened awareness of somatic complaints and appear irritable and frustrated over minor problems, often blaming others and not able to acknowledge feelings of sadness. DSM-IV-TR (2000) states that at least 5 of 9 specific depressive symptoms (which must include depressed mood or loss of interest or pleasure) must be present nearly every day, and persist for most of the day for at least 2 weeks to make a diagnosis of an MDE and that symptoms should cause significant impairment in social, occupational, or other important areas of functioning, such as feeding, clothing and washing oneself. Further classification denotes severity i.e. Mild, Moderate, Severe with Psychotic Features or Severe without Psychotic Features (DSM-IV-TR, 2000). MRDD is a potentially life-threatening condition.

Course of MRDD

MRDD can begin at any age and runs a variable course. Some individuals may experience isolated Major Depressive Episodes with long periods (sometimes years) of remission in between. Others may suffer multiple episodes that occur in quick succession before enjoying a long period of remission, or from an increasing frequency of episodes as they get older. The risk of recurrent episodes increases significantly after a second episode with 70% going on to experience a third episode, and of those, 90% go on to suffer a fourth episode.

Beck's cognitive model of depression (1967, 1976)

Until Beck developed a cognitive model of depression in the late 1960's the cognitive

deficits seen in depression were viewed very much as secondary to disturbances in mood and unsuitable as a target for therapeutic intervention. Since that time, Beck's model has become widely adopted by clinicians and has been the subject of much evaluation through research. The essence of the model is that assumptions or schemata about the self, the world and others are formed in response to early experience and constitute a person's core beliefs by which all future interactions and events are filtered and evaluated (Beck 1967, 1976).

It is of course a normal process to form schemata so that the individual is able to refer new incoming information to past experience and so infer the likely outcome of current and future interactions and events. However, according to the nature of early experience, dysfunctional schemata or assumptions may form that result in patterns of behaviour that are unhelpful to the individual. For example, if a child has learnt that its parent only shows love and affection when he or she is undemanding i.e. affection from the parent is conditional upon the child displaying certain behaviours, then this could result in all future significant relationships being judged and evaluated in the same way. The child may develop as one who is unable to assert or express themselves in any real or valid sense, through fear of rejection or the loss of an intimate relationship. This may result in a lifetime of unsatisfactory and unrewarding relationships whereby that person's emotional needs are never fulfilled or met. In itself, at some point during the lifecourse this pattern of interaction may lead to repeated episodes of depression (if one believes that to be happy one needs to be loved). But also, when loss or rejection does occur in later experience this may act as a trigger for negative thinking about the self. Negative thinking may be triggered whenever a critical incident occurs such as arguments with partners or colleagues and is directly informed by the dysfunctional assumptions formed through early experience, to which the individual yields (Fennell, 1989).

The cognitive model of depression suggests that negative automatic thoughts are a potent force in that they constitute an information processing bias. The situational trigger effectively selects for those negative thoughts, thus ensuring that any deliberate reasoning process which could disprove dysfunctional assumptions or lead to a rational evaluation of a given situation is effectively obscured. Additionally, unpleasant emotions such as sadness and isolation are evoked that are associated both

with the triggering event and past similar events and also with predictions about future events (Fennell, 1989). For example, the depressed individual may have experienced earlier losses to which an element of self-blame may be attached. That sense of blame may be recreated in situations such as losing their job e.g. "it's all my fault, I'm useless, I always make a mess of things I value, nothing will ever go right for me" and is accompanied by feelings of sadness and rejection. Thus, the person over-generalises and selects for the negative aspects of the situation. This produces a cascade of behavioural, emotional, cognitive and physical depressive symptoms. The person may find it impossible to initiate action and withdraws feeling overwhelmed by anxiety or guilt unable to concentrate or make decisions, feeling hopeless and in despair. These symptoms understandably promote more negative thinking and account for the way in which an episode of MRDD can develop in intensity over a period of weeks or months (Beck, 1967).

Not all people who engage in negative thinking become depressed. For some individuals who have experienced adverse circumstances throughout their lives, a negative view of the world is a rational view; it fits with their reality and is a fair evaluation of the evidence. Depression is more likely to arise in response to trauma in individuals who on the basis of past experience have maintained an 'optimistic bias' rather than in those who are realistically negative (Brewin, Dalgleish & Joseph 1996). There may be other pre-disposing variables for developing MRRD: biological, intellectual and social factors may play a part as well as innate temperament (Fennell, 1989). Also, some individuals may defend against acknowledging their emotional needs to such an extent that cognitive processes are not informed by them. This may be the case where extreme deprivation has occurred in early childhood where unconscious emotional processing (an adaptive response) is unable to inform cognitions and subsequent actions and may result in a severe underlying pathology and personality disturbance from an early age (Bowlby, 1969). The emotions associated with the adverse event are effectively detached and stored where they cannot threaten the child's conscious but unrealistic representations of relationships. In this regard, it is reasonable to assert that depression is a painful but healthy response to stored experience.

Beck's cognitive model of depression identifies the symbiotic relationship between

negative automatic thoughts and depressive symptoms and their role in maintaining and strengthening an MDE. This aspect of the model is focused upon in a cognitive behavioural intervention rather than the early experience implicit to the formation of dysfunctional assumptions. The client and therapist collaborate to solve problems through a process of guided discovery effected by Socratic questioning (Young & Beck, 1982). It is essential therefore that the client assumes an equal role with the therapist and does not seek to be persuaded by the therapist. This is a fundamental requirement of therapy without which it may be impossible to encourage the client to develop the skills needed for questioning negative thoughts as they arise. Cognitive behaviour therapy (CBT) is brief, usually around 8-10 sessions. For an MDE however this may be extended considerably (Fennell, 1989). Techniques focus on reducing depressive symptoms, countering hopelessness and helping the client to develop independent thinking and self-help skills. Additionally, sharing the cognitive model with the client and defining goals is implicit to CBT.

Cognitive behavioural strategies focus on identifying, questioning and testing negative automatic thoughts (NAT's). Beck (1967) identified NAT's as a 'cognitive triad' of distorted thinking about the self, the current situtation and the future and described them as pervasive, habitual, automatic, involuntary and made plausible through strong accompanying emotions (Beck, 1970).

Cognitive therapy recognises that strong emotions have lasting impact and are recalled more easily than thoughts, so clients are taught to think carefully about the last time they felt unpleasant emotions and to identify what they were doing at the time and the thoughts that accompanied or preceded the experience together with the intensity of their belief in those thoughts. Once negative thinking has been identified through sensitive and skilled questioning by the therapist the task ahead is one of verbally challenging them and setting up behavioural experiments in order to test out their validity.

There is some debate as to whether endogenous or melancholic depression responds to CBT. Rush & Shaw (1983) suggest that CBT is unlikely to be successful for these conditions whereas Kovacs, Rush, Beck & Hollon (1981) found no clear evidence to preclude CBT where endogenous symptoms may be present. It is of course highly

contentious to attribute depressive symptoms entirely to internal (except in cases of organic deterioration) or external factors and no doubt this area remains a theoretical and diagnostic stumbling block.

The National Institute of Mental Health (NIMH) conducted a major research programme in 1989 comparing the efficacy of CBT, Interpersonal psychotherapy and imipramine in the treatment of depression. Two hundred and thirty nine patients who were either moderately or severely depressed took part. Roth, Fonagy, Parry and Target (1996) report that a reanalysis of the data showed no difference in effect (with the Beck Depression Inventory (BDI, Beck, 1961) and Hamilton Rating Scale for Depression (HRSD, Luborsky et al, 1975) as outcome measures) between treatment conditions for less depressed patients but did indicate that medication was significantly more effective than CBT in patients who were severely depressed. However, at follow-up 18 months later 24% of the CBT patients remained well compared to 23% and 16% of the IPT and imipramine samples respectively. Recovery without relapse was defined by the absence of any two-week period of symptoms meeting the criteria for a MDE during the follow-up phase. Hollon, DeRubeis, Evans and Wiemer (1992) used a similar design to that of the NIMH study in comparing imipramine alone to CBT alone, or to CBT with imipramine. Equal efficacy was demonstrated for all 3 conditions but at 2 year follow-up relapse rates were significantly lower for the CBT group (18% either alone or with imipramine) than those in the imipramine alone condition (50%). Furthermore, the medication only group showed a mean relapse time of 3.3 months after treatment compared to 17.3 months for the cognitive therapy groups. However, as only 44 patients of the original 64 were available for analysis at follow-up, results should be interpreted with caution.

In an interesting small scale study Scott, Tacchi, Jones & Scott (1997) utilised schema-based therapy as part of a brief cognitive therapy (BCT) (Scott, 1995) intervention that was employed as an adjunct to treatment as usual (TAU) for patients suffering from major depressive disorder. Schema Therapy (ST) (Young, 1990/1999) developed out of Beck's cognitive therapy for depression (Beck et al, 1979) and attempts to address some of the limitations that earlier CBT models may demonstrate in treating chronic and recurrent depression. ST focuses on maladaptive schemas that may have developed in childhood or adolescence and the activation of those schemas

in response to life events. A full discussion of ST is beyond the scope of this essay, but essentially, ST uses the therapeutic relationship as a treatment tool for activating and confronting schemas (Young, 1990/1999) and promotes the client's affective arousal in relation to maladaptive schemas in order to bring about modification of those schemas. Accordingly, Safran & Segal (1990) suggest that cognition is much more amenable to change when accompanied by strong emotions. All patients in the study above continued with TAU whilst in addition, the intervention group received 7 once a week half hour sessions of BCT. Results at follow-up (58 weeks from beginning of intervention) showed a significant difference between the groups in depressive symptoms as measured on the BDI and HRSD with more subjects in the BCT group meeting recovery criteria than in the TAU group (n=8). Critically, only one patient in the BCT group relapsed during the follow up period compared to four in the TAU group. Also, a significant difference in group attrition rates at the end of the study may signal improved treatment compliance for the intervention group. However, as the authors point out, considerable skill on the part of the therapist is needed to provide meaningful therapy in such a short space of time (7 once-weekly half hour sessions) and they do not advocate its use by 'novice' therapists.

Freud's theory of Psychoanalysis (1893 – 1960)[2]

According to Freud, psychoanalysis is a theory of psychic energy and the differing amounts by which it is distributed throughout the psychic apparatus namely the *id*, the *ego* and the *super-ego*. In life it is the ego's task to mediate between the instinctual (biological) demands of the id and the authoritative (parental, societal and cultural) demands of the super-ego, whilst taking into account the limitations of external reality. The ego behaves therefore as a kind of central executive whereby perceptual and cognitive processes are utilised in order to ensure an adaptive response both to internal demands and external events. In Freud's view the resulting tri-partite structure of mental life has two possible outcomes. In the first scenario there is an integration of past and present i.e. the id and the super-ego (essentially heredity and the past experience of others) operate upon the ego (the individual's own current

[2] The period in which Freud produced his complete psychological works. The reference section details material referred to for this essay.

experience) as conflicting and dynamic forces whereby the ego selects that which will be permitted or prohibited whilst remaining coherent and strong. In the alternative scenario should the ego not succeed in satisfying the demands of the id and the super-ego and reconciling them with external reality then conflict ensues in which the ego may become weakened and altered. In psychoanalytic theory the nature of the conflict and subsequent weakening of the ego is determined through the state of the internal and external relationships that the person holds. An external and much loved object (eg. the mother) has libidinal (sexual) energy invested into it by the ego which it (the ego) then withdraws back into itself. Depending on the amount of energy invested, the ego may be completely subsumed by the object. In essence, internal object relations are the individual's internal mental representations of external objects i.e. the result of the external object being invested with libidinal energy. In depressive illness, Freud postulates that the individual is responding to *loss* of an object that was both loved and hated and through an unconscious internal identification with the object has internalised hate as well as love which is ultimately destructive because it weakens and alters the ego thereby inviting self-hatred.

The basis on which a psychoanalytic intervention proceeds is rooted in the alliance of analyst and client. It is primarily an emotional exercise in which the client is encouraged to collaborate. In Freud's own words "the analytic physician and the client's weakened ego....band themselves together into a party against the enemies, the instinctual demands of the id and the conscientious demands of the super-ego". The client should tell the analyst all that he knows and conceals from others. This, hopefully, reveals a wealth of material which has felt the effects of the unconscious exerted upon it and thus signals the dominant themes therein. The aim of analysis is ultimately the evocation of affect and to make the unconscious conscious in order to extend self-knowledge so that the ego may be strengthened. The analyst's interpretation of the client's experience is aided and abetted through the processes of *transference, free association, parapraxes* (minor slip-ups in speech, writing and memory) and *dreaming.* Whilst the latter three processes have been taken up and adopted for use in common language, transference refers to the phenomena by which the client projects onto the analyst feelings and attitudes which he/she may hold with regard to parents, siblings, partners or authority figures. The client may see the analyst as a reincarnation of some important figure from the past. A major task for the

analyst is to help the client fully experience transference processes and to bring his attention to them as they arise. In this way the client is under no illusion and is able to acknowledge that transference processes (feelings of love, passion, hate and envy) are a reflection of and motivated by past experience and not the result of a "new, real life" (Freud, 1940a) and at the same time the analyst is able to keep his neutrality. Freud observed that that which was taken for real within the framework of transference is almost never unlearned. Freud's observations are supported by recent information processing theories of cognition and emotion. Stimulus features that evoke intense affect for the client are likely to be subject to rapid processing and storage through multiple, parallel levels of input (Brewin, Dalgleish, & Joseph, 1996) whilst cognitive processing may be slower, serial, conscious and limited by capacity. The qualitatively different and anatomically separate nature of cognitive and emotional processing may go some way towards explaining the relative imperviousness that emotional memories have both to retrieval and re-evaluation but paradoxically also to their impermeability to memory loss (Brewin, 2001). The degree to which afferent and efferent connections between the neo-cortex (conscious processing) paralimbic and limbic system (emotional processing) effect inhibition or excitation within these structures is as yet not fully understood but indicate the possible neuro-correlates to evidence Freud's abstract concepts of mental structure and provide insight with regard to the psycho-analytical process itself and the mechanisms by which free association and dream interpretation (Freud's 'royal road to the unconscious') may reactivate emotional memories for the client. In an MDE painful emotions associated with past loss or trauma that have been defended against are reactivated in response to cues of later rejection or losses that may bear similar features to the original stimulus, but their significance for the client may not be clear. In summary, a psychoanalytic intervention constitutes an interpretation of the evolving process (which signals important events for the client) between therapist and client as informed by psychoanalytic theory and strives to bring the contents of the unconscious into conscious awareness.

John Bowlby (1907-1990) was a major contributor to the expansion of psychoanalytic theory. In three papers Bowlby (1958, 1959 & 1960) outlined his formulation of Attachment Theory in which he departed from Freud's interpretation of the mother/child relationship as one that is driven by reward or feeding (gratification of the id) but that there is instead a "primary attachment bond" between mother and child

from birth that is driven by the need for love and affection. This view recognised the importance of the environment for the developing child and signals an "inter-personal, rather that a intra-personal process" (Holmes, 1995, p. 25). Winnicott also had similar ideas of an "environmental mother" as well as "object mother". Winnicott (1965) states "there is no such thing as an individual but a society of parent and child whose interactions are gradually internalised to form the intrapsychic structures that psychoanalysis has delineated". Mary Ainsworth, a contemporary of Bowlby's developed a procedure known as the Strange Situation (Ainsworth & Wittig, 1969) in which the security of the child's attachment to its mother was explored. The implications of this work are that secure attachments in infancy may act to provide the basis on which the child develops a sense of both intimacy and autonomy that persists into adulthood. Specifically, the development of depressive illness may signal "long buried yearnings for intimacy" (Holmes, 1997) resulting from insecure or unsatisfactory early attachment relationships.

Assessing the outcome in psychoanalysis for MRDD is problematic, not least because of the dearth of research so far as major controlled studies is concerned, but also because research tends to focus on outcome per se rather than diagnostic group. One such study is a follow-up report of 84 clients from the Tavistock clinic in London 3-9 years after the end of therapy (Clememtel-Jones, Malan & Trauer, 1990). Clients were given a global outcome score based on the difference between ratings on the Menninger's Health-Sickness scale (Luborsky, Auerbach, Chandler & Cohen, 1975) at intake and follow-up. Scores ranged from –2 (worse) to +4 (fully recovered) with an average outcome score of 1.19. Sixty patients had improved, whilst 24 were either worse or had not improved. Improvers had on average received twice as many sessions as non-improvers perhaps signalling their motivation to stay in therapy and get well. Additionally, good outcome correlated positively with capacity to relate, problem solving, and good initial adjustment. However, it is impossible to draw definitive conclusions as client conditions were not identified except to say that "21 had some form of depressive disorder". Furthermore, the study did not include a control group. Nevertheless, in a separate paper (Clememtel-Jones & Malan, 1988) some of these clients have been reported as single case studies. Four of those cases are relevant to this discussion in terms of outcome. In the first two cases (both male), one is suffering from a sense of loss and anger (in classical psychoanalysis depression

is conceived of as unresolved anger with the other which is then turned against the self) and in the second case, loneliness, isolation and depression. These two clients are notable in that they did not respond to therapy, most probably due to their persecutory characteristics and schizoid tendencies. Freud (1940) suggested the necessity of ego 'coherence' in the application of psychoanalysis, the absence of which is a feature of psychosis. In contrast, successful outcome is reported for two clients suffering from depression. In the first of these, sadness and anger over lack of expressed affection in childhood from a mother who was "efficient but emotionally distant and apparently unloving" is the central issue. Therapy was directed at helping her to "get in touch with her feelings of sadness" and to "mourn future disappointments " appropriately. In the second case, frequent depressions and anger with a mother were also the focal difficulties, seemingly motivated by a chaotic childhood full of conflict and guilt, rather than a lack of emotional expression as in the above case. In her initial assessment she states "I am frequently depressed and very frightened of being so, which tends to make me more depressed. Often I and life feel very empty" (p.38) The formulation here identifies depression as a result of basic needs going unfulfilled through fear of "being abandoned...being possessed....becoming angry" (p.38) and necessitated a total of 960 sessions over a five year period to reach a successful resolution. These clients presented with good insight as to the aetiology and development of their difficulties. Kantrowitz (1995) suggests that the patient-analyst match will also have considerable impact on outcome which may explain why "some seemingly suitable patients have unsuccessful outcomes and some.... unsuitable patients have favourable outcomes". The importance of correctly interpreting transference and countertransference is demonstrated by a further client from the Tavistock study presenting with severe depression who felt angry with the analyst for being unresponsive and distant, culminating in her terminating treatment and making a suicide attempt. The analyst recorded that her outburst was a way of her finding out if he could cope with her angry feelings. Subsequent history taking revealed that the client had in fact been coping simultaneously with the death of her fiancé, and a male colleague. The client's depression finally lifted when she moved to another therapist.

A long term study of the efficacy of psychoanalysis for depression is currently underway in Hamburg (Brockmann, Schluter & Eckert (in preparation)). Follow up

at 3.5 years shows a higher rate of improvement for the psychoanalysis group compared to a group receiving behaviour therapy, both in depressive symptoms and interpersonal problems as measured by the Symptom Check List (SCL 90-R) (Derogatis, 1977) and the Inventory of Interpersonal Problems (IIP) (Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988) respectively. This is one of the few studies to evaluate a psychoanalytical intervention by diagnostic group. However, the severity and duration of depression found in the sample is not clearly delineated by the authors, making the results somewhat inconclusive. This is a problem that needs to be thoroughly addressed in future studies.

Discussion and conclusion

Whilst CBT promotes the control of negative affect through rationality and intellect and effects change by modifying dysfunctional thoughts and assumptions, psychoanalysis focuses on the evocation of affect and its meaning in relation to past experience and current difficulties using the patient-analyst relationship to inform the process. However, an interesting study by Jones & Pulos (1993) that compared the process in CBT and psychodynamic therapies informed by psychoanalytical theory found that when CBT did contain process factors that were designated as psychodynamic technique e.g. 'therapist identifies a recurrent theme in patient's experience or conduct' and 'therapist emphasises patient's feelings to help him/her experience them more deeply' this was associated with a more favourable outcome that when these factors were absent. Cognitive behavioural therapies that contain elements of the psychodynamic technique have been termed "developmental" in approach (Guidano, 1987). The important point here perhaps is in identifying the factor(s) which may be the "common core of the therapeutic process" (Jones & Pulos, 1993).

Although long, costly and demanding, a psychoanalytic intervention clearly targets emotional experience, its meaning and re-evaluation. It is not clear whether therapies that don't explore the meaning and significance of affect such as CBT will have a long-standing impact upon deep-seated depression. In MRDD the development and longevity of dysfunctional thoughts and their accompanying emotions combine as a powerful force. Can the new therapy induced rational responses of a brief CBT

intervention ever attain the potency of the old ones? The addition of schema therapy to CBT interventions can perhaps address these concerns to some extent. In contrast the Tavistock clinic studies of psychoanalytical interventions (although suffering from small sample size) document successful outcomes for severe depressive illness up to between 3 and nine years after therapy has ended. They afford insight into the nature and depth of the developmental events that may lead to severe and recurrent depression in adulthood.

Psychoanalysis and CBT are two conceptually distinct psychological therapies that may be utilised in the treatment of MRDD. One is long, exploratory and dynamic whilst the other is brief, focal and directed. The theoretical underpinnings of each are evidenced by their respective processes so that whilst psychoanalysis attempts a whole re-structuring of the personality, CBT is directed at reducing and managing symptoms. There is no doubt from major research that CBT is successful in this regard either alone or in combination with pharmacological treatments, at least in the short term. Outcome studies of psychoanalytic intervention suffer from small sample size and are therefore difficult to extrapolate from in any meaningful way. Additionally, it is rare to find studies of psychoanalysis that differentiate MRDD from other conditions. Comparing their efficacy is problematic due to fundamental differences in what they set out to achieve, their application and outcome measures. An assessment of ego strength is undoubtedly more subjective than scores on the BDI. This is an area fraught with philosophical and methodological argument and is perhaps irresolvable. It is also important to regard individuals as individuals and recognise that the nomethetic approach to mental health services may not be the best way forward. Although it would be impractical to suggest that everyone suffering from MRDD should be able to access long-term analysis within government funded services it would be interesting to develop treatments which combine the effective components of each therapy within a clear and theoretically sound framework that can be applied within primary care and acute settings.

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People with Learning disabilities essay

Parenting skills can be assessed and taught to people with learning difficulties. Discuss.

Word count: 4563

Introduction

Over the past two decades people with intellectual disabilities have moved increasingly towards normalisation in many areas of their lives. A recent government White Paper, *Valuing People: A New Strategy for Learning Disability for the 21st Century* (Department of Health, 2001), underlined the need for society and services to recognise, acknowledge and respond accordingly to the rights, independence, inclusion and choice of people with intellectual disabilities. Fundamental to the expression of these key principles is the right to enter into an intimate and reciprocal relationship and raise children. Inevitably, as more people with intellectual disabilities opt to become parents, issues of parental competence arise. As well as becoming parents such individuals are almost always dealing with the additional stresses of poor support networks both social and familial, poverty, isolation and stigma, all of which may reinforce and compound an already impoverished repertoire of parenting skills (Booth & Booth, 1995). It is vital therefore that parenting interventions targeted at this group are properly researched and evaluated in order to assess their likely efficacy and impact.

This essay begins by detailing the possible physical, social, cognitive and emotional risk to children of parents with intellectual disabilities. Parenting assessment methods and parent intervention programmes are then introduced with particular emphasis on the work of Feldman (1998), a prolific researcher in this field. The discussion section focuses on the difficulties that parents may face in generalising new skills and the qualitative differences between skills learned in response to concrete tasks and affect-laden interactions. Problems with design and methodology of interventions are discussed and the obligations of researchers in this field are raised. Finally, suggestions for future research are given.

Throughout this essay the term learning disability refers to an individual with an IQ of less than 70 with onset before 18 years of age (American Psychiatric Association, DSM-IV, 1994) and adaptive behaviour difficulties.

Risk to children of parents with intellectual disabilities

Children of parents with intellectual disabilities suffer a greater risk of abuse and neglect and are more likely to be targeted by child protection agencies than children of parents without intellectual disabilities (Levy, Perhats, Nash-Johnson & Welter, 1992). Evidence suggests that these children are at risk for maltreatment, poor psychosocial development and behaviour disorders (Feldman, Case, Towns & Betel, 1985; Taylor et al., 1991). Parents with intellectual disabilities routinely have their children taken away, more often due to neglect (errors of omission) rather than outright abuse (Taylor et al., 1991). Lutzker (1990) suggests that neglect is as likely to cause as much harm (or even death) to the child as is physical abuse. Greenspan and Budd (1986) found that both child abuse and behaviour disorders tended to increase in families where the parents had intellectual disabilities but the child was not cognitively impaired. Children may also suffer malnourishment and a failure to thrive due to the parent's poor nutritional and feeding skills (Feldman, Garrick & Case, 1997). However, parents with intellectual disabilities are often perceived to be incompetent even without actual evidence of child maltreatment and as a result suffer an increased incidence of termination of their parental rights (Booth & Booth, 1997; Hayman, 1990).

In addition to the above, children of parents with intellectual disabilities have been shown to be at risk from developmental delay. When interacting with their children, mothers with low IQ tend to be less sensitive, responsive and reinforcing compared to mothers in the same socio-economic group without intellectual disabilities (Feldman et al., 1986; Tymchuk & Andron, 1992). Reed and Reed (1965) found the occurrence of developmental delay in such children to be 40%, 15% and 1% where there were 2, 1 or no parents respectively with a learning disability. In a study of two year old children of parents with intellectual disabilities Feldman et al (1985) found scores significantly below the mean for language development on the Bayley Scales of Infant Development (BSID) (Bayley, 1969). This study also found a high correlation between the child's mental development (particularly language) and the quality of the home environment and the number of mother-child interactions. For children without cognitive impairments, they may also reproduce the delayed language of their intellectually disabled parent(s) (Denfield, 1998).

A more recent study of school-age children (Feldman & Walton-Allen, 1997) found that the children of mothers with intellectual disabilities had significantly lower IQs (mean =80.5) than a group of children of mothers without intellectual disabilities (mean = 102.9) who had been matched on age and economic status. The study also showed more problem behaviours for the low IQ children compared to the control group children as measured by the Child Behaviour Checklist (Offord et al., 1987) with boys being affected more than girls. Academic achievement was also lower in children of mothers with intellectual disabilities; again, boys were more affected than girls. Interestingly, Feldman et al (1997) found that the quality of the home environment had more resonance for the children of intellectually disabled mothers than for those children of mothers without intellectual disabilities: the Caldwell HOME Inventory (Caldwell & Bradley, 1984) demonstrated a significant negative correlation with hyperactivity ($r = -.39$, $p < .05$) and conduct disorders ($r = -.43$, $p < .05$) for the children of mothers with intellectual disabilities but not for the control group. Reasons for this are not clear, but it may be that the efficacy of the home environment is more extreme for children of mothers with intellectual disabilities due to a paucity of external supportive and social networks that would otherwise provide diversity and alternative role models for the child to observe and engage. Research suggests that parents with intellectual disabilities are socially excluded both through their own lack of social awareness and social skills and also through the perceptions of others, making opportunities to promote and maintain friendships very few (McGaw, Ball & Clark, 2002).

Further to the physical, intellectual, behavioural and social problems for children of parents with intellectual disabilities there may be an increased risk of developing poor attachment relationships, low levels of self-esteem and a perception of the parent(s) as stigmatising. Bowlby (1969) established that the quality and strength of a child's attachment to its caregiver (usually the mother) is dependant upon the ability of the mother to be warm, nurturing and sensitive and responsive to the child's needs. Accordingly, Perkins et al (2002) found that children who perceived their mothers as warm care-givers were securely attached and perceived the mother's intellectual disability as less stigmatising than in those children whose attachments were ambivalent or avoidant. Furthermore, avoidant and anxious/ambivalent attachments

to the mother tended to be correlated with low self-esteem in the child. Ronai's (1977) personal account of being a child of a mother with intellectual disabilities describes how the ambiguity of her mother's behaviour towards her threatened the mother-child relationship: 'I must face the reality that I am unable to love her again in the intense, unbridled way I did as a child.....she often conspired to save me from Frank (her father), but she also beat me and delivered me to Frank for sexual abuse..' (p.430). The dynamics between all of the factors described above and their relative contribution to the child's development warrant further investigation. However, from these results it is reasonable to suggest that warm care-giving in mothers with intellectual disabilities may protect against low self-esteem in their children and that in turn high self-esteem is incongruent with stigma. It would, after all, be difficult (although not impossible) to conceive of an individual who is truly happy and confident in their sense of who and what they are and at the same time feel ashamed or embarrassed of the person who was key in helping them to develop that identity. However, Nichols (1989) found significant levels of anxiety, depression and rejection in children of parents with intellectual disabilities even though those children scored within the normal range on measures of self-esteem. This would seem to suggest that self-esteem, particularly for these children, is one of many factors that may contribute to healthy emotional development.

Parenting assessment and intervention programmes

The majority of education programmes for parents with intellectual disabilities seek to provide intensive intervention with the parents and children in their own homes, due in part to cost, but also because of concerns about parents being able to generalise learned parenting skills from one location/situation to another and their ability to operationalise knowledge into skill. (Tymchuk et al., 1992; Bakken, Miltenberger & Schauss, 1993). Specialised day care interventions tend to be directed at increasing and maintaining IQ level in the child rather than addressing the potential for physical and psychological neglect of the child at home by its parents. Feldman (1998) describes a comprehensive parenting assessment and intervention model that he developed with colleagues over a 15-year period. This was primarily an early intervention programme targeting parents with intellectual disabilities for the first

three years of their child's life. Initially, a wide-ranging evaluation of risk factors was made in order to establish the likely success or failure of the programme and also to calculate the level of support parents would require. This evaluation covered parental, child and environmental variables such as stress, social support, marital satisfaction, general physical and mental health (past and current), reading skills and history of physical/sexual abuse. Information was gathered on the child's history with regard to health, temperament, behaviour, abuse and interactions with siblings and peers. All children underwent assessment on the BSID (Bayley, 1969). This model of assessment corresponds with Belsky's (1984) Interactional Model of Parenting and The Parental Skills Model (McGaw & Sturmey, 1994) and reflects the epigenetic view of development such that 'parenting skills are the result of the transaction between the biology of the individual and the environment in which that individual lives' (McGaha, 2002, p.86). This view implies that development is an active system rather than a linear process, and suggests that health care professionals should be directed towards calculating probability of outcome rather than prediction of outcome with regard to the care parents with intellectual disabilities provide for their children. However, calculating probabilities infers the *future* dynamics of specific variables, which in effect makes them unknown variables. This must inevitably present difficulties for child-protection services who have to make decisions about the safety of the child at all stages of their development, based on concrete evidence of the parent's skills or lack of skills at any one time. Whilst it is true to say that integration of services for intellectually disabled parents is moving in a positive direction, current levels of support may be unsympathetic to the epigenetic view.

On entering the programme described by Feldman (1998), baseline functioning was established by observing and assessing the parent on a number of child-care tasks that had been agreed upon by child health care professionals as being essential parenting skills. Each of these skills had initially been subjected to a task analysis to aid therapists in their observation and assessment of a parent's skill level. For example, 'feeding solids' to the child was broken down into twelve steps starting with 'serves food at room temperature or slightly warmer' (step 1); 'Presents different foods separately on the dish' (step 2) moving through to step 12 'Wipes the child's face after the meal'. The parent was observed performing the task during a home visit and checked off against the Task Analyses for that skill. However, the normative data for

this process revealed that the average parent does not always perform a given task to the optimum level e.g. washing hands after every nappy change or making sure there are no toys placed in the cot. This presents difficulties with regard to assessment issues i.e. what level of skill should professionals reasonably expect from parents with intellectual disabilities given that in the 'real' world children can and do survive less than perfect parenting *and* the competing demands made for their parent's attention? However, Booth (2001) comments that parents with intellectual disabilities come under such intense and unrealistic scrutiny from child-health and social service agencies such that they need to become super parents in order to satisfy the professionals that they can be effective parents. Similarly, Goodinge (2000) found that Social Services make critical decisions about removing children from learning disabled parents using inappropriate and inadequate information. Perhaps in an attempt to obviate any possibility of failure, most parents in the Feldman (1998) study opted to learn the ideal set of target skills.

After establishing baselines Feldman's (1998) programme focussed on any immediate and critical aspects of child health and safety that had been identified as needing training input, such as prevention of malnutrition due to poor feeding skills, and gastro-intestinal problems associated with poor food preparation and poor hygiene (failure to sterilize baby bottles and feeding utensils). The programme also focussed on developing skills to treat nappy rash effectively and to keep the child safe from physical dangers such as placing the baby on a changing mat on the floor rather than a table and not filling the bath with water that was too hot. Therapists taught parents how to give medications correctly and to keep dangerous objects away from the child. Once these issues had been addressed, the programme moved on to teach the parents how to foster a more stimulating home environment in which to nurture the child's social, physical, cognitive and language development. A major consideration of the programme was to encourage a positive parent-child relationship and to tackle child problem behaviours. Feldman (1998) used skill-teaching techniques that had been validated in other studies most noticeably for teaching parents without intellectual disabilities (Hudson, 1982) such as simple instruction, modelling, positive reinforcement, role play and pictorial prompts. Observational probes were conducted during and just after training sessions to assess learning, and also weekly (in order to assess the parent's level of retention of specific skills from one week to the next). As

far as possible assessment was arranged to fit in with the families' normal schedule, but if a particular skill had not been observed by the end of the visit then the parent was asked to demonstrate the skill. Feedback by the therapist to the parent would emphasise positive reinforcement for all skills performed correctly, and modelling and exaggeration of skills (by the therapist) that were missed or needed further training. The parent would then be asked to perform these latter skills again with the therapist observing and giving praise and encouragement alongside. For example 'He's climbing on your lap – now's a good time to give him a hug and a kiss' (Feldman, 1998 p. 411). Performance was measured by dividing the number of correct unprompted steps by the total number of steps. Training coupons that could be exchanged for goods or travel were also distributed to parents, initially dependant on performance but then gradually thinned to a Variable Ratio (VR) reinforcement schedule i.e. it was highly unpredictable when reinforcement would occur. Ferster and Skinner (1957) showed a VR reinforcement schedule to be the most powerful of all reinforcement schedules in making target behaviours highly resistant to extinction.

As an adjunct to training, parents were also urged both to broaden the scope of their own learning and experience (by enrolling for various courses) and that of their children by placing them in day care.

Outcome studies

There have been several outcome studies of the intervention programme described above. One such study (Feldman, Case & Sparks, 1992) evaluating the training of basic child care skills such as nutrition, preparing formula, treating nappy rash and toilet training,) found significant differences in skill levels between training and control groups post-training. The training group (n=11) had increased their child-care skills to levels observed in a comparison group of parents without intellectual disabilities. Increases in child-care skills were maintained over the follow-up period (2-76 weeks) with the control group (n=11) replicating these results once they themselves received training. The utility of an increased skill level was evidenced through increases in rate of weight gain for four previously malnourished children, elimination of nappy rash in six children and successful toilet training for one child. Unfortunately the authors do not detail the total number of children suffering these

conditions in the first place, making it difficult to assess the overall impact and efficacy of the intervention. However, rate of child removal dropped dramatically after the intervention with only 19% of parents losing parenting rights. Prior to the intervention, 82% of parents with a previous child had had their child removed. Again though, the authors do not define exactly how many parents had a previous child, making actual comparisons difficult.

Feldman, Sparks and Case (1993) assessed whether the part of the intervention programme that trained mothers to increase specific interactional skills had improved language development in their children. Using a between groups design to control for maturational effects, training focussed on teaching mothers to praise the child, imitate and expand the child's verbal and non-verbal vocalisations, to talk and make eye-contact and display physical affection with the child when interacting (e.g. feeding or changing the child). The control group received training in home safety skills. At the beginning of the study the children's ages ranged from 4-28 months. Both groups received training for a mean of 45 weeks. After training, the interaction-training group demonstrated a significantly greater incidence of each interaction skill and total interactions than the control group. The training group parents showed more affection and reinforcing of their child's language. Total parental interactions for the control group (but not the training group) were significantly below that of a comparison group of mothers without intellectual disabilities. Importantly, there was a significant increase in child vocalizations for the interaction group compared to the control group during training and a significant increase in reciprocal play and affection in the interaction group compared to the control group post-training. The training group scored significantly higher on the BSID (Bayley, 1969) with regard to language and social items and began talking sooner than the control group. Children in the interaction group showed a level of vocalisation that placed them in the same range as their peers who had mothers without intellectual disabilities. However, results from a similar study (Tymchuk & Andron 1992) using Feldman's (1998) interactional training model were less impressive with only limited improvements to positive child behaviours. The authors attribute these results to an increased incidence of physical and mental illness and abuse in the parent's history. Nevertheless, the same risk factors were not seen to correlate with outcomes in the Feldman (1998) studies.

Feldman's intervention programme was used in another study (Feldman, Garrick & Case, 1997) where feeding and nutrition skills were successfully taught to two mothers with intellectual disabilities who had children aged 7 months and 10.5 months respectively. Before training both children had been diagnosed as non-organic-failure-to-thrive with weights that fell below the third percentile. Post-training, weight had increased to reach the 15th and 25th percentiles respectively. Rate of weight gain in both children was maintained at 28 month and 59 month follow-ups. Using a model of intervention similar to that of Feldman (1998) Greene et al (1995) demonstrated improvements in child care skills for a single mother with an IQ of 71, specifically with regard to the serving of nutritious food. However, although weight gain in the child was associated with foods the mother served, the child remained in foster care throughout the study and training was limited to being carried out during supervised visits. It is difficult therefore to attribute these gains solely to the intervention itself.

Discussion

From the literature it is clear that children of intellectually disabled parents are at risk from an array of environmental, social, biological and genetic factors. Conversely, the outcome literature on teaching parenting skills tends to be generally positive (Feldman, 1994). Although this could reflect a tendency to publish only 'good' results it may also be an indication of the way in which design, observation and measurement of parenting skills is carried out. Research has tended to concentrate on designing parent intervention programmes for use with pre-school children focusing on tasks primarily concerned with physical health and safety. The essence of learning a concrete skill is that it can usually be taught to occur in response to an environmental trigger and can be demonstrated through modelling or teaching the required response to those specific triggers, which then allows for quantitative measurement. For example, a dirty nappy may or may not initiate a sequence of steps that result in the nappy being changed. However, observation by therapists of learned skills is usually time sampled and planned, the results of which are presented as evidence for an increase in those skills, at least in research studies. It is difficult to assess whether an observation of a particular skill infers its use when the therapist is not there. It is possible that the parent may have been responding to the therapist as an additional trigger to demonstrate a particular skill. In this sense success rates may in part be

related to the methodology of intervention programmes. The challenge for researchers is to establish rigorous methods of assessment so that child-protection agencies can be confident in their utility for determining risk. Rigour is especially important in this field as the growing body of research may contribute to social trends and inform government legislation. Feldman (1994) suggests that parents could live temporarily in group homes with their children where the effects of training could be more closely monitored and for a longer period of time. The effectiveness of training programmes may also be increased by placing families with foster parents who can teach child-care skills on a more natural, ongoing and integrated basis (Feldman, 1994). These innovative ideas may offer more ecologically valid and methodologically sound interventions, and also reduce reliance on highly questionable methods of reinforcement such as tokens.

A specific and fundamental difficulty that parents with intellectual disabilities have is in interpreting and responding to emotionally laden expression, language and behaviours. This in turn may have profound implications for the emotional, social and cognitive development of the child given the durability of intergenerational transmissions of behaviour (Steele & Steele, 1994) and also the quality of the child's attachment to its parent (usually the mother). The richness and diversity of the minutiae of routine interaction between mothers and babies is complex. When a situation arises that requires an interaction or response which is affect laden, the response needs to be intrinsically generated by the parent from a store of previously learned responses. The potential for the response not to resolve the situation is far greater in an affective interaction than in a concrete task as the parent must first interpret the trigger accurately. The ambiguity of the need of a crying baby presents the parent with having to make choices from multiple possible responses. Learning affective interaction skills within intervention programmes is essentially a linear cognitive process and may not in itself promote the flexibility required to demonstrate a reliable affective response when needed. On the one hand, training seeks to break tasks down into small chunks but, paradoxically, in the case of an affective interaction is dealing with a stimulus that depends on its dynamic complexity for meaning. However, the reinforcement provided by the child's subsequent response may help to consolidate learned responses in emotional memory and promote emotional 'growth' within the parent.

Hobson, Ouston and Lee (1989) showed that people with intellectual disabilities were more able in recognising and naming concrete objects than they were in recognising and naming emotions. These findings are in line with the emotion specificity hypothesis (Luckasson et al, 1992) that suggests there may be specific deficits in decoding emotional stimuli for people with learning disabilities rather than a 'general task demand deficit' (Rydin-Orwin, Drake & Bratt, 1999, p. 254). However, Rydin-Orwin et al (1999) suggest that these deficits may be due to failures in development with regard to the parent's childhood experiences such that they received biased socio-emotional feedback. For example, their own parents may have felt that negative emotional experience would be unacceptably traumatic for their intellectually disabled child and sought to protect them accordingly. In so doing, the child may have been subject to situations which were incongruent with the perceived surrounding emotion. Similarly, high levels of childhood neglect and/or abuse in this population may result in maladaptive emotional development (Feldman, 1998). However, there is some evidence to suggest that emotion recognition skills are open to mediation through education. Rydin-Orwin et al (1999) found that training with appropriate cues and group discussion did significantly increase emotion recognition for facial expressions in individuals with intellectual disabilities in comparison with a no training control group. This type of training could be used in conjunction with strategies that teach parental warmth and sensitivity as in the interaction skills training described by Feldman (1998) above in order to optimise and facilitate generalisation of skills. To assess their impact, more studies are needed that evaluate the quality of the child's attachment to its mother and other interpersonal aspects of the mother-child relationship.

One other way of assessing the impact of interventions with regard to affective interaction is to ask the children themselves about their childhood experiences when they reach adulthood. Currently, there are hardly any accounts of the view of the adult child and their experience of growing up in families where one or both parents have intellectual disabilities. The present generation of children being raised in such families should yield a rich source of information in ten years or so. This kind of research may demonstrate more clearly how families fare on a day-to-day basis.

Conclusion

Given that more individuals with intellectual disabilities will opt to become parents in the coming decades it is vital that services should respond with a level of support that can meet this group's diverse and complex needs in order to ensure that another generation of children and parents are not subjected to a maladaptive existence. From the above it is clear that some parents with intellectual disabilities will in all probability need varying levels of ongoing support throughout their children's pre-school and school years. If interventions are to be offered as a possible alternative to removal of the child from its parents then levels of support should be timely, integrated and thoroughly evaluated as to their effectiveness. Specifically, intervention programmes should attempt ecological validity and be formulated in such a way that they can confidently predict if learned skills observed in parents with intellectual difficulties are being maintained, generalised and used consistently. However, the literature is encouraging and demonstrates that effective parent-skill programmes are gradually evolving. Together with research on which parent training interventions are the most effective more research is needed on other variables that may impact upon parental competency such as social isolation, support networks, marital satisfaction, availability of other family members and number of children in family to name but a few.

The cognitive and emotional development and quality of life of children is informed by their internal world which is a constantly evolving process effected through interaction with the environment in which parents are by far the major contributors, at least during the pre-school years. The cost-value benefits of parenting interventions needs to be continually assessed against this fundamental consideration.

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Child and family essay

What developmental and psychological theories could explain Asperger's Syndome and what implications do these have for assessment and intervention?

Word count: 5000

Introduction

It is only fairly recently that Asperger Syndrome (AS) also known as Asperger's disorder has begun to emerge as a diagnostic category in the scientific literature, being used to describe those individuals who display autistic-like behaviours but who, nevertheless, differ qualitatively from those persons with more severe impairments in communicative and social functioning. As Frith (1991) points out this is due both to the fact that Asperger's original description of his patients was, for a long time, only available in German and that his paper, the 'Autistichen Psychopathe', published in 1944 coincided with Kanner's (1943) original widely read paper describing autism.

Whereas Kanner described peculiarities of language such as echolalia and deficits in comprehension, Asperger highlighted a pedantic, almost adult-like use of language in the children he observed. He described anomalies of non-verbal communication such as body posture, eye gaze and most notably a lack of humour (Frith, 1991). Kanner's description of autism was characterised by children either without language or who used strange personalised phrases, often obsessed with ordering objects and with an extraordinary memory for meaningless facts and most importantly of all seemingly oblivious to others. Asperger's patients on the other hand demonstrated an interest in people, but lacked an understanding of social nuances and the rules of etiquette that govern interactions with others often appearing gauche and ungracious. Shortly after Asperger's death in 1980 Wing (1981) published an account of her own cases that were strikingly similar to those of Asperger.

AS is now widely accepted as being underpinned by neurobiological dysfunction of the brain and disordered developmental processes resulting in cognitive, emotional and behavioural consequences and not related to methods of parenting or the child's early experience (Wing, 1988).

Diagnostic criteria for Asperger syndrome

Opinion is divided as to whether AS and High functioning Autism (HFA) are in fact indistinguishable from each other or if AS constitutes a distinct disorder in its own

right. In spite of this, AS is now included as a separate category in the Diagnostic and Statistical Manual of mental diseases (DSM-IV) (American Psychiatric Association, 2000) under the heading of Pervasive Developmental Disorders (PDD). The features listed below are the main diagnostic criteria for AS in DSM-IV:

- Marked impairment in nonverbal behaviours such as body posture, eye gaze, facial expressions and other aspects of body language that initiate and maintain social interaction.

- Difficulty in initiating appropriate peer relationships.

- No significant delay in developing language, as in autism, although speech may be pedantic, stereotyped and literal but vocabulary and grammer are good. Communication is poor with a lack of social and emotional reciprocity and no engagement in shared attention ie. pointing out things of interest to others.

- An all-enveloping preoccupation with a very restricted and repetitive range of activities and interests evidenced through stereotyped patterns of behaviour and adherence to rituals or routines that have no functional purpose. The individual may engage in hand or finger flapping or repetitive whole body movements. There may be an intense preoccupation with small details or parts of objects.

- The disorder will cause significant impairment to the person's social and occupational functioning.

- Cognitive development, exploration of the environment and self-help skills are not significantly delayed although impairment to social interaction may impact on adaptive behaviour.

Due to impaired cognitive and language skills it may not be until the child starts school that problems with social functioning emerge. Visual-motor and visual-spatial abilities may be weak and the person may appear clumsy or awkward. The condition

is often confused with Attention Deficit Hyperactivity Disorder due to symptoms of overactivity and inattention. It is diagnosed much more frequently in males than females and is more common in families where other first-degree relatives exhibit social difficulties or show features of autistic spectrum disorders. AS is a life-long disorder (DSM-IV, 2000)

Biological theories of Asperger syndrome

Biological theories suggest that AS may be caused by either genes, pregnancy or birth complications, congenital viruses or a combination of these factors (Gillberg, 2002). Research into the neurobiology of AS has focused on extrapolating findings from studies both on autism and AS itself to explain deficits in functioning.

The medial temporal lobes and the orbitofrontal cortex (OFC) are implicated in odor detection and identification respectively. Suzuki, Critchley, Rowe, Howlin and Murphy (2003) found that AS subjects were impaired on odor identification but not detection compared to matched controls, suggesting abnormal functioning of the OFC. Both the OFC and the medial temporal lobes are also thought to mediate social behaviour. Insult to these regions typically results in impaired social functioning both in human and non-human primates (Bachevalier, 1994; Eslinger & Damasio, 1985; Adolphs, Tranel & Damasio, 1994) so it is interesting that Suzuki et al (2003) show a deficit specific to the OFC. It is not yet known if these findings generalise to autism but it may signal a possible differentiation from AS.

Animal lesion studies suggest three areas of the brain are involved in social functioning: the amygdala, the OFC and the superior temporal sulcus and gyrus (STG). Taken together Brothers (1990) refers to this triad as the 'social brain'. Broadly, the amygdala receives visual, auditory, olfactory and somatosensory input and has afferent connections with and efferent connections to the limbic system, basal forebrain and the hippocampus, among other areas (Baron-Cohen, Ring, Bullmore, Wheelwright, Ashwin & Williams, 2000). In humans, amygdalar stimulation is most commonly associated with fear and its accompanying autonomic arousal (increase in heart rate, release of adrenalin and dilation of pupils) in preparation for action. Three

distinct groups of nuclei have been identified within the amygdala: the basolateral, centromedial and peripheral groups. In monkeys the basolateral nuclei neurons respond specifically to facial stimuli (Rolls, 1984). Studies of amygdalar lesions in monkeys have shown wide-spread impairment to social functioning (Kling & Brother, 1992). Kling & Steklis, 1976 found that a failure to initiate social interaction or respond to social gestures led to social isolation and even death. These effects have been replicated in rhesus monkeys (Dicks, Myers & Kling, 1969) in vervets (Kling, Lancaster & Bentone, 1970) and in macaques (Kling & Cornell, 1971). Kluver and Bucy (1939) found that lesions in the monkey amygdala produced hypoemotionality, hyperorality and hypersexuality. Further lesion studies in monkeys have shown a reduction in maternal behaviour towards their infants and a stronger likelihood of neglect or physical abuse (Bucher, Myers & Southwick, 1970). Interestingly, amygdala lesions in infant monkeys do not disrupt attachment behaviour (Baron-Cohen et al., 1999) but do negatively impact on social interaction with peers (Bachevalier, 1994). This fits well with observations that children with autistic spectrum disorders are more inclined to experience extreme anxiety when separated from their main care-giver (usually the mother) and become distressed when faced with new and unfamiliar surroundings. It is possible that impaired decoding and processing of social stimuli leads to greater dependency on attachment figures.

Functional Magnetic Resonance Imaging (fMRI) studies show reduced amygdala volume in autism sufferers (Abell et al, 1999) and significantly less amygdalar stimulation in adults with HFA or AS compared to controls when differentiating mental states (e.g. sympathy, concern) inferred from facial stimuli (Baron-Cohen, Ring, Bullmore, Wheelwright, Ashwin & Williams, 2000). This study in fact showed that the clinical group demonstrated a complete absence of amygdalar activation when processing the stimuli. Interestingly, the clinical group had greater activation than the control group in the bilateral superior temporal gyri which are located in the fronto-temporal neo-cortex. The authors suggest this may reflect compensatory mechanisms in which a complex and emotionally laden visual stimulus is processed through being verbally labelled by temporal lobe structures. Whilst this supports observations of an associative use of language (without reference to a conceptual or personally meaningful store of information) that is so characteristic of individuals on the autistic spectrum it also indicates that one part of the social brain is able to compensate for

deficits in another part. Further, the role of the amygdala in the fear response has been widely demonstrated (Baron-Cohen et al, 2000). Accordingly, the authors suggest that AS individuals may demonstrate less fear arousal because of their amygdalar impairment. Further evidence for the neurobiological origins of AS comes from a PET (Positron Emission Tomography) scan study showing atypical fronto-striatal activation in response to stimuli where the subject must assess what someone else may be thinking (Happe et al., 1996). Whereas controls showed activity in left medial pre-frontal cortex (LMPFC), AS subjects demonstrated an absence of activity in that area altogether. Instead, cortical areas directly adjacent to LMPFC were stimulated in the AS group (more than in the control group) indicating that deficits in neural functioning in AS appear to be highly circumscribed (Happe et al, 1996). Clearly, further research is needed to fully delineate the functional and compensatory mechanisms of these brain structures.

However, although biologically pre-determined discrete areas of the brain may be involved for specific functions it's likely that through experience and brain plasticity that brain anatomy and function differs in each and every one of us by minute degrees. The question for research is what degree of difference or diversity constitutes pathology? As Cohen et al (2000) point out, in everyday life some people are exceptional at Maths or physics but find social interaction confusing whilst there are many who function well socially but find 'non-social problem solving' (Cohen et al., 2000, p.355) difficult. It is interesting to note that the latter group are not so pathologised in the literature as the socially impaired group.

In addition to the above fMRI studies may be subject to artefacts of the scanning process itself, making interpretation complex. Also, how much do the observed neural correlates of behaviour reflect the primary organic deficit? In the autistic spectrum, neural growth mediated both through impaired early developmental processes and experience may differ from one individual to another making a universal neural map in this condition, or in fact any condition, problematic.

Psychological models of Asperger Syndrome

Psychological models of autistic spectrum disorders seek to conceptualise the hypothesised impairment to cognitive and emotional processing that may result from the underlying neurobiological deficits. One such theory of cognitive processing is proposed by Frith (1989). She suggests that the need to integrate information in order to make sense of and extract meaning from the environment is normally achieved through the synthesis of context, gist and gestalt (Happe, Briskman & Frith, 2001), and terms this process as being one of 'central coherence' (Frith, 1989). In an interesting study, Happe et al (2001) explored whether families of children with autistic spectrum disorder tended towards a centrally coherent global style of processing or a more piecemeal and locally focused style of processing. They found that parents, especially fathers, were faster than controls at processing unsegmented block-design tasks. The authors suggest that superior performance on the task is facilitated through an ability to focus on the detail of constituent parts of the design rather than the design as a whole which may act to visually confuse or obscure possible combinations of blocks. Shah and Frith (1993) had similar results with autistic subjects on the Weschler Block Design task (Weschler, 1981) and propose that local detail processing confers an advantage over global processing in these tasks. Happe et al (2001) also found that fathers from families with autistic spectrum disorder had significantly faster performance compared to controls on the Embedded Figures Task (EFT), (Witkin, Oltman, Raskin & Karp, 1971) where the goal is to detect a simple figure that is hidden within a much more detailed and complex shape. Additionally, the experimental group made fewer errors than controls when judging the absolute dimensions of illusory figures, that is, their judgement of stimuli was not significantly effected by its presentation within an illusory context that had the effect of making the stimuli appear larger or smaller than it actually was. This might be because processing at a local rather than a global level may lead to less assumptions or predictions being made about the attributes of a stimulus. Normal contextual processing may be likened to priming where the brain is cued to remember past instances of similar stimuli. This of course is an adaptive process which in some situations may confer an advantage. However, on tasks such as the EFT and the Weschler Block Design, making assumptions about *specific* stimuli on the basis of past experience with *similar* stimuli could actively impede performance.

Other studies show similar results in favour of detail-focused processing in families with autistic spectrum disorder. Baron-Cohen and Hammer (1997a) found superior performance for fathers of children with autistic spectrum disorders on the EFT, whilst Landa, Folstein and Isaacs (1991) found less coherent and more fragmented narrative performance in parents of autistic children than in controls.

Given that these studies suggest a cognitive phenotype or style of weak central coherence in people with autistic spectrum disorder, what are the implications for AS individuals? If AS and autism differ only by degree and do not represent distinct disorders, should a slightly less weak central coherence processing style apply to AS. Results from Jolliffe and Baron-Cohen (2001) show that both AS and HFA subjects were significantly impaired in their ability to mentally integrate fragments of a visual stimulus, and that the autistic group performed significantly less well than the AS group. Both groups were unimpaired at recognising whole objects from a single part (e.g. part of the core of an apple, which was sufficiently detailed to suggest the complete object). However, a possible confound to this study concerns who was assigned to each group. DSM-IV classifies autism as being with or without language delay depending on the amount and type of other concurrent symptoms which could possibly lead to an individual being diagnosed with autism rather than AS. Jolliffe et al (2001) differentiated the groups on the basis of early language development so that all subjects without a history of language delay were classified as having AS. The authors point out that some of the individuals in the AS group may be regarded by DSM-IV as having autism without language delay.

When Asperger first presented his clinical cases, the most striking feature in his description was that of naïve and peculiar social interaction with others. Although his patients were not shy or avoidant of social situations they tended to behave in a very one-sided and ego-centred way, with a complete disregard or lack of understanding for the rules that govern social behaviour, making them appear somewhat gauche and impolite. Wing (1981) noted, in addition to the above, an absence of pretend and symbolic play together with a lack of initiation of shared attention and activity. These features suggest a profile of an individual who lacks the ability to imagine the experience and mental state of others and who is unable to manipulate representations

of other people's mental states for the purposes of ambiguous situations or creative pursuits. The ability to infer the mental state of other people and make predictions about their subsequent behaviour (whether or not the content of that mental state is congruent with what is actually true in the external world) has been termed by Baron-Cohen (1985) as having a Theory of Mind (TOM). Studies with low-IQ autistic children have frequently shown that they are unable to understand stories where the protagonist believes something to be true when it is if fact false (Baron-Cohen, 1985; 1988; Baron-Cohen, Leslie & Frith, 1985), that is, they cannot predict the subject's behaviour on the basis of his or her false beliefs. Autistic children typically predict behaviour on the basis of what *they* know to be actually true. The Sally-Ann task (Baron-Cohen et al., 1985) has been widely used in tests of TOM: Sally and Ann, two doll protagonists, are in the same room. Sally places a marble in basket A and then exits the room. Ann then moves the marble to basket B, Sally then comes back into the room. Where will Sally look for the marble? Autistic children generally say Sally will look in basket B where the marble actually is, rather than where Sally *believes* it to be because they are unable to understand that people can hold false beliefs about the world. Normally developing children pass these so-called first order TOM tests at around four years of age and go on to pass more sophisticated second-order TOM tests around six years old (Perner & Wimmer, 1985). The latter test the subject's ability to predict a protagonist's behaviour on the basis of their (the protagonist) false belief about another person's true belief. According to Leslie (1987) the capacity for symbolic play (using one object to represent another) and thinking about the mental state of others (TOM) are indicators of metarepresentational ability. Both require the individual to tolerate and negotiate ambiguity. Some authors regard autism as showing specific developmental delay in metarepresentational ability (Baron-Cohen, 1989a; Leslie & Frith, 1990) but do acknowledge the likelihood that first order TOM may develop at a later stage.

Bowler (1992) tested fifteen adults with AS on first and second order TOM tasks. Of those nine subjects whose developmental history was available, none had ever engaged in joint-referencing behaviours (e.g. pointing out objects of interest to another person, looking alternately at a person and object whilst pointing to the object), pretend play or creative pursuits in either child or adulthood. However, results showed AS subjects to be as capable as controls in solving first and second order

TOM tasks. Ozonoff, Rogers & Pennington (1991), also found AS subjects could solve TOM tasks whereas HFA subjects could not. This may offer some basis on which to clinically differentiate AS from HFA without necessarily assuming entirely disparate pathology. It is perfectly possible that the two conditions may share some inhibitory and/or excitatory neurobiological pathways whilst being dissociated on others. However, if AS subjects demonstrate a capacity for TOM without ever having engaged in symbolic play, this raises obvious problems for metarepresentation theory (Leslie, 1987) as an explanation for the observed social impairment (Bowler, 1992). Hermelin and O'Connor (1985) argue that people with autism and AS may solve TOM problems through logical, computational processing rather than using intuitive skills in the emotional domain and term this as a 'logico-affective' state. According to this theory, due to their relatively intact cognitive skills AS subjects are able to compensate for and circumvent deficits in intuition when solving TOM tasks but have problems when it comes to real life (Bowler, 1992). This implies that individuals with AS may have *knowledge* about other people's minds but are unable to apply it successfully in the outside world. It may be that neurobiological impairment leads to information processing in the cognitive domain that is efficient but linear and solitary without reference to its ecological utility and interpretive function. This fits well with evidence from neuropsychological studies that show AS subjects to be unimpaired on tests of executive function in an experimental situation (Rinehart, Bradshaw, Moss, Brereton & Tonge, 2001; Rinehart, Bradshaw, Tonge, Brereton & Bellgrove, 2002). Executive function requires attention, cognitive spontaneity and flexibility as well as the inhibition of some responses and initiation of others. Whilst AS individuals perform at the same level as controls on these tasks they seem unable to generalise these skills to meet their daily living requirements, so much so that they may need sheltered accommodation and employment.

A study using more advanced TOM tasks that required the subject to detect *faux pas* has shown AS and HFA individuals to be impaired in interpreting the mental state of others (Baron-Cohen, O'Riordan, Stone, Jones & Plaisted, 1999). AS/HFA children were matched with controls on chronological and verbal mental age and had passed first and second order false belief tasks. The children listened to stories after which they were asked if anyone in the story had said something they shouldn't have, and to identify what that might be. They also had to recognise that the faux pas had occurred

as a result of a false belief. AS/HFA children with an average age of 12 years achieved scores equal to normative data for 7-9 year old girls and nine year old boys.

Assessment Issues

It is still unclear and will probably remain unclear for some time as to whether AS and HFA constitute distinct disorders or are variants along a continuum. To some extent these issues may resolve as diagnostic systems move ever more towards dimensional rather than categorical classification, but currently, assessment for the clinician is fraught with theoretical concerns over the conceptual validity of AS as a condition in its own right. Although AS and autism are now included separately in both ICD-10 and DSM-IV, a clear diagnosis may be confounded by common criteria and confusion over distinguishing features for each condition. For example, some individuals with normal IQ may show social and repetitive abnormalities such as a failure to develop peer relationships and hand or finger flapping (common criteria for autism and AS) with no early language delay (criteria for AS only) but do have difficulty in initiating or sustaining conversation with others and have never engaged in make-believe or imaginative play (criteria for autism) (Howlin, 2000). Also, significant delay in language development is cited in order to differentiate autism from AS but it is not clear how this delay may be measured and assessed. DSM-IV and ICD-10 do not offer any guidelines on diagnostic criteria for children who may have used single words at age two and phrase speech by three years, but show significant delay in other linguistic areas such as receptive language and reciprocity (Howlin, 2000). Although DSM-IV indicates that diagnosis of autism takes precedence over AS in cases where criteria for both are met, interpretation in clinical practice and research is far from universal. Various studies have differentiated between HFA and AS on the basis of motor clumsiness, current cognitive and linguistic skills or no early significant language delay but rarely adhere to strict diagnostic guidelines (Manjiviona & Prior, 1999). This has resulted in an array of contradictory findings with no clear evidence for or against differing levels of cognitive, motor, social or neuropsychological impairment in AS and HFA. Further, liberal interpretation of diagnostic criteria has led to AS being misused as a label for social and obsessional disorders, learning

disability (non-verbal) and pervasive developmental disorder, not otherwise specified (Klin, Volkmar, Sparrow, Cicchetti & Rourke, 1995).

Given the above, various diagnostic systems and criteria have been formulated to classify AS but there remains a paucity of actual assessment instruments. Although Asperger's (1944) original account of his cases is evocative and detailed, in practice a more concise method of assessment is needed. From her own observations Wing (1981) felt that language can sometimes be poorer and more delayed than Asperger first described. She also notes that thought processes are pedantic, narrow and logical rather than original and creative as Asperger had suggested. Gillberg and Gillberg's (1989) criteria for AS largely concur with that of Wing, whilst Tantum (1991) differentiates between children and adults stating that symptoms of autism in the former may actually indicate AS instead.

Co-morbid psychiatric disorders in Asperger syndrome

Soderstrom, Rastam and Gillberg (2002) suggest that neuropsychological deficits in AS may pre-dispose the individual to developing personality problems. In a study of personality, 27 out of 31 AS subjects had high scores on harm-avoidance and significantly below-average scores on measures of self-directedness and cooperativeness. Soderstrom et al (2002) propose this may reflect immature character development and a poor sense of integrity which according to Svarkic, Whitehead, Przybeck and Cloninger (1993) could pre-dispose the individual to developing personality disorder. Added to this, AS individuals may be more at risk from developing psychiatric disorders than autistic individuals due to the somewhat covert and subtle nature of their problems which may go unnoticed in childhood (or may not be considered as warranting specialist intervention) but may still manifest in odd and eccentric behaviour. This could lead to marginalisation and isolation by peers resulting in disorders such as anxiety and depression. It may be critical for service providers to consider these issues when allocating resources for early screening and assessment procedures.

Assessment tools for Asperger syndrome

The Autism Behavior Checklist (ABC) (Krug, Arick & Almond, 1980), and the Autism Diagnostic Interview-Revised (ADI-R), (Lord, Rutter, & Le Couteur, 1994), have both been used in diagnosing AS and HFA but are not sensitive to differentiating the conditions. The Diagnostic Interview of Social and Communications Disorders (DISCO), (Wing, Leekham, Libby, Gould & Larcombe, 2002) is a semi-structured interview for diagnosing autistic spectrum and related disorders and psychiatric conditions. As mentioned above, AS individuals may be at particular risk from developing psychiatric problems, but what is less clear is the extent to which they are driven by AS itself or are co-morbid. Assessment tools are useful in this respect, but ultimately the experience and skill of the clinician must be called upon. Currently however, a patchy and limited knowledge of AS amongst mental health workers may confound accurate diagnosis. In spite of these concerns, the DISCO is a valuable aid in that it seeks a full developmental history from birth including information on visuo-spatial skills, self-care and independence. It also asks for a detailed description of current behaviour as well as assessing responses to sensory stimuli and checks for the presence of motor stereotypies and repetitive activity. In this respect, although the DISCO is not able to differentiate AS from other forms of autism it can be used to make recommendations concerning the education, employment, domestic and social needs of all individuals on the autistic spectrum. It is suitable for use with children and adults of all abilities. Interestingly, the authors point out that on the basis of clinical experience and research they feel there is little to warrant differentiation of AS from other autistic spectrum disorders.

Assessment instruments specific to AS such as The Australian Scale for Asperger Syndrome (Garnett & Attwood, 1995) suffer from a lack of data on reliability and validity (Howlin, 2000). In fact the only instrument that provides detailed reliability and validity data is the Screening questionnaire for Asperger syndrome and other high functioning autism spectrum disorders in school age children (ASSQ) (Ehlers, Gillberg & Wing, 1999) with test-retest correlations of $r > .90$ and inter-rater correlations of $r = .66$ The authors also found that scores on the ASSQ corresponded closely with diagnosis ($p = .0001$). However, even the ASSQ does not differentiate

AS/HFA. Although both the Disco and the ASSQ do not differentiate AS/HFA they do seek to draw out the extent of subtle patterns of functioning and behaviour and help to establish a profile of strengths and needs, which in conjunction with a full neuropsychological assessment may inform an intervention.

Intervention

Education about AS is critical for parents and teachers in that it may lead to greater understanding and tolerance of unusual behaviours and may be especially important where children with AS are receiving mainstream education. Low self-esteem in children with AS can sometimes result from feelings of anxiety, frustration and despondency (Szatmari, 1991). A brief, problem solving focus is indicated rather than insight-oriented psychotherapy. There is no evidence to suggest that the latter has any benefit at all for either children or adults with AS (Szatmari, 1991). Low self-esteem may also result from isolation, and in this respect Attwood (2003) has developed a programme for use with children and adults with AS that helps develop friendship skills. Children learn how to join a group of their peers appropriately and develop skills in cooperation and dealing with conflict. Cooperative, rather than competitive games are encouraged with an emphasis on contributing to a common goal whilst acknowledging the suggestions of others. Further elements of the programme include affective education, cognitive restructuring, stress management and self-reflection.

Treatment for adolescents and adults with AS aims to improve adaptive functioning in areas of socialisation, communication, imagination and daily living skills, as well as helping to alleviate some of the more negative symptoms and behaviours such as anxiety, depression and aggression. In view of the specific impairments to conceptual processing of information in AS, skills are best taught using explicit and rote methods where verbal instructions reflect a sequential, parts-to-whole approach (Klin & Volkmar, 2003). Problem solving strategies can be applied to situations that are frequent and troublesome.

Social skills training is typically aimed at compensating for the social impairment

caused through TOM deficits in AS individuals. One such programme for adolescents (Barnhill, Tapscott-Cook, Tebbenkamp & Smith-Myles, 2002) was adapted from Teaching Your Child the Language of Social Success (Duke, Novicki & Martin, 1996) and involved identifying different emotions implicit to voice intonation and facial expression and teaching the meaning of utterances such as 'ahh' or 'mm', using flashcards, modelling, videos, role-play and reinforcement through feedback. In addition, recreational activities were encouraged in order to foster friendship and to practice skills under more ecologically valid conditions. Participants were reminded to maintain eye contact and notice and respond to non-verbal communication. There was limited evidence for the efficacy of the programme with no significant difference between pre and post-test scores for non-verbal communication skills. However, 71.4% of participants did show a non-significant increase in these skills, and perhaps more importantly, 75% developed and maintained friendships within the group. Other studies of teaching TOM to children with AS have shown limited success in transferring skills to social situations (Ozonoff & Miller, 1995; Hadwin, Baron-Cohen, Howlin & Hill, 1997).

Conclusion

AS represents a pervasive and life-long impairment to an individual's social and emotional functioning. Research indicates a biological aetiology with profound implications for developmental processes in childhood and beyond. Detailed assessment of the individual is essential in order to establish their pattern of functioning and intervention needs to be targeted at enabling the person to develop to the best of their ability and reach their full potential. This is essential so that the risk of isolation and secondary psychiatric disorders is reduced. Theoretical arguments over the classification of AS as distinct from HFA may reduce as services are encouraged to address the individual's strengths and needs.

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Older Adult essay

Outline some of the major life transitions and their impacts faced in older age. What contribution can psychological theory and practise make to understanding and managing such transitions?

Word Count: 4996

Introduction

The dramatic increase in life expectancy during the 20th century means many more people are negotiating the transitions of later life. This has significant implications both for the individual and the society they live in. The growing numbers of people over the age of sixty five present new challenges to service provision in that as a cohort they have aged during one of the most expansive socio-economic and culturally diverse periods of our history and will reflect the hopes, desires, ambitions and disappointments and losses of that age plus their own individual interpretation and internal experience of themselves. Many older people will be living out their final years in a society they hardly recognise where the formative experiences which shaped them in their youth may go unacknowledged. Set within this context the impact of transitions for older people such as bereavement, illness, moving into residential care, multiple losses and so on will most certainly effect a differential response in psychological terms. It is vital that psychology and the related disciplines seek to understand this response in terms of the individual's unique experience.

In considering the complexity of the ageing person's past experience, present functioning and vision of the future this essay necessarily takes a developmental perspective which is conceived as a framework in which the individual meets and negotiates challenge and transition. The essay begins by exploring the developmental theories of Erikson and Levinson before considering how, in the face of change, a coherent and continuing sense of self may be maintained through flexible and adaptive strategies. Developmental theory, research and practice are linked through a consideration of the various forms of reminiscence and their effects.

Erikson's (1950) developmental theory of the life span

Erikson developed his theory to reflect, as he saw it, the negotiation of developmental tasks that an individual must face at particular stages of their life from birth through to death. Erikson argued that development is a dynamic process in which psychological development is continuously influenced by the successful negotiation or not of

previous and current developmental challenge. Further, this process takes place within the society of the 'other' such that the world of the newborn infant and beyond is populated by adults in the midst of their own continued and life-long challenge.

According to Erikson each stage offers up specific psychosocial tasks that ideally should be fulfilled in order to develop ego qualities or strengths that eventually, in old age, facilitate ego integrity in the face of declining abilities and the move towards death. He described ego integrity in old age thus:

> "It is a post-narcissistic love of the human ego – not the self – as an experience which conveys some world order and spiritual sense...."
>
> (Erikson, 1963 p. 241).

The first psychosocial task the baby encounters in response to crisis or challenge is that of developing a sense of trust rather than mistrust. The ensuing tasks through to school age are conceived as developing a sense of autonomy rather than shame and doubt, initiative rather than guilt, and industry rather than inferiority. Beyond school age comes adolescence and young adulthood in which forging one's identity and developing a capacity for intimacy become the focus for growth. Role confusion and isolation respectively may result from unsuccessful negotiation of these stages. Middle adulthood brings the challenge of generativity, that is, a sense of guiding and caring for the next generation which is expressed either through one's own children or in the wider society. Erikson suggests that even those individuals bound by 'philosophical and spiritual tradition' (ibid.) to lead a celibate life are in fact just as concerned with generativity through the charity and care they bestow on the community. In the absence of generativity, stagnation may set in. Finally in old age integrity vies with despair, despair signalling a fear of death and regret for the life lived, although despair may be hidden and disgust expressed instead especially towards the young.

Table one gives an outline of Erikson's stages of the life-span together with the possible outcomes of developmental challenge and emerging ego qualities.

Table 1. Erikson's Eight Stages of Man, taken and adapted from *Childhood and Society* (Erikson, 1963).

Stage	Developmental task	Ego quality
Infancy	Basic Trust *v* Basic Mistrust	*Hope*
Early childhood	Autonomy *v.* Shame and Doubt	*Willpower*
Play age	Initiative *v.* Guilt	*Purpose*
School age	Industry *v.* Inferiority	*Competence*
Adolescence	Identity *v.* Role Confusion	*Fidelity*
Young adulthood	Intimacy *v.* Isolation	*Love*
Middle adulthood	Generativity *v.* Stagnation	*Care*
Old age	Ego Integrity *v.* Despair	*Wisdom*

Erikson believed that wisdom in old age could only emerge as a result of a full and active involvement in the world in the previous developmental stages. With this comes an acknowledgement of human experience, both individually and as the family of man, in all its beauty and pathos. Erikson's concepts of positive and negative forces essentially mirror the ontological consequences of being both agent and recipient in the world in an individual and collective sense and stress the continuous *interactive* nature of existence. Erikson also emphasises an acceptance of the time one lives in and the ability to perceive universals of human experience being expressed now and in the past as important for maintaining integrity and not fearing death. This may be especially difficult for some older people who inhabit a world where they may have become disenfranchised by the culture around them and have not engaged vigorously in the generative period of middle age.

Erikson's theory is underpinned by psychoanalytic concepts and as such is dynamic, assuming a global, meta-perspective of development. The strength of psychoanalytic theory has always been that it provides a *complete* account of personality development and as such may give insight into how one encounters the implicit and explicit transitions of old age. According to Havighurst, Neugarten and Tobin (1968) it is likely that successful ageing is dependent on personality factors as much as it is on physical or mental deterioration. They found that although elderly people who remained active and engaged had high levels of satisfaction and happiness, personality

traits also impacted upon the relationship between level of engagement and perceived quality of life. Neugarten (1988) suggests that people pursue a style of ageing that reflects their personality and experience.

Although highly influential, Erikson's theory has been heavily criticised for its lack of clearly defined stages and descriptions of developmental crises (Coleman & O'Hanlon, 2004). Erikson formulated his theory during the 1950's (reflecting the customs and *mores* of that time) when rigorous empirical investigation in developmental theory had not yet taken hold and when classical styles of writing and theorising in psychology were still very much in the ascendancy. Nevertheless, Erikson's concepts have since been taken up by researchers and received empirical support especially in relation to wisdom and generativity.

The generative activities implicit to guiding and supporting the next generation may be particularly important in the contribution they make towards gaining insight and wisdom in later years. McAdams and de St Aubin (1992) developed a complex model, grounded in the theory of earlier researchers such as Erikson (1950) and Kotre (1984), to measure generative concerns, commitments and actions through the use of a 20-item self-report scale, a sentence completion task and a 50-item behavioural checklist respectively. Although criticised for its individualistic western perspective and lack of cultural sensitivity the measures have good relative validity and reliability. Stewart, Osgrove and Helson (2001) report findings from a longitudinal study in which three groups of women were followed from graduation through to middle age. They found that generativity increased steadily with age but particularly between early and late middle age, that is between the forties and fifties. These findings would seem to support a continued development of generativity in preference to Erikson's discrete developmental task of middle age (Stewart & Vandewater, 1998). However, as Coleman and O'Hanlon (2004) argue, the onset and occurrence of generativity is likely to be influenced by many other factors such as early experience, caring for frail parents and socio-economic status. In terms of the effects of generativity, Keyes and Ryff (1998) found a strong positive association between all aspects of generativity and social and psychological well being except for those adults who had high levels of primary obligations.

Wisdom is a difficult concept to define. Whilst Baltes, Staudinger, Maercker and Smith (1995) hypothesise a knowledge-based state of wisdom, others view wisdom as an integration of affect and cognition. Kramer (1990) suggests that wisdom translates as spiritual reflection. Sternberg (2001) and Webster (2003) feel that an empathic understanding of others is critical in the development of wisdom. However, although it is likely that wisdom taps into all these qualities lack of consensus over definition makes its measurement problematic. In this regard interview-based methods probably offer the most comprehensive route to measuring wisdom. Baltes, (1987) used focus groups in which participants were given vignettes of challenging situations and were then invited to consider out loud what course of action they might take and what factors would influence their decision. Conversations were rated according to the degree in which they demonstrated factual knowledge, a cost-benefit analysis as a rationale for the advice offered, and the significance of past, present and future context. This approach is promising in that it has real ecological validity and can reach varied cultural, socio-economic and age groups which may be more difficult with questionnaire measures.

In terms of life-span experience many researchers argue that wisdom is relatively rare. Erikson, Erikson and Kivnick (1986) suggests that wisdom can only manifest if certain criteria from earlier stages have been met such as early experience with adults who are sensitive and responsive to the child's emotional needs. However, an interesting study by Staudinger, Maciel, Smith and Baltes (1998) revealed the differential effect of professional training. They found that Clinical Psychologists were more likely to score highly on knowledge-based aspects of wisdom than other professionals such as teachers, lawyers and architects. It could be argued that psychologists select their profession on the basis of personality variables and this, rather than training effects the development of this aspect of wisdom. However, the authors caution against drawing strong conclusions as they did not include measures of creativity and social intelligence.

Levinson's theory of development

Levinson, Darrow, Klein, Levinson & McKee (1978) undertook research in which forty American men between the ages of 35 and 45 were subject to a series of in-depth biographical interviews. The interviews covered areas such as work, education, friendship, marriage, politics and religion. They found clear evidence to suggest developmental stages similar to Erikson's and sub-divisions of 'era's and 'periods' within those stages, some being stable and others unsettled and challenging. Levinson et al (1978) found that the timing of developmental periods were relatively similar across their cohort varying only by about two or three years and identified middle age as falling between 40 and 65 and late adulthood as 60 plus. Their findings denote a life structure which is comprised of the self, the impact of socio-cultural factors on the individual and the self's involvement in the world. Conscious and unconscious components of the self, some of which have their beginnings in earlier development, may to some extent influence which aspects of the self are expressed or inhibited within the environment. The key issue here is that both the individual and the environment are defined by each other. This is interesting for its link to Erikson's concepts of wisdom and spirituality in old age whereby realisation and enlightenment allow the individual to acknowledge the random, *symbiotic* nature of human existence: "an individual life is the accidental coincidence of but one life cycle..with one segment of history" (Erikson, 1963, p. 241). But this also raises questions over what factors mediate a positive acceptance of the transient nature of existence (a state of integrity) or a tortured one (a state of despair) as expressed in the irreconcilable plea of the poet Dylan Thomas: "do not go gentle into that goodnight...Rage, rage against the dying of the light". The very finite period of each human life juxtaposed with the continued existence of the species makes for this awful paradox, one which Erikson perhaps attempts to resolve at a higher level during his own old age when he talks of 'some sense of premonition of immortality' (Erikson et al, 1986, p. 336).

Developmental theories have been criticised for being limited to a particular socio-cultural context. They do not address diversity and individuals whose lives fall outside of the conditions necessary to fulfil particular developmental tasks (Coleman & O'Hanlon, 2004). However, it can be argued that Erikson's adult developmental

tasks and ego qualities are universals and as such are negotiated through all kinds of relationships and challenging life experience that transcend cultural norms.

Riley (1973) rejects the idea of fixed developmental periods altogether and points instead to socio-historical change as the driving force of the perceived differences between the generations. However, fixed developmental periods driven by biological, cognitive and affective change are accepted as a given for infancy, childhood and adolescence so why not beyond albeit in a more fluid sense? One reason for this may be that earlier research into ageing has been heavily influenced by sociological theorists whose interest in social trends may have obscured or left out altogether the internal experience of individuals and the changing sense of self throughout the life span. In therapeutic terms this is even more significant. As Crusey (1986) points out, in dealing with the problems of the older person, therapists may tend towards manipulating their external world to the detriment of concomitant psychic conflict. This may be particularly important where the person has suffered life-long unresolved losses which may have compromised earlier efforts at separation and individuation and contribute to a heightened fear of death. Continued efforts are needed to ensure that all aspects of functioning are addressed in delivering services to older people.

Disengagement Theory

To some extent, psychological and social factors had received attention in Cumming and Henry's (1961) controversial Disengagement Theory. They argued that the changes brought about by ageing such as withdrawal and physical decline were in fact a normal and healthy part of the ageing process but largely perceived by society to be deleterious and to be avoided at all costs wherever possible. Disengagement referred to the relinquishing of social obligations by the individual and society's withdrawal of its demands on the individual, ushering in a new, liberated way of being for the older person. This is interesting in that one is distancing oneself from the context in which one has known and experienced life and may lead to a re-evaluation of long-held opinions and beliefs about the self, the world and others. Within the family and systemic therapies, removing context is recognised as a very powerful process, opening up new insights for individuals.

Disengagement Theory was heavily criticised over concerns that it may allow social policy makers to reduce services to older people and legitimise inadequate institutionalised care (Coleman & O'Hanlon, 2004) and for its theoretical generalisations that took no account of the diversity of older people (Achenbaun & Bengston, 1994). However, Gutmann (1987; 1997) partially supports the principle of disengagement in older people but gives it greater utility in that it becomes the vehicle for a new engagement with the values and beliefs and religious practices of their culture. He argues that elders become guardians of those symbolic and abstract elements through their increasing passivity which in turn is observed and reflected on by other younger individuals.

Post-modern western society has to a great extent disenfranchised older people in their role as protector and exponent of cultural values and beliefs. The imposition of the work ethic on society (amongst other things) as highly desirable may have led to a de-valuing of other ways of 'being'. This is true for younger people as well in that real choices about raising children are limited and driven by the necessity of two incomes in order to live. This is a huge paradox in that the burgeoning social-democratic thinking of the west heralds diversity as a central focus of political initiative and yet only seems able to tolerate diversity at an individual level if we all eventually appear to be doing more or less the same at a societal level. Hence the popular media image of an eighty year old is that they should be a slightly less active version of a sixty year old. These issues present real difficulties for younger health care professionals on two levels: First, they are steeped in an enterprise culture which may inhibit validation of a 'wise old age' and second they may have only experienced a boundary-less, homogenised culture in stark contrast to the structured, value-laden world the older person may inhabit. However, it may be that these concerns are mediated somewhat through the common internal experience of both client and therapist. King (1980) suggests that within a psychodynamic formulation, older people are operating within chronological, psychological and biological timescales that are all subject to unconscious processing which is in itself timeless. The primitive phantasies of the unconscious are as significant for the younger therapist as they are for the older client.

Tornstam (1997) suggests that imposing mid-life values and patterns of living on older

people was in part responsible for the controversy surrounding Disengagement Theory, and argued that a further withdrawal in late life on a level of spiritual meditation that transcends cultural belief and practice was a necessary and natural part of the ageing process. This links well with Erikson's 'premonition of immortality' (Erikson et al., 1986, p.336) and may function to facilitate a connectedness to all life rather than just the particular moment in time one is born into, which in turn may make death easier to accept. Tornstam's theory of gerotranscendence suggests that a decreasing interest in the social world and the material concerns of life accompany greater insight into all aspects (good and bad) of the self. Coleman and O'Hanlon (2004) link these processes to the healing quality of Life Review in old age (which is discussed below) and cite Gutmann's (1987) concept of 'passive mastery' as indicative of a volitional withdrawal in older people and increasing dependence on 'interiority'.

Tornstam (1997) asserts that although cultural factors do impact upon an individual's development in later life, internal resources are implicit to the process of gerotranscendence which he describes as a developing cosmic awareness where the boundaries of time and space have less significance, death is not feared. Self-interest decreases and a more altruistic outlook develops. There is an acceptance of the self and experience for what they truly are and an increased need for solitude with less interest in superficial relationships. However, it would seem vitally important to distinguish just what aspects of behaviour can be attributed to any form of disengagement with the external world as opposed to those aspects that signal maladaptive coping strategies driven by depression or other psychological problems.

The normative stage theories of ageing explored so far delineate a developmental process as distinct from a coping process. Coleman and O'Hanlon (2004) question whether this distinction is warranted. After all, development must surely occur at the level of observable qualitative shifts and at the level of cognitive re-evaluation and appraisal in response to life events and the ageing self. The ageing self being both a separate and related entity. Further, Rowe and Khan (1998) argue that many biological and social factors influence the ageing process, whilst Baltes and Baltes (1990) suggest that ageing should be conceptualised within a framework that acknowledges the variability between, and the 'plasticity' within individuals in their capacity to age

successfully.

The cognitive and physical decline and personal and social losses of late life might lead to an automatic assumption by others that most older people, as a matter of course, do not age successfully and experience more depression and anxiety and are more fearful than the rest of the population. In addition Brandtstädter and Greve (1994, p.52) argue that 'construction of the self and personal continuity' are under considerable threat during that decline. Surprisingly, research shows no evidence to suggest a general decrease in self-esteem in older people (Robins, Trzesniewski, Tracy, Gosling & Potter, 2002; Coleman, Ivani-Chalian & Robinson, 1993) or an increase in anxiety and depressive disorders (Kunzman, Little & Smith, 2000; Dietz, 1990). How do some older people maintain their continuing sense of self in the face of change and move towards wisdom, integrity and spiritual awareness?

Stabilising and coping processes in older people

Brandstädter and Greve (1994) explore coping processes in their theory of self-representation and self-esteem during the transition to old age. They suggest that problems may arise when:

> "firmly entrenched self-referential beliefs are threatened
> by discrepant evidence...when personally valued aptitudes,
> traits, or dispositions vanish or lose their individuating
> valence....when structures...that provide a stable
> directional context and support a sense of "internal"
> or "external"continuity are disrupted"
>
> (Brandstädter & Greve, 1994, p.55).

Long held aspirations about the person one hopes to become that is, the 'normative' or possible self, may, during the active period of one's life be inspiring and motivating, as long as they are feasibly attainable. However, in old age the non-realisation of those goals may herald depression and self-alienation depending on the person's ability to adopt and adjust to a more realistic view of what is possible. Brandstädter and Greve (1994) propose that discrepancies between the actual and normative self

can be negotiated in three different ways through the processes of *Assimilation, Accommodation and Immunisation.*

Assimilation

Assimilation refers to problem directed action in which the individual may engage in phases of self-evaluation and adjustment in order to preserve the feasible attainment of the hopes, values and goals that have always been part of their normative or possible self-concept. The degree to which an individual can be self-corrective will be driven by their perception of self-efficacy and available resources (ibid.).

Accommodation

Accommodative processes may develop when assimilative efforts prove to be futile because prior goals are no longer attainable. This necessarily involves a disengagement from and devaluing of those prior goals as defining the normative self. With this comes a realisation that long-held beliefs/values about the self as defined by those goals must be relinquished. By adjusting normative expectations about the self to be more in line with the actual perception of the self Brandstädter and Greve(1994) suggest that a decrease in self-esteem is avoided. However, this realisation may be extremely painful and induce varying levels of dysthymia/depression during the transition from assimilation to accommodation. At this point therapy could focus on both reducing the attractiveness of goals that are no longer attainable and on an adjustment of goal preference to what is possible, thereby enhancing the person's sense of control and efficacy. A readiness to flexibly adjust personal goals may protect against depression (Brandstädter & Greve, 1994). In addition, Brandstädter, Wentura & Greve (1993) found that the level of depression accompanying perceived developmental loss is moderated by the degree to which subjects compare themselves in a good light to similar-age individuals.

Research shows that assimilative and accommodative processes are mutually exclusive and underpinned by increases in age. In a meta-analysis (n=3689)

Brandstädter and Renner (1990) found that on measures of Tenacious Goal Pursuit (TGP) and Flexible Goal Adjustment (FGA) - reflecting assimilative and accommodative strategies respectively - both men and women increasingly use FGA as they age whilst reducing their use of TGP. Brandstädter and Greve (1994) strongly suggest that these processes do not signal resignation or regressive tendencies but function primarily to maintain a positive view of the self.

Immunisation

When self-referential beliefs are resistant to discrepant evidence the individual is in effect immunising themselves and negating self-threatening evidence through data-oriented and concept-oriented processes. An example of the latter might be that in order to stabilise and enhance their self-concept an older person may downplay previously held ideals about physical beauty and decide that wrinkles are an indication of laughter lines or of a life that has been well-lived. The interpretation of the function and meaning of appearance to the person, that is its self-referential significance may be highly important to their self-esteem. Within a rational framework alternative interpretations of 'evidence' may function protectively and adaptively.

Life Review and Reminiscence

Working with older people may lead the clinical psychologist to think of their difficulties such as physical illness, cognitive decline, bereavement and other losses soley in terms of their current situation, that is the problems of *being* old. However, as Woods (2003) points out, taking a developmental perspective admits the whole of the person's life to their current situation and allows a consideration of that person as child, adolescent and adult and all the experience contained therein. One of the ways in which this perspective can be facilitated is through the process of Life Review (Butler, 1963) which has come to define a particular category of reminiscence, that is, a narrative, integrative understanding of the person's past in terms of the possibilities it might offer for the resolution of difficulties surrounding transitions, and for further change and development. Life Review is driven by Erikson's concept of the *search* for

ego integrity (Santrock, 2002) involving introspection and self-reflection and as such is not necessarily a skill that all older people will have the capacity or need to develop (Lieberman & Tobin, 1983). Butler's (1963) original concept of life review indicated integration with the current self-concept of memories that may have been long forgotten. Giving up or revising long held perceptions of the self could of course precipitate great distress or a sense of despair (Myers & Schwiebert, 1996) and defend against its use especially in those who are relatively content anyway. A longitudinal study by Wink and Shiff (2002) supports this view. In a sample of 172 participants in their late sixties and mid-seventies that had been followed since childhood they found that only 22 per cent engaged in a struggle for improved self-understanding with the rest of the sample being either unclear or showing no evidence at all to support such a struggle. However, engaging in life review had a positive association with generativity, creativity and spirituality (Wink, 1999) as well as a global measure of negative life events. Wink and Shiff conclude that life review is more a product of past difficulties than a life free of conflict. Nevertheless, Haight, Michel and Hendrix (2000) report significant improvements to self-esteem and life satisfaction as well as reduced levels of depression in a cohort of nursing home residents who received life review as an intervention.

A particular application of life review is that it could be integrated with an attachment-focussed intervention where early anxieties related to dependency and separation may resurrect themselves in later life as chronic loneliness (Cohen, 1982) and/or depression. In this regard the Adult Attachment Interview (Main, Kaplan & Cassidy, 1985) further developed and extended by Crittenden (1999) could assist in assessing the impact of attachment style on the interpretation and response to threat in old age.

Other forms of reminiscence have sometimes been shown to be maladaptive, such as excessive rumination on painful memories without resolution, reflecting guilt and regret (Coleman, 1986) and may signal depression. Excessive recall and paradoxically avoidance of painful memories in old age can also be linked to post-traumatic stress disorder. Avoidance of trauma memories as a coping mechanism ensures their potency (Brewin, 1998) whereas a coherent narrative of that trauma should allow for its development and integration into a person's life story that is still personally significant but no longer disturbing (Coleman & O'Hanlon, 2004). This is particularly relevant

for survivors of the holocaust and world wars.

Different functions of reminiscence have been cleverly delineated through the use of scales such as Webster's (1997) Reminiscence Functions Scale. In addition to the more positive functions such as 'intimacy maintenance' or 'problem-solving' the scale also assesses 'Bitterness revival' which could act to justify continued negative thought and affect towards others (Webster, 2001). However, the downside of this function is its association with a reduced sense of personal well-being (Webster, 1998). This type of scale could be a useful aid in tracking down the source of unresolved conflict in older people.

Conclusion

There are many areas of working with the elderly that have not been covered in this essay due to space limitation. These areas include the special needs of diverse groups such as cultural, religious and ethnic minorities, the learning disabled, advanced old age and the terminally ill. Instead this essay has taken a broad approach and focussed on illuminating the link between developmental theory, research and practice to enable an understanding that problems in late life are not simply a reflection of an older person's current situation but reflect the passage of their lives. A developmental perspective promotes an understanding of what it is to age and takes into account declining physical and cognitive capacities together with the unresolved issues of the past, and the struggle to maintain a continuing sense of self, all of which may combine to produce wisdom and integrity or varying degrees of psychological difficulties. This essay has also sought to emphasise how the diversity of old people is somewhat invalidated by an enterprise culture: the very thing that old people have in abundance, experience and wisdom, does not find a vehicle of expression in our society and may account for feelings of alienation and depression.

However, that is not to say that discrete psychological problems do not exist for older people. For example, the disorienting experience of re-locating, recovering from surgery or the sudden loss of a child for an aged parent bring unique difficulties

whatever the level of growth and development and may require specialist intervention.

More research is needed to explore quality of life and the factors that mediate it in older people. This may help to delineate current research findings that suggest the relationship between relatively adequate levels of well being and ageing is by no means straight forward and poorly understood.

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Summary of Adult Mental Health Case Report

Cognitive behavioural therapy with a 22 year old woman Presenting with Obsessive Compulsive disorder and Post Traumatic Stress Disorder.

Some details have been changed to preserve anonymity.
All names used in the report are fictitious.

April 2003

Year 1

Adult Mental Health Case Summary

This 20 year old white British woman was referred to the community mental health team by her GP for help with compulsive checking and ritualistic behaviour. She had not received psychological therapy before but was taking medication for depression.

Assessment

On assessment Sarah described her behaviour as interfering with her life on a global level. She had obsessive thoughts about arguments with close family and friends and engaged in and ritualistic behaviour in order to ward off 'bad' things happening to her or her five year old son. She was also very worried about the physical threat her ex-boyfriend posed and repeatedly stated how unsafe it felt to live in her flat. He had subjected Sarah to physical and emotional abuse in the flat throughout the time they were together. Her obsessions and rituals took the form of not moving any object at all in her flat as she felt that somehow this would invite bad events to happen. This behaviour was so extensive that she was only able to be in the flat during the late evening and early morning. For example, she was unable to change bed-clothes or wash up dishes. Consequently Sarah and her son spent most of their time at Sarah's parents' house.

Sarah described her sleep as poor. She was very anxious in the flat, and reported being hyper-vigilant to sudden noises, repeatedly checking doors and windows before going to bed. Sarah often saw her ex-boyfriend's face and feared that he was somewhere in the flat.

Sarah suffered from separation anxiety as a young child and was later bullied at school. Her mother also suffered from anxiety and depression and her father had recently made a suicide attempt in response to ill-health.

Initial formulation

Sarah's symptoms of recurrent obsessive thoughts and compulsive behaviour indicated the presence of Obsessive Compulsive Disorder (OCD. Her compulsive

behaviour was repetitive and ritualistic and aimed at reducing subjective anxiety and gaining control over her environment. She also met DSM-IV criteria for a diagnosis of Post Traumatic Stress Disorder (PTSD) in that she had recurring episodes of numbing, re-experiencing and was hyper-aroused in response to stimuli related to past trauma. Sarah's flat represented a global stimulus for memories and intrusions of past trauma that was complicated by the very real and current threat of her ex-boyfriend's presence in the vicinity. It was possible that trauma was significant in the genesis of Sarah's obsessive and compulsive behaviour. Janet (1903) suggested that in some cases OCD was caused by 'emotional shock'. Sarah's history indicated that she had had little control over her environment when she met her ex-boyfriend and it was likely that the relationship compounded her sense of helplessness and was significant in the development of her depression. The beliefs and assumptions that were driving Sarah's excessive anxiety over arguments may have been related to thoughts about pleasing others. Displeasing others through disagreement may have signalled rejection and isolation for Sarah and bring to mind negative affect associated with past episodes of bullying.

Action Plan

Sarah wanted to address her obsessive compulsive symptoms as they were having damaging effect on both Sarah and her son. These symptoms were only one aspect of her difficulties but within the time available it was agreed with Sarah to concentrate exclusively on this one area. The effectiveness of behavioural treatments for OCD is well documented (Rachman & Hodgson, 1980; Salkovskis & Kirk, 1989), whereas outcome studies for a cognitive component to treatment are less conclusive. However, it was not possible to include in vivo exposure/response prevention strategies in the therapy sessions as the trainee's supervisor felt the threat of Sarah's violent ex-boyfriend posed a considerable risk to safety. However, Salkovskis and Kirk (1989) suggest that a cognitive component in treatment may be helpful in complex cases and suggest an approach that aims to modify distorted thinking patterns in order to reduce distress.

Intervention

Sarah attended for seven sessions and cancelled three. She was ambivalent about therapy at the beginning but this changed towards the middle of treatment and she was keen to attend.

The overall aim of therapy using the Salkovskis and Westbrook (1989) approach is, through Socratic questioning, to encourage the client to consider an alternative view of their situation. In Sarah's case this meant introducing her to, and reinforcing throughout therapy, the idea that it was not the content of her thoughts per se that caused distress but the meaning she attached to them. Initially, the work focussed on creating a shared understanding of a cognitive conceptualisation of Sarah's obsessions and compulsions. This involved socialisation to an adapted cognitive model of OCD (Salkovskis, Forrester & Richards, 1998). Further psychoeducation focussed on the normalisation of intrusive thoughts and their relationship to taking action, with regard to Sarah's appraisal for being responsible for avoiding argument and disagreement and also in respect of the Thought Action Fusion model (TAF) of Rachman (1993).

Sarah was provided with homework sheets to record the content of her intrusive thoughts so that verbal reattribution techniques (e.g. questioning the evidence, generating rational responses) could be applied in the sessions. However, Sarah was extremely reluctant to complete the sheets and on the advice of the trainee's supervisor this issue was not pursued. Further sessions focussed on exploring with Sarah the maintaining factors in her obsessive-compulsive behaviour and challenging the irrational basis of her magical thinking. We also practised detached mindfulness (Wells & Matthews, 1994) and addressed Sarah's tendency to attribute negative outcomes to events and generated alternative perspectives. We explored the circularity of negative affect and cognitions.

Outcome

Objective measures of change showed that there was no improvement in Sarah's mood. However, she had challenged her beliefs by effecting change in her behaviour in that she had recently washed her son's clothes and cooked a meal in her flat. This

was a real achievement for her. Her PTSD symptoms were still very distressing and she attended further sessions with the supervisor after the trainee had left the service.

Summary of Learning Disability Case Report

Extended assessment of a 26 year old man
with learning difficulties presenting with
self-induced vomiting and challenging behaviour

Some details in this report have been changed to preserve anonymity.
All names used in the report are fictitious.

November 2003
Year 1

Learning Disability Case Report

John was a 26 year old white British man with severe learning difficulties and autism. His mother phoned the team to ask if we could see John as he had recently been very aggressive towards her and his father. He was also making himself vomit and would not let his parents leave him in a room by himself. A formal referral was made through the care manager.

Initial assessment

John's parents reported that John was often agitated and restless in the early evening and was refusing to get ready for bed at around 10pm. He had taken to throwing various large items out of his bedroom window and shouting 'I'm not going to that place, cancel the bed' meaning the respite centre which he attended in the middle of each week. During these times John 'glazed over' and appeared to be 'in a world of his own'. On one occasion John's father had to defend himself from John with a rolled up newspaper. These were traumatic and distressing occasions for the whole family and afterwards John would often ask 'what's wrong with me' or 'why did you make me do that'. John needed constant reassurance about routines and was very upset by any last minute changes that were made. He did not particularly look forward to going to the day centre and often had to be collected from there by his mother in response to phone calls from staff, usually because he had been sick. John did not like his mother to engage in activities outside the home and she found that her life had increasingly been 'put on hold' when John at home. John's mother felt they 'couldn't do without respite care' whilst his father questioned whether he should be 'going there at all'. They both felt that John enjoyed going to his work placement one day a week and attributed this to the small, friendly and predictable environment that it offered.

Developmental history

John's birth was induced at 28 weeks and he suffered hypoxia. He developed epilepsy at 10 years of age and had problems with fine and gross motor control. He was diagnosed with autism when he was 17 years old. However he had learnt to say certain phrases very well even though he lacked an understanding of the wider meaning of

language and had limited social interaction skills.

Initial formulation

John always had major problems separating from his mother and it is likely that his behaviour at weekends was driven by his anxiety over respite care and his mother's absence in the middle of the week. John's learning disability and autism may have precluded the formation of a secure attachment with his mother and the ability to predict when or how he could regain proximity in her absence. Such absence may have been perceived by John as a threat to his safety (Bowlby, 1973). However, the pathway from his anxiety to his behaviour at increasingly aggressive behaviour at night was not clear and needed further investigation. It was also considered that John was experiencing a delayed adolescence and with it a growing awareness that he had limited control over the environment and few opportunities to make real choices. He no longer wished to go to bed at 10pm and may have felt angry and frustrated that he was unable to communicate his feelings and wishes to his parents.

Action plan

Further assessment of John's difficulties was needed to inform the intervention process. The assessment covered the following areas: cognitive and emotional understanding; ability to function in other settings; a functional analysis of John's target behaviours that included information about the communication function of ecological variables such as 'I want' or 'I feel'.

John's parents gave their consent for the assessment to be carried out. It was agreed that John's verbal consent would be sought before each assessment was carried out.

Extended assessment

John would not participate in an assessment of his IQ and walked out of the room. However he did agree to collaborate in an administration of the British Picture Vocabulary Scale (Dunn, Dunn, Whetton & Pintilie, 1982) which assesses receptive language ability. John obtained a score equivalent to that of a seven year old. The test

revealed that John had difficulties focussing his attention and tired very quickly.

John's ability to correctly identify emotions was mixed. He was able to label the emotion correctly on pictures of individual faces but had difficulty in assessing the sentiments being expressed in pictures of groups. However, during this part of the assessment John revealed that he was 'quite keen' on a girl who attended the day centre and that 'it wasn't fair' that he had respite care in the middle of the week. His ability to express himself was further evident in that he was able to say *why* he had been unhappy in respite. It was *because* he had missed his mother.

Further meetings with John's parents focussed on a functional analysis of target behaviours but also revealed that they were not clear about what they were requesting for John. This seemed to reflect a reluctance to acknowledge that John was no longer a child and would at some point move out of the parental home. Understandably they wanted more time to themselves but also felt sad that John may have to live somewhere else. The frustrated behaviours they described during these meetings were very similar to that expressed by any adolescent.

Interviews with care staff

The respite care manager described several incidents where John had placed objects in his throat and choked. Staff felt this was to provoke them into calling John's mother so that he could go home. However, they decided to stop positively reinforcing his behaviour after which it ceased happening. This indicated that John was able to modify his behaviour according to consequences.

Further formulation

John's anger occurred when aspects of his immediate environment were not under his control, such as having to switch the television off. Novaco (1979) suggested that cognitive mediation of anger refers to cognitive processes that influence each other before, during and after a triggering event, that is, prior expectations influence attention during the event and the resulting behaviour. John may have perceived his lack of agency as unfair, holding his parents responsible, thus priming him to experience anger when being asked to get ready for bed or turn the television off. At

these times John's behaviour was ultimately reinforced by the continued proximity of his mother as she would often sit with him until he eventually fell asleep about 3.30 in the morning.

Recommendations

It was recommended that John's parents should start looking for a residential facility that would meet John's needs with regard to a predictable and structured environment but would also encourage John in developing some independence as a young person. It was hoped a support worker would be appointed to assist John in the transition between home and residential care and also to provide an appropriate relationship outside of the parental one. The need to support John's parents in understanding the communicative function of John's behaviours and to develop effective strategies for interacting with him was also recommended.

Summary of Child and Family Case Report

Motivational interviewing and cognitive behavioural therapy with a 16 year old female presenting with eating disordered behaviour

Some details in this report have been changed to preserve anonymity
All names used in this report are fictitious.

April 2004
Year 2

Child Case Summary

Clare was a 16 year old white British girl who was referred to the Child and Family service by her GP over concerns about her restricted diet and episodes of self-induced vomiting.

Assessment

Clare presented as very quiet and withdrawn. She was tall and quite slim although her body mass index of 20 was within the normal range. She said she was depressed but felt that her weight was adequate and didn't know why people were so concerned about her. She felt fully in control of her diet and did not see any reason to increase her food intake. However, she acknowledged that she had irregular periods and was often very tired and cold which sometimes impacted on her ability to complete her college work or go out with friends. However, she was meticulous about her college assignments and worried constantly that she would fail them.

Clare said that when she ate whatever she liked, she would then look in the mirror and hate what she saw. At these times she would 'lose it' and hit out at her legs or head and would have to make herself vomit. She also described screaming uncontrollably. Clare said that she didn't trust many people and would never confide in anyone.

Previous therapy

Clare had been referred to a dietician who reported that Clare was not eating enough to meet her dietary requirements. She was doubtful that Clare would accept her dietary advice. Clare had not sought any help for her depression.

Background history

Clare was one of three siblings. Another sibling died of cot death at the age of four weeks when Clare was two. Clare's mother and father separated when she was five years old. Clare felt that her father blamed her for the break-up of the family and he insisted on reminding her of this every time she saw him. Throughout her childhood she remembers arguments with her father who was often angry and drunk when he

visited, although he was never physically abusive. She was upset that her mother allowed him into the house on these occasions and felt that his needs were always given priority.

Clare had a history of separation anxiety and 'jealous' behaviours towards her brother and sister. As a small child and after her father had left, she had extreme temper tantrums and threatened to jump out of the window if her mother showed any affection towards her father on his visits.

Measures

Clare had a score of 35 (extremely severe range) on the Beck Depression Inventory II. She was also given a food diary and measures of self-esteem and eating disordered behaviours but refused to complete them.

Formulation

Clare's symptoms of dieting and cognitive distortion with regard to her body shape were consistent with a diagnosis of anorexia nervosa (DSM-IV TR, 2000). Her difficulties were formulated within a psychodynamic model.

Bruch (1988) proposed that anorexia nervosa represents a defective self-concept which is experienced as a fear of inner emptiness or badness. Clare may have internalised from a very young age feelings of being 'bad' as a result of her father telling her she was to blame for her parents separation. The tensions between her mother and father may have led to her mother being emotionally unavailable for Clare, intensifying those feelings of rejection and 'badness'. After the separation Clare may have conflated her father blaming her for the break up with the death of her brother. This may have led to her later feelings of being out of control and overwhelmed by this realisation of an internalised bad self. Bruch (1988) argued that 'badness' must be concealed at all costs and so the person becomes perfectionist in areas they can control, such as diet or academic performance.

Clare's affect dysregulation and restricted eating may have reflected a struggle to find some self-respect. In addition, Clare's rigid cognitive style evidenced by her

reluctance to trust anyone indicated that she wanted to protect herself from further rejection and left her poorly equipped to negotiate periods of transition such as adolescence when further integration of cognitive and emotional processing is taking place.

Precipitating causes

Clare said she had been teased at college about her weight before she started restricting her eating. A subsequent lowering of self-esteem and sense of loss of control may have led Clare to become depressed

Maintaining factors

Bruch (1988) suggests that anorexic patients cling to 'early childhood concepts' delaying the development of abstract thinking and consequently giving rise to cognitive distortions such as polarised and magical thinking. Clare's mistrust of everyone was a demonstration of all or nothing thinking and may have been an adaptive strategy as well as a maintaining factor. Not trusting anyone protected Clare from ever having her core beliefs about her own 'badness' confirmed. However, periodic reminders from her father regarding blame and her fear of being out of control maintained the need for Clare to demonstrate control over other areas of her life such as eating.

Action Plan

In consultation with colleagues in the eating disorders service it was agreed that I could continue to see Clare on my own as long as her weight did not fall below the normal range. Clare would also be monitored by the dietician who was part of the child and family team.

The primary aim of therapy was to increase and stabilise Clare's calorie intake. However, her presentation suggested she had little motivation in changing her behaviour and contra-indicated a psychodynamic approach to therapy. Clare's resistance to change was conceptualised by the Stage of Change Model (Prochaska & Di Clemente, 1992). Clare appeared to be at the precontemplation/contemplation stage in that she didn't really acknowledge overtly that she had a problem at all but at the

same time had sought help through her GP. Recent approaches to enhancing motivation for change in eating disorders have a strong cognitive-behavioural component (Vitousek et al., 1998).

It was decided that a motivational model of therapy might be helpful to Clare. She agreed to attend the centre for a block of 8 sessions.

Outcome

During the course of therapy Clare experienced considerable distress. On one occasion at home she had been screaming and shouting uncontrollably about her weight and called an ambulance to take herself to casualty after her mother had refused to be drawn into a conversation about her appearance.

However her behaviour was difficult to interpret. In our last session together she appeared to be very happy generally and had just started seeing a boy at her college. She had also been in touch with an old girlfriend and felt much less isolated than previously. There was no way of knowing if her improved mood was due to the therapy or to these new relationships. Her unwillingness to collaborate on homework tasks and her resistance to challenging her thoughts and beliefs about herself suggested the latter.

Clare continued to be monitored by the team's dietician after her appointments with the trainee came to an end.

Summary of Elective Case Report

Forensic Service

Neuropsychological assessment of a 32 year old man detained in a special hospital, presenting with Schizophrenia and a history of drug and alcohol use

Some names and details in this report have been changed in order to ensure confidentiality

September 2004

Year 2

Elective Case Report

Mr Cox was a 32 year old white British man who was detained in a maximum security special hospital under Section 47/49 of the Mental Health Act (1983) under the category of Mental Illness. On admission he was referred to the psychology department of the hospital for a neuropsychological assessment in order to give a detailed picture of his strengths and needs.

Background

Mr Cox had been transferred to the hospital from a Regional Security Unit (RSU) in response to concerns about the level of risk he posed to staff. He had destroyed property and assaulted a female psychiatrist.

Assessment

Presentation

Mr Cox felt aggrieved at being detained in the hospital and did not think his behaviour had been unreasonable. He appeared sleepy and confused. He made reference several times to his wife and children although there was nothing on file to support his either being married or having children. He was apprehensive about our meeting saying that his reading and writing were not very good. Rather confusingly he then went on to say that he had won a prize for reading when he was 13 years of age. However, he agreed to the assessment and maintained a good humour throughout our sessions together.

Psychiatric history

Mr Cox had been diagnosed with Schizophrenia in 1998 although later his symptoms were also attributed to aspects of personality and a long history of drug and alcohol abuse. Mr Cox had made extensive use of cannabis, diazepam, heroin and hallucinogenic agents during his early adolescence. He described himself as a 'cannabis lover'. During a stay in prison in 2000 his mental health deteriorated and he was transferred to the RSU.

Personal history

Mr Cox was subject to a chaotic and disruptive family environment throughout his development. He was described by teachers as hyperactive and was sent to a boarding school for children with challenging behaviour. He violent behaviour at the school led to his being taken into care at 10 years old. Mr Cox left school at fourteen and since then had spent most of his time detained in prison or hospital.

Previous assessments

A speech and language assessment indicated that Mr Cox had poor literacy and language skills and suggested 'pervasive developmental problems'.

Assessment

Mr Cox was assessed with a series of tests that were selected to tap into a possibly broad range of difficulties that he was expected to demonstrate. From his history of Schizophrenia and substance use it was predicted that Mr Cox would evidence deficits in short-term memory, visuo-spatial function, visual search and scanning ability, sequencing of information, cognitive flexibility and goal-directed stategies. His reported history of hyperactivity and dyslexia was unreliable. However his presentation and the results of the speech and language assessment suggested that he would demonstrate limited language ability and show some degree of impersistence in his approach to testing.

Mr Cox was unable to read any of the words on the NART making it impossible to assess his pre-morbid functioning. His overall level of functioning fell within the extremely low range with an IQ of 68. He had the most difficulty in holding, transforming and sequencing information in working memory and visuo-perceptual and spatial organisation. He also found it very difficult to concentrate and kept making comments that distracted him from the task in hand. On tests of abstract reasoning and verbal comprehension his scores were well below average.

Mr Cox was very impaired on measures of memory and new learning. Although he was able to copy a design quite well, he was unable to reproduce it immediately after. Similarly he was unable to recall any of the conceptual detail of a story. His memory

for faces and topographical stimuli was consistent with his general level of functioning. His performance on tests of visuoperceptual organisation (HVOT) suggested a degree of fragmentation in his conceptualisation of the stimuli. This inability may have reflected executive impairment in that he was unable to perceive the 'whole' picture. In addition his poor abstract and verbal reasoning skills on the WAIS-III were indicative of impaired concept formation. Lezak (1995) suggests low scores on this HVOT task reflect psychotic disturbance but this was not consistent with Mr Cox's presentation during the assessment.

It was clear from the results and the way in which Mr Cox approached almost all the tests that his memory was severely impaired. He was very aware of this in that he quickly became flustered when challenged by the tests. However, coupled with his impaired ability was his tendency towards distractibility and consequent inattention and reduced processing of stimuli. The literature suggests that poor short-term and working memory in heavy drinkers may relate to encoding rather than retrieval errors. Thus, attentional deficits together with Mr Cox's low levels of impulse control may have caused or compounded his memory impairments and may have been related to his alcohol and cannabis use. However, attention and memory impairments are also recognised as core deficits in Schizophrenia (Randolph, Goldberg & Weinberger, 1993). It was also considered that Mr Cox's attention difficulties may have reflected an early developmental disorder and was driving his challenging behaviour. Unfortunately this could not be clarified further as it had not been possible to assess pre-morbid functioning.

Recommendations

Although Mr Cox's test results confirmed the predicted impairments they were unable to illuminate aspects of aetiology. However, in terms of care planning, his impaired memory, attention and language skills may have impacted substantially on his interactions with staff and patients and on his ability and motivation to engage with the therapeutic regime of the hospital. These considerations were highlighted in the subsequent report and it was recommended that any intervention with Mr Cox should be pitched at a non-threatening and easy to understand level.

Summary of Older Adults Case Report

A psychodynamic formulation and intervention with a seventy year old woman presenting with a history of anxiety

Some details have been changed in this report to preserve anonymity
All names used are ficititious

April 2004

Year 3

Older Adults Case Summary

Lilian was a seventy year old white British woman who was referred to the Older Adult's psychology service by the manager of the mental health day facility that she attended. The manager reported that Lilian was very anxious and continuously seeking support and reassurance from staff about routine day to day issues.

Assessment

Lilian's anxiety was palpable in that she sat hunched in her chair and rubbed her face with her hands throughout the session. She avoided eye to eye contact and broke down in tears several times. However, she welcomed the opportunity to talk about her problems.

Lilian reported that she had no confidence and felt inadequate and inferior when in company. She hated upsetting people and tried to avoid doing so. She found it difficult to relax and her sleep was fretful. Consequently she felt exhausted most of the time. She was in the process of divorcing her husband and felt that her anxiety had worsened.

Lilian's scores on the HADS confirmed she was suffering from anxiety and was clinically depressed.

History

Lilian felt that her three children thought she was selfish for divorcing their father, but that she could not have carried on in a marriage where she felt intimidated and humiliated. She had recently embarked on another relationship and described her new partner as kind and considerate. Even so, Lilian was apprehensive about expressing herself in this relationship and feared losing her partner if she disagreed with him. She worried about her children's opinions and their perception of her as disloyal. For much of her marriage she had been angry and frustrated. In contrast, her new partner made her feel like a human being. It was difficult for her to relax into this new freedom and she feared the worst, almost as if it would be taken away from her.

Lilian remembered her mother and father as being very unhappy together. Her father 'just lived in the house and drank a lot'. Lilian and her eight siblings were ashamed of him and worried that he would embarrass them in front of their friends. Her abiding emotional memory of home was a lack of 'true affection' with 'no warmth or kisses'. On one occasion she overheard her mother saying to her father 'if we hadn't had Lilian we would be a lot better off. Consequently, Lilian said that she knew what it was like to feel 'unwanted'.

Between the ages of six and nine Lilian suffered the loss of three of her siblings through illness and world war two. She had also lost a nephew in adulthood whom she was very close to and thought of as her own son.

Psychiatric history

At forty five years of age Lilian was diagnosed with Schizophrenia that did not respond to medication. Electro convulsive therapy eventually reduced her symptoms but she had suffered with anxiety ever since.

Previous interventions

Lilian had been offered cognitive behavioural therapy on three separate occasions in the preceding 4 years but had never been able to engage with it to any great extent.

Formulation

Lilian's difficulties were formulated within a psychodynamic model, given that cognitive conceptualisations in the past had not been fruitful.

It was possible, given the circumstances of Lilian's family and the inevitable strain with providing for so many children whilst coping with an alcoholic husband that Lilian's mother was not emotionally available for her. As an infant this could effectively have left Lilian in a state of unrelieved anxiety. According to Bion (1962) failure of the mother to contain the infant's anxieties may result in avoidance of some situations liable to provoke anxiety although the person themselves may feel they are continuously persecuted. Further it was likely that at an unconscious level, Lilian's internal representation of her parents was one in which neither of them acknowledged

or met the emotional needs of the other. This developing unconscious awareness of family dynamics may have led Lilian to believe that her own emotional needs would also not be met. The degree to which Lilian could approach situations liable to give rise to anxiety was indeed limited in that she felt driven to avoid her husband's and her children's annoyance and irritation at all costs. It was difficult for Lilian to tolerate perceived difference of any kind without becoming overwhelmed. Bion suggested that the infant's developing capacity to think about experience may be impeded if unbearable feelings remain 'raw' rather than transformed. The life transitions of divorce and a new partnership that Lilian was negotiating had proved to be very stressful. Although Lilian had left an unhappy marriage she was temporarily moving through a very uncertain period and her fears of abandonment may have been reawakened by this process.

Action Plan

Lilian wanted to reduce the anxiety she was experiencing and in the first instance agreed to attend for 10 sessions of therapy. It was decided that a psychodynamic approach may be of help to Lilian as she felt that she wanted to understand why she had always experienced so much anxiety in her close relationships.

Lemma (2003) suggests that suitability for therapy needs to be considered within the context of 'our own experience with the patient in the room' and in this regard the trainee felt that Lilian's level of engagement during assessment indicated that she could engage in a brief psychodynamic intervention that focussed on her core conflict of abandonment and to make explicit her functioning within relationships through interpretation of the transference and countertransference. Some additional sessions were also planned with her partner and children in order to address some practical issues surrounding her divorce.

Outcome

Lilian evidenced change in two important areas. First, there was an improvement in her relationship with her children and secondly there was a shift in her thinking around her new relationship which had started from a position of idealised romance

but eventually progressed to a more realistic appreciation of what was possible. She continued sessions with another psychologist at the service after the trainee had left.

Adult Mental Health Placement

Core placement – October 2002 – March 2003

This placement was based in a large Community Mental Health Team serving a wide multi-cultural population and situated in a general hospital with an inpatient facility.

I was supervised by a clinical psychologist who had recently completed training and was very enthusiastic about the role of psychologists in the community. He gave me first-hand experience of what I could expect when I qualified. During supervision we focussed on a CBT model to formulate client's problems but I was also encouraged to think about the clients in the wider context of their relationships and life circumstances. I also had the opportunity to be supervised jointly with another trainee and her supervisor. Group supervision sessions were very stimulating and productive. My supervisor also encouraged me to broaden my assessment and formulation skills with a psychodynamic model.

I undertook home visits both with by supervisor and other team members, including the social workers and community psychiatric nurses. This gave me some insight both to the role of those team members in caring for clients and also with regard to the day to day difficulties that clients face when suffering from long term mental illness. I also visited community homes and day facilities.

I conducted my Service Related Research Project at this placement and enjoyed having contact with patients who may not necessarily have been referred to a trainee for psychology input. Staff were very appreciative of the research study and gave me their support throughout its duration.

I had the opportunity to co-facilitate a group on the inpatient ward focussing on the topics of depression and stress and found this to be very rewarding.

Learning disability placement

Core placement – October 2002 – March 2003

This placement was situated on two sites with two different supervisors. The primary setting was within the community mental health team for people with learning disabilities and was located in the middle of the town. The other site was located in nearby countryside in one of the old long-stay hospitals for people with learning disabilities. It was in the process of being closed down with just a few remaining patients waiting to be offered places in community homes. Mostly, this location was used for psychiatrists and psychologists to see clients based in the hospital as well as a facility for presentations and training.

I carried out a number of extended assessments in this placement in order to assess clients' strengths and needs. This was often requested by other services when clients were moving from the parental home to a community home. An extended assessment covered cognitive, communication and daily living skills and gave me the opportunity to become familiar with psychometric testing in this client group. The comprehensive assessment of clients required consultation with all of the other professionals involved in their care. This included visiting parents, home managers, day-centre managers, key workers and work-placement supervisors. I also carried out dementia and behavioural assessments in the community in order to plan and implement interventions in collaboration with other professionals.

The placement covered the full range of learning disability and served clients ranging in age from mid-adolescence to older adults. I also had the opportunity to observe my supervisor in an intervention with a learning disabled couple who had a young child and required assistance with parenting skills. In addition, I was able to take a CBT approach with a client who was mildly learning disabled.

In particular this placement gave me insight into the relationship that evolves between professionals and clients, not least because of the intermittent life-long involvement that may develop for the latter.

Child and Family Placement

Core placement – October 2003 – March 2003

For this placement I joined a busy Child and Family team in an affluent suburb of London serving a community that was dominantly white British but also had a strong multi-cultural population.

This placement was co-supervised on two different sites and provided different models of working: CBT, Behavioural and Systemic. I had the opportunity to co-work with my supervisors within both these models, with children and their parents. I also had the opportunity to participate in work with families as an observer (behind a one-way screen) and to offer reflections during the sessions to the team. In addition I received supervision from and gained valuable experience of working with other team members. In particular I gained knowledge of psychoanalytic and attachment models.

I carried out a range of psychometric testing on this placement. I also had the opportunity to make observational assessments of children in playgroups, schools and the family home. These assessments addressed difficulties relating to: Asperger's Syndrome; Attention Hyperactivity Disorder; Ring Chromosome –22 disorder. I co-facilitated a group for dealing with anxiety in adolescence and gained extensive experience of working with an eating-disordered client.

I gave a presentation to the team about early experience of trauma and its implications for cognitive and emotional processing. This provoked a lively debate.

There were many opportunities in this placement to attend team meetings and psychology team meetings. These were always very interesting and incorporated a reflecting team in which I took part.

Elective Placement 1 – Forensic Service

Elective Placement 1 – April 2004 – September 2005-07-22

This placement was situated in the psychology department of a maximum security special hospital which served many high-profile patients. The average stay in the hospital for patients was approximately ten years. Most patients, but not all, had committed a serious criminal offence. I worked with patients who had committed murder and sexual offences.

Patients presented with a broad range of cognitive, emotional and communication difficulties and often severe mental illness. I had the opportunity to work with clients who had very disturbing and violent histories, mostly very early on in their development. I carried out a range of assessments with regard to likelihood of re-offending and acknowledging responsibility for the offence. These were very detailed processes and required patients to talk in detail about and reflect on the nature of their past offence and their current perspective on it. This was a very rewarding aspect of the assessment. I also used a CBT intervention in working with a client who had difficulties with impulse control and addiction to alcohol. Additionally, I implemented a narrative approach with this client as he had recently been bereaved and wanted to explore many unresolved issues.

I had the opportunity to co-facilitate a group with a fellow trainee for Dialectical Behaviour Therapy and Borderline Personality Disorder on a female ward. We received weekly supervision for this from the team who had attended a training course for DBT. The group ran for eight sessions.

I conducted an extended neuropsychological assessment with a patient who evidenced significant cognitive impairment and received supervision from the consultant neuropsychologist.

This placement expanded my knowledge and thinking around social and cultural issues both with regard to their significance in the evolution of patients' difficulties and in the provision of services.

Older Adults Placement

Core placement – October 2004 – March 2005

This placement was situated in a community mental health team located in a hospital serving the mental health needs of the older adult population. The psychology department was housed in a separate building to the rest of the team.

My supervisor was a clinical psychologist who had extensive experience working with older adults and used an integrative approach in her work. In particular we focussed on a narrative model and Erikson's life span model with regard to clients' unresolved issues and bereavement. Using these models, I had the opportunity to work closely with a client for the whole placement on issues of regret and loss. I worked on my own and with my supervisor for a number of individual clients and couples, and also with clients' families. My supervisor observed me with clients on two occasions and was able to give me valuable feedback about my work. We were also able to use role play and active listening to explore some of the issues that may be pertinent to older adults.

I carried out psychometric testing with people suffering from dementia, stroke, and cognitive impairment both in the hospital and in clients' homes and made home visits with other team members. I had the opportunity to give a presentation about Alzheimer's disease to nurses on the ward and attend a workshop on formulating clients' difficulties in different models.

This placement showed how an older person may be involved with and highly dependent on many services. I had the opportunity to liaise with those agencies and also other professionals such as neurologists, occupational therapists and prosthetic technicians.

Elective placement (2) Specialist psychological therapies – Family Therapy

Elective placement (2) – April 2005 –

This placement was situated in a centre for specialist psychological therapies that also included psychology and psychotherapy services. My supervisor was a clinical psychologist and family therapist. I also received supervision from a family therapist at the centre and group supervision from a clinical psychologist who was external to the service and acted as a consultant to the team.

This placement gave me the opportunity to work with many families for either one or two sessions or for the whole of the six month placement. I always worked with a co-worker, either as an observer or a keyworker. The centre operated within a family systems model and had video and one-way screen facilities which were extensively used. I also made several home visits to clients with my supervisor. I gained broad experience of relationship issues for couples and families within the context of mental illness. My ability to reflect on my own relationships expanded a great deal as a result of this experience. There were excellent facilities for teaching and presentation which the psychology and psychotherapy departments utilised on a regular basis.

In the next two months it is proposed that I will undertake a short research study in assessing one year post-treatment outcome for clients.

Research

SERVICE RELATED RESEARCH PROJECT

"A patient satisfaction survey of a Clozaril clinic"

June 2003

Year 1

ABSTRACT

Aims

Patients suffering from psychosis and taking Clozaril are at risk from developing Agranulocytosis (a life threatening blood condition) (Macpherson,1992) and must be carefully monitored whilst taking Clozaril. To address this issue a Community Mental Health Team introduced a special outpatients clinic for Clozaril users in order to provide a safe environment for the prescribing of Clozaril. Staff wanted to find out how satisfied patients were with the clinic and also whether or not patients preferred attending the clinic or the inpatient psychiatric ward (the old system).

Method

Nineteen patients completed the Satisfaction Survey for People using the Clozaril Clinic. The survey asked questions about the following areas: Quality of information; clinic opening times and location; waiting times; quality of consultation with clinic staff; efficiency of clinic procedure; facilities in the coffee/waiting area and overall impressions of the clinic with suggestions for improvements.

Results

Patients generally expressed high levels of satisfaction with the service. In particular they felt they had been well informed about their illness, medication and reasons why they needed to attend the clinic. Most patients were seen within 15 minutes of their arrival and were satisfied with this. Patients preferred going to the clinic rather than the old system of attending an inpatient ward although some patients stated they missed seeing the doctor. Patients felt looked after and cared for by clinic staff. However, some patients stated that the clinic did not always afford them complete privacy when asking questions about their illness or related issues.

INTRODUCTION

In recent years the trend in the health service towards evaluation of services by patients has become the norm. An audit of patients' views and opinions is now seen as fundamental to the provision and continued development of a comprehensive health service. This process has in part been driven by past criticism of service providers (Department of Health & Social Security, 1983). A government white paper *Working for Patients* (Secretaries of State for Health, Wales, Northern Ireland & Scotland, 1989) underlined the contribution to be made by patients in service evaluation. More recently, in line with clinical governance initiatives a user-centred approach in the delivery of health care and treatment has been adopted as one of the guiding principles of the government's National Service Framework (National Service Framework, 2003) for adult mental health services. This requires all health service providers to ensure that regular audit of service users' views is an integral part of their practise.

The aims of the current study were to find out how the needs were being met of a group of patients who attend a Community Mental Health Team (CMHT) clinic that monitors and prescribes Clozaril medication. Clozaril is one of the new atypical anti-psychotic drugs used in the treatment of psychosis and produces fewer of the extrapyramidal symptoms (e.g. tremors and muscular rigidity) associated with the older style neuroleptics. However, Clozaril can cause a condition known as Agranulocytosis, in which white corpuscles in the blood fall to dangerously low levels and may be life-threatening (Macpherson, 1992). It is essential that patients are carefully monitored through blood tests for the duration of their Clozaril use.

The introduction of a Clozaril clinic was prompted both by the specific medical needs of patients and also by the inadequate arrangements that had been in place. Previously, patients were required to go to the psychiatric inpatient ward (where occasionally they may have been inpatients themselves) and could wait for up to three hours to have

their blood taken by a doctor, during which time, potential for disruption on the ward was great, either between patients or from the competing demands made on staff. Furthermore, no one person was responsible for coordinating the blood testing and 'blood alert' procedure whereby the patient and the pharmacy would need to be informed if the result of a blood test indicated that Clozaril should be discontinued. The Clozaril clinic was introduced in May 2002 with the following specific aims: To provide a caring and professional service to Clozaril patients; To educate patients about their illness and Clozaril; To offer a safe environment for prescribing Clozaril and also to alleviate pressures on inpatients and ward staff (appendix 1). The clinic aims to provide a welcoming atmosphere where patients have the opportunity to talk with each other and build supportive relationships with staff. These 'non-specific' factors have been shown to be important to patient care and may help to significantly reduce hospitalization (Fraser, Fraser, Delewski, 1985).

The aims of the current study were to assess if the original goals of the clinic were being fulfilled and to find out what patients like and don't like about the clinic together with any improvements and changes they would like implemented.

METHOD

Participants

Out of twenty seven patients attending the Clozaril clinic, 21 patients (70.37%) agreed to take part in the study. Of the other six patients, three declined to take part and a further three were considered too thought disordered by the researcher to give reliable responses to questionnaire items.

All patients had been diagnosed as suffering from psychosis prior to their first appointment at the clinic. Mean age of patients attending the clinic was 40.13 years (range 26 – 67 yrs). Patients were drawn from Afro Caribbean, Caucasian and Asian-British populations.

Measures

Three different sources were utilised to compile the Satisfaction Survey for people using the Clozaril Clinic (appendix 2). First, four patients were chosen at random from

Clozaril clinic files and telephoned by the researcher. These patients were asked if they would like to suggest which areas of service provision were most important to them. This process yielded communication, information, clinic opening times and empathy. Second, clinic staff were consulted on their ideas for questions related to the original aims set out in their document 'Clozaril Clinic Operational Policy' (appendix 1). Furthermore, staff wanted to find out if patients actually enjoyed coming to the clinic and if there was anything they missed about going to the ward. Third, guidance on patient satisfaction surveys and items for inclusion was found on the Department of Health website (NHS Trust-based Patient Surveys).

The questionnaire (appendix 2) consisted of 41 items that covered the following five areas: Provision of information regarding the patient's illness and Clozaril (7 items); convenience of clinic location and opening times (4 items); quality of facilities in the coffee/waiting room (7 items); waiting times, length of consultation and quality of interaction with clinic staff (14 items); efficiency of clinic procedure (4 items) and overall opinion of the clinic (5 items). Additionally, 3 open-ended questions asked 'Was there anything particularly good about your visit to the Clozaril Clinic?'; 'Was there anything that could have been improved?' and 'Anything else?'.

Each of these areas were idiosyncratic in response options ranging from a yes/no response for questions such as 'The clinic staff have given me clear information about why I need to attend the Clozaril clinic' through to whole sentences where patients were asked to give an explanation for their level of satisfaction. For example, the question 'How do you feel about the length of time you spend in the clinic consulting room?' gave response options of 'very satisfied', 'satisfied', 'dissatisfied' and 'very dissatisfied' followed by 'Why?'. This was felt to be useful in providing the CMHT with the reasons that may drive levels of satisfaction.

The questionnaire was piloted on 3 patients. This process did not reveal any anomalies and they were included in the final analysis.

Procedure

Data was collected at the clinic over a period of 6 weeks on Tuesday mornings in order to maximise contact with the cohort.

It was thought that Clozaril patients may be coping with a number of issues that could impact upon their motivation to take part in the study. For example, the side effects of Clozaril (e.g. drowsiness and weight gain) and enforced isolation through reduced social activity and unemployment. In addition Tilbrook (1997) cites impairments to working memory, paranoia and confusion as possible obstacles to an elucidation of patients' views. So, in order to maximise the response rate, it was decided to approach patients in a proactive way, face to face in the waiting room when they attended the clinic. This approach had the added advantage of providing assistance with filling in the questionnaire (should the patient require it) and to rectify immediately any missing data. The researcher was also able to reiterate that the survey was confidential and that a decision to take part or not was entirely volitional. Patients were assured that their treatment would not be affected by their participation or non-participation in the study. Questionnaires were completed by patients in the waiting room. A small side room was available for the patients who required assistance from the researcher (n=5).

Five patients who took part did not attend the clinic during the period of data collection (for various reasons). They were telephoned by the researcher to ask if questionnaires could be posted to them for completion and return in stamped addressed envelopes to a non-hospital address. These questionnaires were numbered in order to assist follow up of non-respondents. A brief covering letter was enclosed (appendix 3). By the time of writing this report two of the postal questionnaires had not been returned and are not therefore included in the analysis.

RESULTS

Section A: Provision of Information

Items 1-5 in this section were assessed using a yes/no response (table 1). Collapsing these items revealed a mean of 85.6% of patients felt that clinic staff had given them clear information about their illness, Clozaril, potential side effects, reasons for attending the clinic and clinic procedure. Item 4 'the clinic staff have given me clear information about why I need to attend the Clozaril clinic' is notable for its 100% yes response. A multiple choice response on items 6 and 7 shows a mean of 86.4% of patients felt clinic staff had given family or friends the 'right amount' of information about their illness and reasons for attending the clinic (table 2). Taken as a whole, items 1-7 show a mean of 86.6% of patients felt that they and their families/friends had received clear and sufficient information from clinic staff with regard to their illness and reasons for attending the clinic.

Table 1. Patients' YES/NO responses to items 1-5 of the Provision of Information Section A.

Item	RESPONSE	
	Yes	No
The clinic staff have given me information about my illness that is understandable and clear.	15	4
The clinic staff have given me information about Clozaril that is understandable and clear	16	3
The clinic staff have given me information about the possible side effects of Clozaril	16	3
The clinic staff have given me clear information about why I need to attend the Clozaril clinic	19	0
The clinic staff have given me clear information about the Clozaril clinic procedure	15	4

Table 2. Patients' responses to items 6&7 of the Provision of Information Section A.

*one missing data point RESPONSE	Item	
	How much information about your illness have clinic staff given to your family or someone close to you? *	How much information have clinic staff given to your family or someone close to you about the reasons why you need to attend the Clozaril clinic?
Not enough	3	2
Right amount	15	17
Too much	0	0
No family or friends were involved	0	0
My family or friends didn't want or need information	0	0

Section B: Convenience of clinic location and opening times

Over half the patients (57.9% n=11) took less than half an hour to get to the clinic with 42.1% (n=8) taking half an hour or more. All patients used public transport to travel to the clinic with 47.4% finding it 'very convenient' to do so and 36.8% 'convenient'. Of those who found public transport inconvenient for travelling (15.8% n=3), only one patient related this to the time it took them (over half an hour) whilst two other patients cited work commitments (less than half an hour) and tiredness (half an hour).

Patients demonstrated an equivocal response to appointment times with 42.1% favouring an allocated time and 57.9% preferring to drop in during clinic opening hours (the present system). However, 95% of patients found clinic opening times either convenient or very convenient suggesting perhaps that preferring an allocated appointment may be related to issues not related to convenience. A 'Why?' option should be added to this item for future use.

Section C: Quality of facilities in the waiting/coffee area

Patients were generally very positive in their views about the waiting/coffee area. The surroundings were evaluated as being calm, clean and tidy and with adequate seating by 94.7% of patients (items 3, 4 &5). All patients except one felt that hot drinks should be available when they arrived. However, 28% of patients said that coffee and tea was not always set out by the time they arrived at the clinic (items 1&2). Tables 3 and 4 show these results.

Table 3. Patients' responses to items 1-4, Section C. (*one missing data point).

Item	YES	NO
Do you think coffee/tea should be available in the waiting area? *	17	1
Is coffee/tea always available when you arrive? *	13	5
Is there always a place to sit in the coffee/waiting room area ?	18	1
Is the coffee/waiting room area always clean and tidy?	18	1

Table 4. Patients' responses to item 5, Section C.

RESPONSE	Item 5: Is the coffee/waiting room noisy?
Noisy	0
Noisy	0
Not noisy at all	10
Just right	8
Too quiet	1

Suggestions for improving the facilities included soft music, snacks, a greater variety of teas (herbal) and biscuits. Five patients commented that the waiting room was a relaxing place to sit before having a blood test. Another patient reported feeling uncomfortable waiting with 'some other people'

Section D: Waiting times and consultation

Patients demonstrated high levels of satisfaction with waiting times, in fact 77.7% were satisfied and 22.3% very satisfied. No patients responded with the dissatisfied or very dissatisfied options. The median waiting time fell between 5 and 15 minutes with 5 patients waiting more than 15 minutes. The average consultation lasted between 5 and 10 minutes (83.3% of patients), with only one patient spending more than 10 minutes in the consulting room. In all, 89.5% of patients were satisfied (78.9% satisfied, 10.6% very satisfied) with the length of consultation and 10.5% were dissatisfied (table 5). Interestingly, the Why? option for this item was only utilised by patients who were satisfied: 'It's not too long' (satisfied, less than 10 minutes); 'I am happy that I'm attended properly' (very satisfied, less than 10 minutes); 'I just feel it's something that has to be done so I don't mind being in the clinic for any length of time' (satisfied, less than 10 minutes); 'Because you can't expect to talk to a nurse in the same way as a doctor' (satisfied, less than 10 minutes). These responses seem to indicate that some patients value a consultation in terms of how *short* it is rather than the actual business of the consultation itself whilst others relate the length of

consultation to the member of staff they are seeing, which may impact upon their expectations of that consultation.

Table 5. Patient satisfaction with waiting times and length of consultation, Section D. (*one missing data point).

	Item	
RESPONSE	**How do you feel about the length of time you wait to have your blood tested? ***	**How do you feel about the length of time you spend in the clinic consulting room?**
Very satisfied	**4**	**2**
Satisfied	**14**	**15**
Dissatisfied	**0**	**2**
Very dissatisfied	**0**	**0**

Sixteen patients (84.2%) felt that there was enough time during consultations to ask questions about their illness and that they could understand the answers whilst 17 patients were satisfied there was enough privacy to ask questions (89.47%). However, these items provided 'yes definitely' and 'yes, to some extent' options and responses were spread fairly evenly between the two (table 6). Patients reported the following reasons for not asking questions: embarrassment (n=1); forgetting (n=2); not enough time (patient (n=3)); not enough time (staff (n=1)). All patients reported that if they had questions about clinic protocols they would discuss them with staff.

Over half the patients (52.6%) said they saw the same member of staff on each appointment, and the same percentage of patients (not necessarily the same patients) stated this was important for them.

Table 6. Items 8, 9 & 10 Section D.

	Item 8	Item 9	Item 10
RESPONSE	**Is there enough time during your appointment to ask any questions you may have about your illness or treatment?**	**Do you get answers you can understand?**	**Are you given enough privacy when discussing your illness, treatment or other important issues in your life?**
Yes, definitely.	**4**	**8**	**9**
Yes, to some extent.	**12**	**8**	**8**
No.	**0**	**0**	**0**
I haven't asked any questions.	**3**	**3**	**N/A**
I haven't discussed any of these.	**N/A**	**N/A**	**2**

Section E: Efficiency of clinic procedure

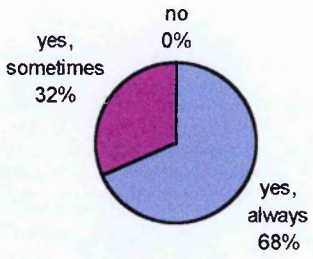
Of the Patients who had experienced a 'blood alert' four were contacted by staff within 2 days of their blood test and 1 patient within 3 days. Two patients (who had not been contacted) had experienced withholding of their medication by pharmacy when they arrived to collect it. Over half the patients (55.5%) stated that their medication was always ready for collection when they arrived at pharmacy. Thirteen patients (68.4%) were satisfied with clinic procedure and 5 (26.3%) were very satisfied.

Section F: Overall opinion of the clinic

In general, patients had a good opinion of the clinic but with some caveats. Items 1 and 2 (figures 1 and 2) show 'fair' and 'yes, sometimes' responses for a total of 8 patients. However, reasons for these choices are not clear, as the 'Why?' option was not used by anyone. Nevertheless, most patients preferred coming to the clinic (75%) rather than going to the ward (0%) with 25% having no preference at all. Common reasons for preferring the clinic related to shorter waiting times, a cleaner and less noisy environment and more privacy. Other comments included 'it can be annoying on the ward'; 'there are less ill people around who might make me nervous'; 'don't have to go back to the ward'; 'there are other patients on the ward who are unsettled'; 'I feel more cared for in the clinic'. Patients did however miss some things about going to Vine ward: 'I enjoyed seeing staff'; 'I enjoyed seeing patients on the ward'; 'there may be the odd person I know to say hello too'; 'I was attended by doctors'; 'talking to a doctor'; 'I was at ease with the person attending me'.

figure 1. Patients' overall rating of quality of care received at the clozaril clinic. Section F.

figure 2. Do patients feel they are treated with respect and dignity at the clozaril clinic? Section F.



Section G: open-ended questions

This section asked patients to say what they felt was good about the clinic and what they felt could be improved. Positive comments not already included in previous sections were 'having my blood pressure and my temperature done'; 'I like being weighed'; 'relaxing, patients being attended to makes me feel better'. Suggestions for improving the clinic were 'having a prognosis for my illness and explanation of how Clozaril works'; 'I think I would like more privacy to check weight and health and see how you are, and be able to speak in confidence'; 'leaflets about self-help and information, things one can do to help cope and keep cheerful'; 'yes, blood test could have been done more quickly, sent to phlebotomy as difficulty in taking sample'.

CONCLUSION

The results of this survey show that overall, patients attending the Clozaril clinic expressed a high level of satisfaction with the service. In particular patients felt they had been very well informed about their illness, medication and the necessity of regular attendance at the clinic. The survey reveals that patients are satisfied with tea and coffee facilities and are able to experience the space as a relaxing environment prior to the blood test procedure. Just under half the patients would prefer a fixed appointment. The majority of patients are seen within 15 minutes of their arrival and are satisfied with this. The survey also demonstrated that patients do ask questions about their illness and related issues but with some reservations over the privacy of the environment and clarity of the answers. Concern over lack of privacy was elicited

both through open and closed questions. The majority of patients preferred attending the clinic because it provided a caring, quieter and more relaxing environment than the ward. Patients had been upset sometimes by the ward environment and unsettled inpatients. However, some patients missed seeing ward staff and patients, and in particular missed speaking to and being attended by the doctor. A further study could ask patients what differences they perceive between seeing clinic staff and seeing the doctor.

As the cohort was relatively small, serious consideration should be given both to patients' suggestions as to what could be improved about the clinic, and to areas that produced less than satisfied or negative responses. Also, it should be considered that the views of non-participating patients may either support or conflict with the overall levels of satisfaction found in this study. Less than satisfied patients may be less willing to express their views for fear of upsetting or alienating the staff involved in their care. Patients suffering from a severe mental illness have been shown generally to be less assertive and less confident in expressing themselves (Wykes, 1993). Also, as Fitzpatrick (1991) suggests, patient surveys tend to find high levels of satisfaction with services and this could be due to investigating areas that patients are satisfied with rather than dissatisfied with. If this study is repeated in the future these concerns should be borne in mind.

The results of this survey will be fed back to the clinic staff in July 2003.

Acknowledgements

The author would like to thank the patients and staff of the CMHT in which this survey was conducted for their participation and support and also for their input in designing the questionnaire.

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Appendix 1

Clozapine Clinic Operational Policy

CLOZAPINE CLINIC OPERATIONAL POLICY

OPERATIONAL POLICY

The overall aim of the Clozapine Clinic is to ensure that it prescribes
and monitors the Clozapine prescription in a timely safe manner for those patients with a diagnosis of schizophrenia who are on Clozapine.

The clinic will:

. Assist in the care of all the patients on Clozapine
. Provide a comprehensive and professional service to these patients
. Educate patients about their illness and all aspects of Clozapine
. Provide opportunities for carrying out audit and research to improve the standards of care in the use of Clozapine
. Offer a safe and controlled environment for current outpatients who are being maintained on Clozapine.

Clinic Procedure

The clinic will be based at the CMHT outpatient department at The service will run on Mondays from 10.00 am to 1.00pm. Patients will attend by drop-in/appointment system. The operation of the clinic will be subject to regular review and the necessary alterations will be made to accommodate changes in for example fluctuations in the demand for the service etc.

Patients will be referred by their Consultant or Keyworker and will attend either on a weekly, fortnightly or monthly basis. This will be based on the length of time the patient is on Clozapine and on their blood results.

The Venepuncture will be carried out two days before Clozapine is dispensed in order to allow time for pharmacy to receive the results from CPMS.

The clinic staff will undertake the Venepuncture. It is also expected patient's mental state will be assessed as and when necessary and appropriate action taken. Physical observations such as blood pressure, pulse, temperature will be carried out monthly.

The clinical staff will be required to keep up to date with current research developments in the use of Clozapine and attend training courses as required.

2. Role of the SHO

2.1 SHO's will register the patient with the Clozapine Patient Monitoring Service (CPMS).

2.2 Refer the patient to the Clozapine Clinic by completing the referral form (APPENDIX A), which is available from the clinic.

2.3 Review all patients as requested by the Pharmacist and/or Nursing staff.

2.4 Ensure the repeat prescriptions are made in conjunction with the frequency of blood tests and are on file.

2.5 Inform the Pharmacist, CMHT, GP and the Clozapine Clinic when Clozapine is discontinued. The patient must continue with blood tests for four weeks after the last dose has been administered and is expected to continue the clinic without receiving the drug.

2.6 If a local blood test is taken ensure that the Pharmacist and CPMS are informed.

3. Role of the Clinical Staff

The Clinical Staff will act as resource for the multi-disciplinary team involved in the Clozapine Patient Monitoring Service and will liaise and co-ordinate with the patients, their carers, keyworkers, inpatient nursing staff, CPMS, pharmacist, consultants and GP.

The Nurse will:

a) Check that the referral form is fully completed and correct.
b) Liase with pharmacy about the dispensing of Clozapine when necessary
c) Ensure that a blood sample is taken in accordance with CPMS requirements, packaged and collected by the CPM courier service
d) Ensure that the Trust's protocol on Venepuncture is adhered to
e) Carry out on a regular basis a nursing assessment, which includes an initial baseline, which is followed by a regular record of patients' weight, blood pressure, pulse and temperature,(APPENDIX B) and inform the Keyworker of the

revelant changes

f) Monitor adverse effects of Clozapine and liase with Keyworker with regards to this
g) Inform patients of the dates they will be required to attend the clinic for blood samples and that these are recorded in their clinical notes and clinic diary
h) Inform the SHO and other relevant team members of red results as backup for the CPMS and pharmacy if necessary
i) keep a record of other concurrent medical investigations/physical investigations eg..EGG etc.
j) Liase with the patient's RMO or keyworker when concerned about the patient's mental and physical health
k) Offer education and advice to patients who are starting or being maintained on clozapine
l) Monitor patients' attendance and ensure that the DNA procedure is followed when a patient fails to attend (APPENDIX G)
m) Ensure that all records regarding patients on Glozapine are correct and are updated regularly.
n) For all outpatients, request a repeat prescription before the current one expires and send this to pharmacy
0) Will notify their line manager of any planned absences and ensure that cover arrangements for the clinic are made.

N.B. The RMO and identified keyworker for the patient will continue to be responsible for the overall care of the patient e.g. CPA requirements etc. The clinic staff's role is to ensure that CPMS requirements are met and to liase with the multi-disciplinary team about the relevant changes in patient's mental and physical health and any adverse reactions to Clozapine.

4. Role of the Pharmacist

4.1 To receive acceptance of Clozapine from GPMS and liaise with the SHO and clinic about dosage
4.2 To dispense Clozapine and receive repeat prescriptions
4.3 Liaise with the SHO and the Clozapine clinic staff on issues related to Clozapine.

Appendix 2

Satisfaction Survey for people using the Clozaril Clinic

Section A (please indicate your response with a tick)

(1) The clinic staff have given me information about my illness that is understandable and clear. **yes** **no**

(2) The clinic staff have given me information about Clozaril that is understandable and clear. **yes** **no**

(3) The clinic staff have given me information about the possible side effects of Clozaril. **yes** **no**

(4) The clinic staff have given me clear information about why I need to attend the Clozaril clinic. **yes** **no**

(5) The clinic staff have given me clear information about the Clozaril clinic procedure. **yes** **no**

(6) How much information about your illness have clinic staff given to your family or someone close to you?

not enough **right amount** **too much**

no family or friends were involved

my family/friends didn't want or need information

(7) How much information have clinic staff given to your family or someone close to you about the reasons why you need to attend the Clozaril clinic?

not enough **right amount** **too much**

no family or friends were involved

my family/friends didn't want or need information

I don't want my family/friends to have any information

Section B

(1) How long does it take you to travel to the clinic?

less than half an hour **half an hour** **more than half an hour**

(2) How convenient is it for you to use public transport to get to the clinic?

very convenient **convenient** **inconvenient**

very inconvenient

don't use public transport

if inconvenient, why?

(3) Are the clinic opening times convenient for you? (please tick)

very convenient **convenient** **inconvenient** **very inconvenient**

If inconvenient when would have been more convenient?

(4) Would you prefer an allocated appointment time for your visit to the Clozaril clinic? (please tick)

yes **no**

Section C

(1) Do you think coffee/tea should be available in the waiting area? **yes** **no**

(2) Is coffee/tea always available when you arrive? **yes** **no**

(3) Is there always a place to sit in the coffee/waiting room area? **yes** **no**

(4) Is the coffee/waiting room area always clean and tidy? **yes** **no**

(5) Is the coffee/waiting room area noisy?

very noisy **noisy** **not noisy at all** **just right** **too quiet**

(6) What do you like about being in the coffee/waiting room area?

(7) Is there anything about the coffee/waiting room area that could be improved?

Section D

(1) Do you see the same member of staff every time you attend the clinic? **yes** **no**

(2) Is it important for you to see the same member of staff every time you attend the clinic? **yes** **no**

(3) If your family or someone close to you wants to talk to the clinic staff, do they have enough opportunity to do so? (please tick)

yes, definitely **yes, to some extent** **no**

family/close friends don't want or need to talk to clinic staff

I don't want family/close friends to talk to clinic staff

(4) How long do you have to wait to have your blood tested? (please tick)

5 minutes	**more than 5 minutes**	**more than 15 minutes**	**more than half an hour**

(5) How do you feel about the length of time you wait to have your blood tested?

very satisfied **satisfied** **dissatisfied** **very dissatisfied**

(6) How long on average do you spend in the clinic consulting room?

Less than 5 minutes	**less than 10 minutes**	**more than 10 minutes**

(7) How do you feel about the length of time you spend in the clinic consulting room?

very satisfied **satisfied** **dissatisfied** **very dissatisfied**

Why?

(8) Is there enough time during your appointment to ask any questions you may have about your illness or treatment?

yes, definitely **yes, to some extent** **no**

I haven't asked any questions

(9) Do you get answers that you can understand?

yes, definitely **yes, to some extent** **no**

I haven't asked any questions

(10) Are you given enough privacy when discussing your illness, treatment or other important issues in your life?

yes, definitely **yes, to some extent** **no**

I haven't discussed any of these

(11) Do you have any questions about your health that are related to the Clozaril treatment that you want to discuss but do not?

yes **no**

(12) If yes to above, why didn't you discuss these questions?

I was embarrassed about mentioning them
I forgot to mention them
I didn't have time to mention them
The member of staff didn't have time to listen
There were too many interruptions
There was not enough privacy
Other

(13) Do you have any questions about clinic procedure that you want to discuss but do not?

yes **no**

(14) If yes to above, why didn't you discuss these questions?

I was embarrassed about mentioning them
I forgot to mention them
I didn't have time to mention them
The member of staff didn't have time to listen
There were too many interruptions
There was not enough privacy

(15) How satisfied are you with the way clinic staff take your blood?
Very satisfied satisfied dissatisfied very dissatisfied

why?

Section E

(1) How soon are you contacted by staff if the result of your blood test indicates that Clozaril should be stopped?

1 day after blood test **2 days after blood test** **3 days after blood test**

none of these **my blood test has never indicated that clozaril should be stopped**

(2) Have you ever been told by pharmacy that you can't have your Clozaril prescription when you have arrived to collect it?

yes **no**

(3) Is your clozaril prescription always ready when you go to collect it from the pharmacy?

yes **no**

(4) Overall how satisfied are you with the whole of the clozaril clinic procedure?

very satisfied **satisfied** **dissatisfied** **very dissatisfied**

Why?

Section F

(1) Overall, how do you rate the quality of care you receive at the Clozaril clinic?

excellent **very good** **good** **fair** **poor**

(2) Overall, do you feel you are treated with respect and dignity while you are attending the Clozaril clinic?

yes, always **yes, sometimes** **no**

If not, why not?

(3) If you are a patient that previously attended Vine ward for your blood tests, do you prefer coming to the clinic or did you prefer going to Vine ward?

Clozaril clinic **Vine ward** **no preference**

(4) What aspects of coming to the Clozaril clinic are better than going to Vine ward?

(5) What aspects of going to Vine ward were better than coming to the Clozaril clinic?

Section G

Was there anything particularly good about your visit to the Clozaril Clinic?

Was there anything that could have been improved?

Anything else?

Appendix 3

Letter enclosed with questionnaire to postal respondents

Dear

Further to our telephone conversation yesterday, I enclose a questionnaire for you to complete and return to me in the stamped addressed envelope. Thank you very much for agreeing to take part in the survey and please don't hesitate to contact me if you need more information. To ensure confidentiality, please do not write your name on any part of the questionnaire.

Yours sincerely,

Vanessa Bryant
Trainee Clinical Psychologist
Department of Clinical Psychology
University of Surrey
GU2 7XH

Appendix 4

Letter of thanks for feedback of findings

[redacted] NHS
Mental Health NHS Trust

[redacted]

Tel: [redacted]
Fax:

Our Ref: [redacted]

Date: [redacted]

Vanessa Bryant

[redacted]

Dear Vanessa,

Just a note to say thank you for coming to see us at [redacted] CMHT on Friday 16th January 2004 and presenting your research project on the Clozaril Clinic. It was most informative and enjoyable.

Best wishes.

Yours sincerely,

[redacted]

Qualitative Research Project

"More than the score: the role of Football in everyday Emotional expression"

Year 2

2004

Abstract

Objectives

This study explored the perspectives of committed football supporters in relation to the emotions experienced and expressed during matches.

Method

Five in-depth interviews were conducted with supporters of a number of clubs from the English League. Interviews were transcribed and analysed, using interpretative phenomenological analysis, in order to explore recurrent themes reflecting football supporters' views about the utility of the football context to facilitate the experience of emotions and emotional expression.

Results

Results from the study suggested that participants experienced intense emotions connected to football that served a number of emotional functions. The ability of football to serve such functions appeared to be dependent on the perceived safety that the football context provided and was connected to concepts of social identity and enhanced self-esteem. A number of strategies appeared to be employed to sustain emotional well-being.

Conclusions

The results were discussed in the light of current theories of football and provide an alternative account for continuing football support that may have therapeutic value in the clinical setting.

Introduction

There has been a great deal of interest in what drives football fans to support their team, with a number of theories originating from psychology, sociology and anthropology (Sloan, 1979). An obvious motivator is that football is a source of entertainment and Sloan argues that the attraction comes from the aesthetic qualities and the value of sport in shaping character and providing lessons on life (Pavli, 1998). An alternative theory comes from the work of Elias and Dunning (1986; Dunning, 1999) identifying that football fans may seek emotional excitement that may be missing from everyday life. Another theory linked to emotion is that watching football can be cathartic for the supporter. Sloan (1979) notes that early research has suggested that watching aggressive acts will subsequently reduce feelings of aggression in the observer. However, more recent findings have found the opposite effect, with an increase in aggressive acts (Sloan, 1979).

Other motivators for supporting football relate to themes of identity. Cialdini, Borden, Thorne, Walker, Freeman and Sloan (1976) identify a tendency to 'bask in reflected glory' where fans associate themselves with the positive aspects of their teams as a means to increase self-esteem. Allied to this, Jones (2000) suggests that supporting a particular team provides a strong sense of social identity which influences the person's thoughts, feelings and behaviour. In addition, Sandy Wolfson (personal communication, 8th March 2004) has identified other psychological benefits of being a fan which include social interaction, tension regulation and intellectual challenge.

There are, therefore, a number of explanations for why football fans continue to support their team. Walton, Coyle and Lyons (in press) and Pavli (1998) found an alternative function of football whereby its specific, rule-governed context permitted male fans to express emotion. Therefore, a further function of football is that it may provide a context for the safe expression of emotion. Following on from this, the aim of this research was to explore the potential utility of football as a vehicle for emotional expression.

As the research question was broad and essentially exploratory, it was decided that a

qualitative methodology, specifically interpretative phenomenological analysis (IPA: Smith, 1996), would be most appropriate. This is because IPA aims to reflect the views of the participants and create a dialogue with their thoughts and intentions using a 'realist' epistemology. IPA was felt to be relevant to this research on the premise that fans think and reflect about their experiences of football.

Method

How the idea was conceived

The topic was identified by one of the research team with a personal interest in football. Fellow researchers identified themselves as having an interest in the topic and the ways in which emotion is felt and expressed at football matches. In addition, some researchers self-identified as football fans.

How the schedule was constructed

An interview schedule (see appendix 1) was constructed from a review of the literature and questions that interested or puzzled the researchers during their discussions. The schedule consisted of structured contextual questions and semi-structured questions. A timeline (see appendix 2) was also incorporated into the schedule to help identify when certain events happened during the respondents' time as a football fan, and to facilitate their recall of surrounding circumstances in their lives at that time. The semi-structured questions afforded the respondents the opportunity to expand on their emotional experience of being a football fan in five major areas (Table 1):

Table 1: Areas explored in the interview schedule

No.	Areas of exploration
1	Emotions felt
2	Emotions expressed
3	Concurrent life events
4	Exploring the expression of emotions at football and outside football
5	The psychological effects of being a football fan

Selection of respondents

Respondents were gathered from associates of the researchers. Criteria for inclusion in the study were that participants described themselves as being long-term and committed football fans. Demographic details of the respondents are presented in Table 2 below.

Table 2: Demographic details of the participants

Demographic	Category	Data
Gender	Male	4
	Female	1
Age	Range	22-39 years
	Mean	32.2 years
Ethnicity	White British	4
	Black British	1
Level of education	M.A./M.Sc.	2
	B.A.	1
	G.C.S.E.	2
Years as a football fan	Range	15-33 years
	Mean	22.6 years

Conducting the interview

Written consent was gained from each of the participants before the interviews commenced (see appendix 3). All interviews were conducted in a location convenient to the participant and lasted between forty-five minutes to an hour.

How the analysis was conducted

After the data had been collected, copies of the transcripts of each interview were distributed to all members of the research team for an initial reading (see appendix 4 for an example transcript). The researchers met as a group to analyse one of the scripts to ensure that as much as possible they adopted a uniform approach to the analysis of

the data. Each researcher then carried out a preliminary analysis of their own interview transcript by noting down in the left-hand margin anything that was of interest or significance. The team then met in order to contribute any additional comments or observations about each other's transcripts. This entailed going through and discussing each transcript in turn thus giving a richer interpretation of the material. The researchers then agreed to analyse their own transcripts further and to identify the major themes emerging from the material. At a subsequent meeting they were able to identify a number of themes and subsidiary themes. The relevant parts of each transcript, according to these themes, were then collated in readiness for reporting the results.

Reflection

Members of the team reflected individually on their experience of the research process (see appendix 5). In addition, towards completion of the project, the researchers met as a group and reflected together on their experience of conducting the research as a team (see appendix 6).

Results

Themes derived from the analysis are shown in Table 3 overleaf. In view of limited space, the team decided to focus on the first five of the listed themes, as these appeared to afford the most interesting and evocative insights into the emotional world of the football fan.

Table 3: Identified themes and sub categories

No.	Theme and sub category
1	Phenomenology of emotion
	a) Intensity
	b) Duration
	c) Fluctuation
2	Emotional function of football
	a) Escape
	b) Unsafe not to express
	c) Therapeutic
	i) Release
	ii) Catharsis
3	Safety
	a) The football environment
	b) Impact of difference
4	Sustaining emotional well-being
	a) Expecting the worst
	b) Moving the goalposts
5	Wider effects on well-being
	a) Belonging
	b) Basking in reflected glory
	c) A learning experience
6	Pride and shame
7	Loyalty
8	Football mirroring life
9	Team identity and fans' identity
10	Quality of the narrative

Phenomenology of Emotions

Participants described that emotions experienced in a football context were more intense than in everyday life, describing how "*emotions become elemental... it's absolute highs and lows*" (Annette, line 525). Emotions ranged from the "*sheer, sheer exhilaration*" (Henry, line 112) to a "*total demotivation*" (Jim, line 220). The intensity was accentuated by dramatic fluctuations in the course of a match or season. This emotional roller-coaster was welcomed by some participants - "*it can feel that nothing's going right, and then just suddenly something turns on its head, and life's*

brilliant and life's fantastic" (Annette, line 641), but was also seen as potentially dangerous - "*there's some bad physical [...] consequences to stressing yourself up too much or allowing yourself to go up and down too much*" (Andrew, line 321).

Participants were asked how long their mood was affected by an important match. Those who described a positive event (Andrew, Annette and Henry) described a sustained impact "*lasting for weeks*" (Annette, line 302), "*certainly a good month or so*"; (Henry, line 190), whereas those recalling a negative event (Jim and Vincent) both reported a lowering of mood lasting around a week. It may well be that those who wished to bask in their team's glory used strategies to keep their mood elevated for as long as possible and enable them to "*hold on to these little moments of glory*" (Andrew, line 235). Henry described "*wanting to relive that goal time and time again [...] in my mind... on news bulletins or video or whatever*" (Henry, line 181). Negative events also engendered intense emotions which might be prolonged "*by being dragged up in the newspapers*" (Vincent, line 89), but they seemed more fleeting, perhaps due to fans' efforts to move on "*and think, oh well – they'll do it next season*" (Jim, line 268).

Emotional Function of Football

This theme emerged from the participant's descriptions of the role that football served in allowing them to experience and express a range of emotions: "*I don't know what it is about football [...] it's quite a good way of expressing your feelings*" (Vincent, line 243). Participants described how the pressures that build up in everyday life can undergo cathartic release in the context of a football match, "*[football is] useful as a release for their emotions, it may be that they're bringing stresses and strains from [...] their everyday lives [...] and maybe releasing it through that way*" (Henry, line 294); "*[in everyday life] you end up internalising a lot, but you don't have to do that, you've paid your thirty quid*" (Annette, line 514). In addition to releasing everyday stresses, football for some (Henry, Jim, Annette) represented a way of forgetting about day-to-day life: "*it's an escape more than anything*" (Jim, line 637); "*it's engaging and it's escapism*" (Annette, line 659).

Participants were attuned to the "*physical manifestation of emotion*" (Annette, line 335) both as an internal event: "*I've had times where I've had to say to myself calm*

down because I've got headaches and it's felt like I've burst a blood vessel in my head" (Andrew, line 318) and as an observable behaviour: "*[I] just jump up and down and shout at [the referee] and probably swear a little bit and it makes me feel a little bit better*" (Vincent, line 262). However the consequence of not venting emotions was also commented on: "*if you don't you'd just explode*" (Annette, line 334).

Safety

Participants described how the safety and containment of the environment supported their emotional expression "*there's ten or eleven thousand other people doing it as well*" (Vincent, line 246); "*if you're in the crowd [...], shouting quite literally like a dickhead [...] or being slumped in your seat with your head in your hands everyone else is doing it [there's a] uniformity of reaction*" (Annette, line 343). Nonetheless participants described an acute awareness of difference and the effect this had on their behaviour whether due to their age or gender: "*I was conscious of controlling what I was saying and the content of, and obviously the language I was using, because of the presence of women and younger children*" (Henry, line 331) or their identification as being from a minority group: "*if there were more black people I would have wanted to say some different stuff*" (Andrew, line 387).

Sustaining emotional well-being

Participants described techniques to protect themselves against the extremes of negative emotions by anticipating failure: "*if you go in there thinking "oh we've got this sewn up" then you're going to be heavily disappointed – so you always have that anticipation that you're gonna lose*" (Jim, line 286); "*even if they're playing Cheltenham Girl's School you go into games thinking, well I know they can fuck this up*" (Annette, line 234). This was made explicit by Henry: "*I tend to... err on the side of...pessimism*" (Henry, line 196); "*I think I keep expectations low, in order not to be too disappointed*" (Henry, line 251).

Participants tended towards negativity rather than positivity. This could reflect the reality of being a football fan - "*they've never done anything in that whole time [approximately 20 years] so why would I expect them to ever do anything*" (Andrew, line 533). It could also be linked to the fear of enjoying success to the extent that

future disappointment or failure would be too much to bear. One positive strategy used by participants involved emphasising different criteria by which their team's value could be measured, in the absence of obvious markers of success such as trophies: "*Tottenham are shit... but they've got a history and tradition of playing entertaining football and having entertaining footballers... show me something beautiful please*" (Andrew, line 255). By focusing on different measures of success, fans could sustain their well-being and self-esteem in the face of mediocre team performance.

Wider effects on well-being

As well as providing a safe environment for emotional expression, the crowd provided participants with a strong sense that they were part of a particular community. Henry described, "*a sense of belonging or an affiliation with the team*" (Henry, line 520) and this was echoed by others: "*it's quite tribal in respect of you're part of one clan and they're part of another clan and you've got to make sure your drums sound louder than their drums*" (Jim, line 438). There was a wider sense of a community of football fans which overarched team rivalries; "*we're all just football fans at the end of the day*" (Vincent, line 324).

Discussion

Links between the themes

The results identified five major themes arising from the interview transcripts, and a coherent thread emerged linking these themes. The *phenomenology of emotions* showed that the participants were able to describe intense emotions connected to football, which served particular *emotional functions* for them. However, this appeared to be dependent on feelings of *safety* that the football context provided. Connected to the theme of *safety* were the notions of social identity and boosting self esteem through positive associations with the team and a number of strategies appeared to be employed for *sustaining emotional well-being.*

Focusing on the *phenomenology of emotions*, the participants produced rich and vivid descriptions of how they felt whilst watching football. This was likened to a roller-

coaster which was characterised by dramatic fluctuations that were more intense than in everyday life, supporting the previous findings by Elias & Dunning (1986; Dunning, 1999). Therefore, a function of football for some fans could be gaining access to intense emotions otherwise not available to them.

Further to this, other *emotional functions* were identified, whereby football was an escape or distraction from the stress of everyday life. It was also described as 'cathartic' or a way of venting pent-up stresses and strains, which resonated with the beliefs of the researchers where we had hypothesised that football may serve a 'therapeutic' purpose in helping people express accumulated emotions from their everyday lives. However, this notion of catharsis deviates from that previously identified in the literature by Sloan (1979) who described a process of catharsis occurring through the observation of football (specifically aggressive acts). In the current study, the participants described a cathartic release through the expression of emotion rather than through observation alone, suggesting that a more active process may be required.

The theme of *safety* appeared to be a prerequisite to allowing people to express their emotions. Factors connected to safety included being part of the crowd (belonging) and sensing the uniformity of reaction. It was also apparent that the participants were aware that their emotional expression would be affected if they perceived themselves as different from others in the crowd. Being aware of differences within the crowd appeared to strongly influence participants' feelings of *safety* and their ability to express emotions in the football context. Therefore, being part of the crowd and experiencing a sense of *belonging* helped the participants to feel safe, as well as providing a source of social identity (Jones, 2000). In addition, Cialdini (1976) and Jones (2000) identified that associating with a football team and its supporters can boost self-esteem through 'basking in reflected glory' and it was evident that the football fans defended themselves against negative emotions by being pessimistic about the team's performance or by finding 'alternative successes' such as flashes of beautiful or inspired play, a concept also noted by Jones. This desire to protect oneself and *sustain emotional well-being* was commonly reported.

Emotions outside the football context

When describing football events, the participants gave vivid narratives. This produced a powerful sense that during the interviews, participants were fully engaged in the process and were reliving the events they described. However, it was apparent that the participants did not produce the same richness of description for emotions in other contexts. This fits with Walton, Coyle and Lyons (in press) who found that football was a place were it was permissible to talk about emotions.

Although it was felt that the participants were fully engaged in the interview process, some people found it easier to recall their emotional experiences than others and in relative terms, all participants found it easier to discuss emotions in the football context than in other areas of their life. There appear to be four potential explanations for this. Firstly, the participants may have felt inhibited from a more general discussion of emotions due to not feeling 'safe' during interviews. This would support the notion that football serves as a vehicle for emotional expression.

A second explanation is that it could be an artefact of memory processes as the football emotions were particularly strong and possessed rarity value (Wagenaar, 1986). In contrast, emotions at this time outside of the football context may not have had the same salience and significance for the participant, making them less memorable. In addition, memories of emotions were not specifically cued outside of football since participants were not asked to recall a specific event. Thirdly it is possible that the questions were less effective at facilitating the discussion of emotions outside of football. Finally, as participants were known to the interviewers, for some this may have inhibited emotional expression. However, there was no evidence to suggest that this had occurred.

Evaluation of the research

The validity of this research was evaluated against criteria proposed by Yardley (2000) who suggests that good qualitative research contains the essential elements of sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. The current study demonstrates sensitivity to context by consideration and discussion of relevant theories and evidence and by placing emphasis on participants' perspectives, their socio-cultural context and the social

context of the research process. Commitment and rigour has been evidenced by the thoroughness with which data was collected, analysed and reported. For example, this was conducted at both an individual and group level, suggesting the researchers were fully engaged with the data and research process (see appendix 5 & 6). Descriptions and interpretations have been accompanied by extracts from the data, resulting in a construction of reality that is both transparent and coherent to the reader. As a result the investigation provides a rich account of the emotional function of football. It has been able to elaborate on the nature of emotions and the conditions that football may provide in order to facilitate emotional expression, providing an alternative account of why so many people support football.

A potential limitation of the research may be that the interview schedule facilitated the exploration of emotions in the football context, but was less effective at exploring emotions in other areas of peoples' lives. Therefore further research in this area may need to revise this aspect. A possible solution could be to use two timelines, one for a significant football event and one for a significant emotional event from everyday life (non-football). This may help to focus the participant's mind on equally important and salient emotional events, allowing a better qualitative exploration of the participant's emotions in each context. Additionally, the number of participants is problematic, as it is a small sample of people and further qualitative investigation will be necessary to be able to generalise the findings.

Implications for Clinical Psychology

In general, there has been very little published research on football in scientific forums, despite the preponderance of opinions disseminated through the media and social circles. The findings of this research tentatively suggest that being a football supporter may serve purposes for the fan which include the expression and experiencing of intense emotion in a way that feels safe and appropriate. This may be of interest to clinical psychologists as for some people, football may be a topic through which intense emotions can be described and understood. Certainly, a shared interest in football can be an instant way of connecting and joining in conversation with a stranger, a phenomenon described by several participants. Therefore, if nothing else, football may offer a means for clinicians to gain an initial rapport with a person. With creativity, it may also be a way to facilitate exploring or relating to complex

emotions.

Ideas for further research

An idea to explore further is why some people may seek to experience intense emotions at football events. If people lack access to these emotional experiences in other areas of their lives, this would appear to be an area of interest to clinical psychologists.

Summary of the research

Overall, this research has met its aims, as a greater understanding has been gained of the role of football in the expression of emotion from five football supporters using interpretative phenomenological analysis (Smith, 1996). Whilst it is difficult to generalise from a small sample, the results have suggested that supporting football may serve purposes for the fan which are not commonly discussed in the existing literature. This relates to the finding that football may have utility in facilitating everyday emotional expression. Also, the highs and lows of football were seen as mirroring life, as Henry (line 509) articulately summarised - "*[the team's performance] does act as a barometer sometimes for, for your own life*".

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Appendix 1

Background information sheet

The following information is collected so that people who read the final report can know more about the people who have taken part. However, you will not be identifiable in the research as the study is completely confidential.

1. **How old are you?** _____

2. **How would you describe your ethnicity?**

(Please choose one section from (a) to (e) and tick the appropriate box to indicate your cultural background).

(a) White

British ☐
Irish ☐
Any other White background, please write in below

.....

(b) Mixed

White and Black Caribbean ☐
White and Black African ☐
White and Asian ☐
Any other mixed background, please write in below

.....

(c) Asian or Asian British

Indian ☐
Pakistani ☐
Bangladeshi ☐
Any other Asian background, please write in below

.....

(d) Black or Black British

Caribbean ☐
African ☐
Any other Black background, please write in below

.....

(e) Chinese or Other ethnic group

Chinese ☐
Any other, please write in below

.....

3. What is your highest qualification? (please tick appropriate box)

None	☐
GCSE(s)/O level(s)/CSE(s)	☐
A level(s)	☐
Diploma	☐
Degree	☐
Postgraduate degree	☐

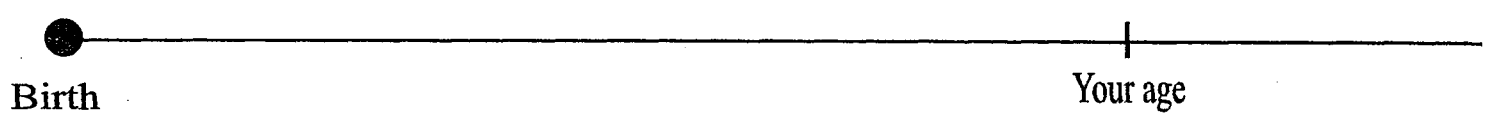
4. What is your current job (or, if you are not working, what was your last job)?

.....

Appendix 2:

The timeline

Time Line - representing your life from birth
until now and a little into the future



Appendix 3:

Information Sheet and Consent Form

INFORMATION SHEET AND CONSENT FORM

An Exploration of the Relationship Between Team Performance and Reported Emotional State of Committed Football Fans

You are invited to take part in a study looking at the types of experiences reported by committed football fans. Your participation will help to develop an understanding of the types of feelings that supporting football can generate in fans and how these may relate to other events in your life.

If you agree to take part you will be asked a number of questions about your team's performance and how you felt about this. You will be asked some questions about what it is like to be a football supporter. You will also be asked some more general questions about yourself.

The interview will be audiotaped and the conversation will be transcribed to provide a paper copy of the interview. On this paper copy all names and identifiable information will be changed to preserve anonymity. Once the study is completed, the audiotape will be erased. The anonymised paper copy may be kept as a record. All members of our research group will have access to the transcripts. If, at any time, you decide that you wish the tape to be erased immediately, let the interviewer know.

The total duration of the study is about 45 minutes.

You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason.

The data collected from your participation will be completely confidential.

I agree/do not agree to take part in this study. (Please delete as appropriate)

Signature of Participant: ..... Date: .....

Name in Block Capitals: .....

Signature of Interviewer: ..... Date: .....

Name in Block Capitals: .....

Appendix 4:

Example Interview Transcript

Line	Speaker	Text
01	**Teddy:**	The tape's on. Okay I'm going to start with some
02		contextual questions. Who do you support?
03	**Henry:**	Arsenal.
04	**Teddy:**	As if I didn't know that!
05	**Henry:**	[Laughs]
06	**Teddy:**	Okay. How long have you been a fan?
07	**Henry:**	About... thirty... three years. Yep
08	**Teddy:**	Quite a long time then.
09	**Henry:**	Suffering... [Laughs]. Long suffering
10	**Teddy:**	Long suffering okay. How did you start supporting
11		Arsenal?
12	**Henry:**	I think I first became aware of the significance of football
13		and teams and supporting teams around about 1970-71 cup
14		final, day, on cup final day 71 and from that decided that
15		it's good, a good thing to support the team that wins the FA
16		cup, so sort of following that really.
17	**Teddy:**	Could you briefly describe the things you do to follow your
18		team?
19	**Henry:**	I check the website, probably the official club website
20		probably daily, umm, look out for the results err when I'm
21		not actually watching or listening to matches. Try and
22		watch the games when they're on TV, if I can't get to a TV
23		I'll listen to them on the radio and occasionally I'll even
24		make a visit and trip to watch a game.

Teddy: Ok. And how would you rate your, how would you rate Arsenal's performance at the moment on a scale of one to five, where one is very poor and five is excellent?

Henry: At the moment I'd probably put them on a three.

Teddy: Ok. Ok the next bit... I'll need this piece of paper and this is a timeline. It's meant to represent your life past, present and future. We can use it to help you identify when certain things happened or occurred in your time as a football fan and what else might have been going on at those times. I will ask you a few questions and we can use the time-line when you are answering. I'd like you to describe for me some significant event that has happened over the time that you have been supporting Arsenal. It might be a positive event, like an important win, or it might be a negative event, such as relegation. Indicate on the timeline when it happened, and tell me something about it.

Henry: I suppose my first recollection, significant recollection would be the cup final in 1972. So we're looking...this kind of stage here [writing on timeline]... they played in the cup final and lost that game to Leeds United 1-0. That was quite a downer, a very negative event. I would say the next recollection of the team was... in their performance in the late 70s, 78 to 80, and they appeared in three cup finals in succession winning one of them, I especially remember 1979 cup final win against Manchester United. After that [laughs] the team went through I can only describe as a bit of a wilderness, barrens patch and, I think, the next significant event and I suppose this is one which is particularly poignant event for me cause I went, was the Littlewoods Cup Final at Wembley in 1987 and I actually was fortunate enough to be at the game to watch them win that 2-1. Particularly good, I'd, I'd being at a Wembley, Wembley Cup Final to watch the team win, excellent. The next year the 88-89 season was particularly significant because that was the year they won the championship, for in, for first time in about 20 years, and of course there was the err dramatic late winner at Anfield against Liverpool in that match. And I do particularly remember that, watching at home on TV, having given up hope of them winning it and then them scoring in the last minute, I think I can definitely recall screaming and rolling around [laughs]

Henry: on my sitting room floor when that, when that went in. That was another particularly uh memorable one and [unintelligible] a couple of good seasons following that, another championship win a couple of years later. Umm... 1994 I remember... them winning the European Cup Winners Cup, the first time I remember ever seeing them win a European Final. Err, again the following year they appeared in the final again but happened to lose that one... and I would say it wasn't until 1998 when I first saw them win the double... that, I really, again, really remember that cup final watching that with a friend round at his house and watching them beat Newcasical, err Newcastle United in the final 2-0, err win the double that was good. And then err again in 2002 winning the double again, umm... I suppose err devaluing it a little bit, that that the the trophies coming a bit too too thick and fast for me as an Arsenal supporter but err, no particularly enjoyable 2002 that that season there. And I think particularly from the year sort of 98 onwards not only the winning of the trophies but I think it was significant that the style of play and the way that they played football was a significant improvement in what the team and certainly the club had served up before and the, they were playing with a style and panache I think which as an Arsenal supporter I certainly wasn't used to so. Yea. That was good.

92	**Teddy:**	Does that bring it up to the present?
93	**Henry:**	Yep, to the current season, of course which, they're
94		currently umm trying to win the league title having more
95		recently gone out of two competitions and I have to say that
96		was a little sad, but umm, nonetheless playing good football
97		again.
98	**Teddy:**	Ok, you you've identified a number across this time is there
99		one of these which you feel is the most significant out of all
100		those?
101	**Henry:**	I think the one which, the event which... I think just due to
102		the excitement and the climax of the season and the events
103		was the 1989 league championship win at err Liverpool
104		which I saw on the television, yeah I'd say that was the
105		most significant in my lifetime. First time I'd actually seen
106		the team win the league umm, but... so that was good, yeah
107		very good.
108	**Teddy:**	Ok. I'm interested in how you felt about that event, the
109		league championship win, and would like to ask you
110		something about your feelings at this time. Can you tell me
111		anything about your feelings at the time?
145	**Teddy:**	[laughs]... You said that you felt that exhiliration
146	**Henry:**	Hmmm hmmm
147	**Teddy:**	Umm, that excitement, was that throughout the match?
148	**Henry:**	I think ummm

Teddy: Or were there other emotions that you felt during the match?

Henry: Oh certainly other emotions, I, as I said, as I said, prior to the umm the goal, the final goal going in there was a sinking feeling of of been here before, you know we've seen it, been so close, they've got so close this time. And there was the feeling of the inevitable, you know I felt resigned, I think it was that, that combination of of having resigned myself to the fate of them not winning sufficiently to win the league. Err, and and sort of thinking I can't bear to watch this I I want to go out now, but of thinking, for some reason, strange reason wanting to hang on there until the end in the kind of vain hope that something good would come. So I think it was the sheer unexpectedness of it and the kind of air of resignation, disappointment, feelings of despondency really, that had preceded the goal going in. I think that roller coaster if you like of emotions certainly was you know to the fore there, where you, you're kind of sunk and sort of thought, oh well that's it for another year, got so close and to this point, come to that. But then I think, you know to be lifted, in the way, there was no time for Liverpool to come back, and you knew, basically the last kick of the game, I think it was just, yeah, just from, complete low to high in the space of of, of a, you know, half a minute, it was, sheer exhilaration.

Teddy: And that exhilaration, that high, how long did that last for?

Henry: I think the, the intensity of the moment as I said the rest of the evening, I mean it was just impossible really to think about anything else or to hold a a sensible conversation about any other subject really and err, I I would say that probably stayed with me for a few days and I think reading about it, wanted to read every paper, see every report on the TV, you know, relive that that goal time and time again whether it was just in my mind or just, on news bulletins or video or whatever, I can't remember whether I taped it or not. But I, I say, its, you know, for the next week or so just thinking about nothing else really, umm, apart from getting on with day to day life but it mean it was, it was that significant and I would say that the enjoyment of that has lasted, ever since although obviously that initial feeling of exhilaration obviously dissipates after a while, it was certainly, a good month or so I think umm before things really really moved on and err it was just a case of wanting to relive that moment by whatever means, whether papers, or reports or TV, whatever means possible really.

Teddy: Was, was the, was the result of that match in line with your expectations?

Henry: I tend to underplay or err on the side of caution or pessimism with these games and I, if I'm honest, although obviously willing and wanting them to win my head would have said, due to the form of Liverpool at that time, and Arsenal not having won a trophy, err for some, for a significant, the league championship for about 20 years, my expectations I think were, that the, the team wouldn't win, certainly by the significant margin of two goals, to actually win the league, no my expectations were not, positive.

Teddy: So knowing that, that it didn't fit... your expectations weren't positive, how did you think that affected how you felt?

Henry: I'm sure that, as I've said, umm relating to the kind of sensations leading up to the goal going in and the kind of, the air or resignation about everything, sinking into a kind of, oh well we gave it a good go you know, it was you know, a good try a good effort but in the end we just weren't quite good enough. I think it was significant, that the expectations were, not there to win that actually produced the exhilaration of when they actually did win. So I think it was that combination, both over the build up to the game and actually during the course of the game, that led to the incredible high that followed the goal going in, yes.

Teddy: When do you think you feel the strongest emotions during the match?

Henry: I think, [cough] strongest emotions are at the time of goals... either goals being scored by your team, or against, and the inevitable highs and lows, and... that exhilaration when a goal goes in especially when it's a significant goal or err a winning goal, although of course during the course of a game you don't know when a winning goal is going in but I think if they start to extend the lead by two or three goals, you become confident the team should win that match. But again, the lows occur umm, when, I think, particularly the opposing team scores, either really early on in the game, and you think oh no it's going to be an avalanche and they are going to wop us sort of five or six nil, or I think towards the end of the game that the opposing team scores because, if it's, particularly if it's a tight game, there's not many goals in it, you think, I think the tendency is to think well that's it they, they've blown it. So I think at those times, err particularly strong and, I'd say they're the particular low points of a game, when the opposing team scores.

Teddy: On balance, do you think you experience more lows or more highs during a game?

243	**Henry:**	Again I think it's umm, a, a kind of, almost like a defense
244		mechanism, to kind of keep expectations low, and almost
245		accentuate the negative in the belief that, if something
246		positive comes, or a goal comes, it's more like, more of a
247		bonus. So I think it's like a deliberate, even though the
248		evidence and the performance of the team, especially this
249		season suggests that I should be confident and going into it
250		expect expecting them to win, because actually in the
251		league they've been unbeaten, but, umm, I think I keep
252		expectations low, in order not to be too disappointed if they
253		don't fulfill them. [laughs].
254	**Teddy:**	You've described how you've felt about the, this event, the
255		winning the league, and I'd also like to ask you something
256		about what happened to those feelings. Did you show your
257		feelings and how did you show them?
258	**Henry:**	When I was at home and the goal, I was watching it on
259		Television and the goal went in, yes, I I think there was a
260		high degree of, certainly the most intense shouting or
261		screaming that I have ever experienced watching a football
262		match, I think it was partly because I was in the safety of
263		my own home, and umm... it was the sheer disbelief that
264		that, of, of that going in that, that led to that. So I was
265		extremely vociferous [laughs]
266	**Teddy:**	[laughs]

267	**Henry:**	When that goal went in, and I think almost uncontrolled in
268		terms of rolling around the floor or, just jumping around for
269		joy really yeah, certainly the most intense emotions I have
270		ever experienced watching football, yeah, and I think partly
271		that was due to, yeah, being at home and not being in a pub,
272		but I I think if I was in a pub watching with friends or
273		around watching, I would have done the same, I think there
274		would have been a collective, even more of a collective
275	**Teddy:**	So what did you get from showing those emotions and
276		doing that?
277	**Henry:**	A release [laughs] an amazing release, I mean it was, yeah,
278		I don't think it would have been safe to try and contain that
279		in any other way [laughs], yeah [laughs].
280	**Teddy:**	Some people show their emotions more than others when
281		they are watching a match. What do you think are the
282		benefits or drawbacks of that?

Henry: I think, I would say for a lot of people when I have actually been to games and watched or listened to them, as I've been there, taken notes on people it's clear that people find it therapeutic in terms of a release for emotions, and, to some degree I think it's quite healthy, people as a safety valve and having to have that outlet, it's almost like in a safe contained environment where, I think due to the behaviour of those, those other supporters around them it appears to be quite the norm, to, certainly shout, sing or, you know, be emotionally... verbose or, or... trying to think of the right words, articulate, emotionally articulate the one, the when, when one normally is but, and I think a lot of people find that useful as a release for their emotions, it may be that they're bringing stresses and strains from their lives, their everyday lives to sort of, that game, and maybe releasing it through that way, so I think that's useful. But of course the downside to that is when that becomes over the top and it starts impinging either on those sitting around them and clearly people can get upset certainly by the use of, of foul language, and also of course when it overspills into abuse either of players or of opposing supporters, and its clearly, you know, the there are people who who, umm I think, abuse those situations umm to the effect of, detriment of other people.

307	**Teddy:**	What about abusing the referee? Is that cathartic, is that a
308		release or what is that?
309	**Henry:**	In the same way that, I think its all again, its almost a, I
310		think he's amongst football supporters a legitimate target, I
311		mean he's, he's the official so he, he doesn't carry any
312		favour in terms of any supporters but, again I suppose
313		within reason I would say ok to have a go, have a question
314		his decisions but, but again umm he's a human being like
315		anyone else and doesn't deserve to be, verbally abused.
316	**Teddy:**	If you, one of the... you mentioned about the people around
317		you. If you perceive the people around you to be different
318		from yourself, does that affect the emotions you express?

Henry: Interesting point. I, I, I, I compared umm a game, a match or matches that I'd watched err in the early 70s when standing on the North Bank terracing at Highbury to a situation where I was then sitting in the same stand but it all being all seated and I did compare the crowd that was around me in the early 70s, there was an all male crowd, err one of lots of singing and shouting and and foul language I have to say... umm to one where I found myself in later years, I think the early 90s, sitting in a stand with women and children, almost a like a more family err environment, and I must say that, it did, I was more aware of what I myself was shouting and saying, in that, in the latter environment than I was earlier on because I think I was conscious of controlling what I was saying and the content of, and obviously the language I was using, because of the presence of women and younger children. I would say that it was more restrained, in that environment, certainly.

Teddy: Ok, so the emotions you expressed might have been slightly more restrained, depending on the people that were around.

Henry: Yes, certainly would have affected that, I was actually quite conscious of that yeah, at the time, I was there yeah.

Teddy: If you perceive the people around you to be supporting a different team to yourself would that affect the emotions you express?

Henry: Absolutely umm [laughs]...

Teddy: And how so?

Henry: Good case in point, I actually went to a game at Arsenal, but I went with a friend of mine who was err a Spurs supporter, and because err, of the way things worked out I decided to go in to stand with him in the Tottenham supporters end... and it was amazing because, although Arsenal had the good fortune to win the game, when they scored, when Arsenal scored, of course, because I was surrounded and I mean compacted, surrounded in a standing terrace full of Tottenham supporters, I actually changed my responses to the goals, the Arsenal goals going in, so when umm the Arsenal goals went in, in terms of not jumping up for joy in terms of the release of that emotion, I'm sure I shouted words to the effect of oh damn [laughs] and it was clear by my, probably clear by my overreaction [laughs] to these events that, that it was probably quite, quite marked and false compared to the rest of the Tottenham, who just sat stony faced and silent [laughs] so, that that was how I dealt with that in that situation of course yeah. Although the release was there when the goals went in, the content or the, or the guise of it was certainly changed, because I, I, I feared that I would be abused either verbally or probably physically if I had of shouted, started shouting when that goal went in [laughs].

368	**Teddy:**	Do you think that the umm, those emotions that you felt,
369		that release
370	**Henry:**	Hmmm
371	**Teddy:**	The intensity of it
372	**Henry:**	Hmmm
373	**Teddy:**	Do you think that it was diminished because you had those
374		different fans around you?
375	**Henry:**	Yes, oh certainly
376	**Teddy:**	Would you have got a more intense burst of emotion if...
377	**Henry:**	Absolutely I would have been jumping and shouting for joy
378		if I had of been with the right, set of supporters certainly.
379		So I had to contain, you know even even voicing
380		disappointment, I had to temper that or tailor that down, err
381		simply because you, its clear, the normal reaction for an
382		opposing supporter is really just not to do anything
383		emotionally, just stand there stony faced and probably shout
384		the odd word of verbal abuse at the player who had scored
385		but certainly yeah it was more constrained, yes.
386	**Teddy:**	Ok, so looking at the timeline, I'd like you to think about
387		what things unrelated to football were going on in your life
388		at that time. So when they won the league. Can you tell me
389		something about that?

390	**Henry:**	I think at the time umm, I was, working as... as an estate
391		agent... that's right it was a career change and... I think, in
392		a way the football provided an escape or a release... umm
393		probably for the confusion or dissatisfaction, I was having
394		err at the time in that, in that, in that job. Yeah I'd say it
395		was a a positive distraction from an otherwise umm...
396		transitional, career kind of move at the time, yeah. It was
397		quite good. Although I had a a stable relationship with a
398		girlfriend... ummm, most things were pretty ok, umm, but I
399		I think football always acts especially when the team's
400		doing well as a welcome, escape from sort of day to day
401		life, yeah.
402	**Teddy:**	So was it the estate agent part that was
403	**Henry:**	I think yeah, it was the uncertainty of having made a career
404		change umm and and the dissatisfaction job dissatisfaction
405		of the actual work yeah, it wasn't fulfilling actually.
406	**Teddy:**	So that that part of it sounds quite difficult do you think the
407		fact that your team were doing well... helped make things
408		better?

409 **Henry:** Absolutely oh yeah. I, I think umm, in the way that it acts
410 and serves in most people's lives it's a welcome release, I
411 think from the day to day life umm... that you have and I
412 think if if things are p-possibly quite difficult or
413 troublesome, in any err at any level then it serves as a good
414 distraction umm a welcome release I think away from those
415 day to day pressures yeah.
416 **Teddy:** Cause you mentioned how you were kind of on a high for
417 about a month
418 **Henry:** hmmm
419 **Teddy:** weren't you, you were feeling
420 **Henry:** absolutely
421 **Teddy:** how do you think that affected?
422 **Henry:** I'm, I'm sure it had had a positive impact across the rest of
423 my life and you know in terms of, who I was with and, who
424 I was working with or you know in a small office or
425 whatever I'm, I'm sure my mood would have been elevated
426 and and was probably elevated at the time because of that
427 umm result yeah that outcome yeah.
428 **Teddy:** If Arsenal's performance had been the opposite at that time
429 **Henry:** hmm
430 **Teddy:** do you think that would have affected other events in your
431 life?

432	**Henry:**	... it's hard to say umm, I don't think to any significant
433		degree, but I'm sure, that my mood, would have been,
434		would have been sorry somewhat, lower or, I would have
435		been less enthusiassic, enthusiastic, enthusiastic about my
436		work or, relationships at at the time, so I'm I'm, yeah, I'm
437		sure it does, although I think it's difficult to put any kind of
438		umm, tangible kind of measure on it. I'm sure it does have
439		some, some err impact on your mood, yeah.
440	**Teddy:**	Do you think, is it easier to express negative emotions at a
441		football match rather than showing negative emotions in
442		other areas of life?
443	**Henry:**	I think it, it, as I said the football environment certainly the
444		crowd environment does, permit, the release of a lot of
445		negative... emotions or thoughts... and I think consciously
446		or subconsciously they can be channeled out... as a a you
447		know through legiti legitimate targets like either the
448		opposition, or the referee I think, yes, I, I think it's almost
449		like a, a kind of safe environment, to release that kind of
450		negative emotion, even though I think it has umm potential
451		negative outcomes in terms of the, players or referees and
452		and the opposing supporters being overtly, abused, yeah.
453	**Teddy:**	What makes it safer... to express negative emotions at a
454		football match?
455	**Henry:**	I think if you are sitting, sorry
456	**Teddy:**	Rather than generally?

457	**Henry:**	If you are sitting with supporters of, your team, err the
458		safety in numbers element I think you feel, you're amongst
459		like minded people, like thinking people, and and actually
460		this is, you're just following the consensus of what's around
461		you and if that's the prevailing mood or, thoughts that are,
462		you're experiencing which obviously you can hear and pick
463		up on, then you feel that security in actually endorsing
464		what, what's being said. So, it has to do with, with who
465		you're with yeah definitely
466	**Teddy:**	And similarly, is it easier to express positive emotions at a
467		football match than it is to show positive emotions in other
468		areas of your life?

Henry: Yes... umm for the same reasons I think you're, you're amongst... you're... tribe if you like, your, your you know your family or whatever they're, they're people of like minds who, who, who you feel it's safe to release, it's safe to release that that kind of emotion with and of course ironically they're people you might only meet sort of once a week or may, once a month or once a year and actually probably don't know them any more closely than you would someone in the street, but... err I think the... the bond that's held between the football supporters is sufficiently strong... to allow... the safety err valve of of emotional release that probably, wouldn't occur unless you were sort of either within the safety of your your own home or own family.

Teddy: Changing focus a little, I'm interested in the differences between fans of teams that are winning and fans of teams that are losing. Do you think a team's performance can affect how fans see themselves?

Henry: ...I think that's quite umm...difficult question to gauge it but I mean in terms of behaviour, what you would normally find of course is the, the team, supporters of the team that is winning, more exuberant, more vociferous... umm probably singing and chanting a lot more err and I would have thought that they would, they would obviously feel more positively about themselves and be looking to assert that through, the chanting and singing that would be going on. So I, I would think from the behaviour of team's supporters who were losing, it is a question of, they do want to encourage their team and some will react very positively, and keep chanting and singing for them, but undeniably, they're aware, only too aware from the noise going on around them... umm... that they are on the, the wrong end of the, the result so I would have thought their self-perception would, would definitely decrease or fall, absolutely, yeah.

Teddy: What about outside the match, would the the performance of the team, whether they're winning or losing affect how the fans see themselves when you're away from the match and during the week say?

508	**Henry:**	Yeah absolutely, I, I, I think the team's performance, does
509		act as a barometer sometimes for, for your own life and I
510		think if, the team does suffer a particularly negative or bad
511		result, there is a tendency either you want to, immerse
512		yourself in a distraction to, to kind of, alleviate the mood
513		and getting away from thinking about that, or, or I think,
514		alternatively it can highlight other negative aspects or areas
515		going on in your life at the time. But I think it can act as a
516		trigger sometimes, to to channel your, other negative
517		thoughts or emotions err with, yeah, yeah.
518	**Teddy:**	... Umm, what do you get personally from being a football
519		fan?

520	**Henry:**	... I think there's a sense of... I think there is a sense of
521		belonging or an affiliation with the team... and following
522		their progress, is is... a welcome distraction... and and
523		almost umm, it's like acting out successes or failures
524		vicariously, err through someone else's endeavours you
525		feel... umm... a sense of not being in control of events and
526		not, not being able to influence them but nonetheless
527		emotionally bonded or attracted, to, that that end, I mean to
528		their end sorry. So I argh, I, I think it's... it is a question of
529		feeling, of belonging really and, and being... part of
530		something... hopefully... err something good... umm, that,
531		you know can give you, the exhilaration and the pluses...
532		but of course with that I think you have to buy into the fact
533		that, there's going to be some lows, and some
534		disappointments on the way, but umm, I, I think the, the
535		emotional appeal of of that err rollercoaster ride is, is too
536		strong to kind of, for a lot of people anyway to kind of,
537		distract so, yeah or detract from that so no it's good... a
538		positive thing.
539	**Teddy:**	That's it
540	**Henry:**	That's it
541	**Teddy:**	Yep we're finished, thank you.

Appendix 5:

Reflections from each of the researchers

Personal reflection - One

Reflections throughout the research process included consideration of the interview process as well as the conceptions and preconceptions that I brought to the project. The interview was conducted using a schedule of questions. I chose to stick fairly closely to this schedule, using only a small number of additional questions and probes. This was to ensure that, while the participant's perspective was explored I did not influence the process by asking any ad hoc questions that could have been considered leading. The disadvantage of this, of course, is that there may have been some interesting avenues that were not explored in great detail, thereby limiting the data.

Being a female researcher who had not been committed to football in recent years may have had a positive effect on the responses given. The balance between what knowledge and interest I had about football against what I didn't know about the topic made me genuinely curious during the interview. Evidence that this was picked up by the participant came from the elaborate explanation provided during the interview about the system by which teams play each other in a bid to secure league promotion.

Personal reflection - Two

It was a slightly apprehensive time, choosing the research topic from the choices given and waiting to see who else would be interested. The topic seemed to provide an opportunity to add a light-hearted aspect to my clinical training, however this was somewhat dependent on my fellow researchers: would we get on, did they have similar ideas to mine about how the project might "go", would we be able to negotiate whatever differences arose? Nevertheless I recall being pleased with the final group, one of whom I knew fairly well and the remainder I perceived to be friendly and sociable people.

Once discussions began it became clear that others appeared to have the same approach as I did. Banter and friendly rivalry emerged between those of us that were football fans; the remainder joined in with the laughter and sought to gain more understanding about the game. I can say with contentment that the subsequent steps in the research process passed unremarkably. We seemed to be able to listen to one another's ideas, commenting on the positives and negatives where necessary; thinking back I hope that everyone felt as free as I did to both challenge and praise suggestions. I think the interview schedule is testament to our cooperative working style and when it arrived typed and formatted in my email box I was proud of and impressed with the finished product.

The interview itself was a somewhat nerve-wracking experience. I was conscious not only of how the participant perceived me but also what my fellow researchers would learn about me as a clinical interviewer. However I recall enjoying the interview – I had thought myself a football fan until I conversed with my participant! He was able to engage me and take me into the very strong positive emotions he was still feeling despite the chosen event occurring some years previously. However my "high" soon became a "low" when the realisation of the arduousness of the transcribing process hit me. Remaining true to the recording was hard particularly where I perceived my questioning to be slightly flawed, yet I persisted in order to be faithful to the process. Throughout I wondered how my colleagues' interviews had gone and how my transcript would "stand up" to theirs; had I gathered sufficient information to be able to generate themes, had I wandered too far away from the interview schedule?

Handing over the completed transcript to the others was another anxious moment.

Reading the other transcripts was fun! Like my participant the other fans were engaging and even when describing a negative event were able to evoke feelings in me; the life of a true fan really amazed me! For example I recall keeping an eye out for the results of all the participants' teams so that I could have some idea of how they might be feeling on that particular weekend. A similar amount of fun came through re-reading the transcripts with my colleagues; the banter remained and it felt like we were "quite good at this qualitative stuff" having generated a number of themes common to most or all participants.

The final stage – the write-up seems to have gone almost too smoothly. Schedules have been kept to, joint writing has been enjoyable and a high standard of work has been produced. Despite the extra workload I shall really miss this project and am glad to have been left with new football friendships!

Personal reflection - Three

"It became apparent during the course of the research process that my interest in the subject of football and football fandom - which had originally been driven by a scientific curiosity rather than emotional involvement - had undergone subtle changes whereby I began to notice (and worry about!) the fortunes of the football clubs followed by the research interviewees, especially the club supported by my interviewee, poor old downtrodden, stigmatised Millwall. I started to listen to the five minute sport slots after the news on television and even stopped to read the Sun at the newstands in the supermarket! All this was possibly exacerbated by Millwall's gutsy performance leading up to the cup final where sadly they were absolutely crushed by Manchester United, but nevertheless gave me real insight into what it must be like for the committed lifelong football fan and the emotional highs and lows of the football season. My reactions were a complete surprise to me and it will be interesting to see if they are sustained for any length of time. I might even go to a match next season!"

Personal reflection - Four

When the topic was first proposed I expressed immediate interest, and was pleased when several others did too. I was a little surprised to see who joined the group – as a football fan myself, I have a good idea which members of the course have an interest in football, and had expected more of these people to join us. On reflection, I was pleased with the group – had there been less football fans, I would have worried that the project would be too distant from the topic, and could not express what I felt was important about football and emotions. However, I was also aware that in a group containing more (male) football fans, I may have felt the authenticity of my "fandom" challenged. As a female fan, I sometimes feel more pressure to prove my commitment, or display my soccer knowledge. Moreover, living far from my club and no longer going to matches, I am very aware that I do not feel as "true" a fan as in the past, and I was grateful that my research group would not be comprised of those whose season-ticket-holding dedication would expose me as the fraud I sometimes feel.

Throughout the project, I inhabited two roles, that of the fan as well as the researcher. An ongoing interest in the complexities of football fandom certainly helped in applying myself to onerous research tasks such as transcribing. Looking back at the transcription, I was also aware that my status as a fan helped the interview progress smoothly, as my participant (also female) knew of my interest in football and therefore a common language and understanding was quickly established, and a richer vein of information was tapped than might otherwise have been possible. However, in the course of the interview it was a struggle to maintain any semblence of an "outsider" perspective, to the extent that on occasion I finished my interviewee's sentences for her, over-confident that nothing she could say about the emotional highs and lows of football could be a surprise to me.

Naturally, my participant and the others who took part described widely varying experiences and opinions about fandom and their feelings, and it was this privileged insight into the differences and commonalities of fans which was the highlight of the research for me. I was pleased that the write-up seemed to capture the passion, dedication and even some of the humour of our participants. Through this project, I

have gained an insight and empathy into the experience of all fans, beyond the blinkers of traditional club rivalries. I also feel that working as a group has been a worthwhile experience, and a valuable introduction into qualitative research.

Personal reflection - Five

As an enthusiastic football fan, researching this area has been fascinating, engaging, stimulating and fun. I think this is largely attributable to my fellow researchers, who have delighted me with their similar interest and passion for the topic. We have been a great team and I feel proud to identify myself with them.

At the outset of this research we had a belief that football may serve emotional purposes for the fan which we had not heard discussed before. Consequently it was very satisfying to find that our participants described experiences that supported these beliefs and fulfilled the research question. However, the parallels between the research topic and our experience of it seem uncanny. For example, I recently found myself thinking that even if we don't achieve a good mark, then we'll still know that we had the most fun, or we were the best team. Clearly I was finding an alternative success to protect myself. There has also been a sense of unity, with people wanting to be involved in all aspects of the work and supporting each other.

The requirements of the course have affected the research, as the nature of the project has been influenced by the marking criteria. At one point this was particularly notable due to the request that we grade each others' contributions. I felt very strongly against this as it seemed to jeopardize the integrity of our team-spirit, placing us in competition. Since this has been revoked, the project has rolled along very smoothly and entirely without hitches or conflict.

The use of IPA has been very effective, however, this methodology was restrictive and consequently frustrating in one instance. During a group meeting where we were analysing each interview transcript, it was observed that one of the transcripts contained very little emotion. We were finding it hard to identify themes in the transcript and everyone seemed a little 'flat'. In particular I found myself feeling subdued and having nothing to say about it. I remember thinking about this and wondering why I had nothing to say, at which point I was struck by the similarity between my feelings and the content of the interview. I felt nothing, and this seemed to reflect the content of the transcript which had very little emotion.

At the time I found this fascinating, as it had a transference type quality to it, where I felt that I was picking up this 'nothingness' from the transcript and was feeling it myself. However, what could be done with this? It was an interesting observation to us as a group, but what use was it to the analysis? Nothing, really. This was frustrating as there was no way to discuss this, to articulate it, or to represent these feelings that the transcript generated, although at the time I found them striking. In retrospect, the best that I can make of these feelings is that they demonstrate how strongly we were engaged with the data from our participants.

I think the process of completing this research has changed my perception of football. Above everything, football is entertainment and drama, but having intimately encountered the beliefs of our participants, I can see that football is much more than that. There is a diversity and plurality of functions that football serves, and the next time that someone says to me "I don't see why people get so excited watching adults chase a ball for 90 minutes", I will have a number of opinions to share with them.

Group Reflection

Towards the end of the project, we met as a group to share our reflections on our group processes. As discussion progressed, it quickly became apparent the extent to which our experience of being football researchers mirrored the experiences of the football fans we sought to describe.

We had entered into this research topic because football fandom was of interest to us, but also because we had a strong sense that the topic had the potential to be more light-hearted than the other proposed subjects. We welcomed the opportunity to incorporate a frivolous element into our cousework, as an escape from the day-to-day realities of clinical training. Looking back, we are pleased that this sense of fun was sustained throughout the project's life. Opportunities for the use of football analogies in group discussion were rarely missed, and when difficult decisions regarding allocation of work or negotiating contrasting ideas arose, these humorous asides served to deflect potential tensions and make us a more bonded group. For example, when one of the group expressed a reluctance to work late, her commitment and loyalty to the project was questioned with accusations of being a "fairweather fan"!

The fact that the project was a "friendly" (rather than a "competitive fixture") eased performance pressure and allowed us to develop as a team. Had the project counted towards our portfolio, perhaps there would have been more of a clash of individual preferences and styles. As it was, we seemed to forge a safe arena in which opinions could be expressed and ideas challenged, without damage to the group's cohesion. As the project progressed, we became strongly bonded as a group, choosing to sit together in teaching sessions. On an occasion when one group member was unable to sit close to the others, he experienced strong feelings of isolation, likened to being seated amongst the opposing team's fans! Comments made by members of other research groups, concerning our apparent organisation and the laughter so often heard during our discussions, increased our sense of belonging to a "football family".

MAJOR RESEARCH PROJECT

The Relatedness of Superstition, Anxiety and Locus of Control in Obsessive Compulsive Disorder: A Gender Comparison.

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Abstract

This study investigated the relatedness of superstition, anxiety and locus of control in men and women suffering from Obsessive Compulsive Disorder (OCD). Although earlier research has shown that superstition and anxiety are not specifically associated with each other in a non-clinical population, it was hypothesised in the current study that the meaning and value placed on superstition as a possible coping/compensatory strategy in OCD may have implications for the level of general or 'trait' anxiety experienced by the individual. Thus the primary aim of the research was to investigate if holding superstitious beliefs functioned to reduce trait anxiety in OCD and whether these relationships were the same or different in men and women. A secondary aim of the research was to confirm results of previous studies that have found a positive association between superstition and an external locus of control. In addition, an exploratory hypothesis for the study was that an external locus of control would be negatively associated with trait anxiety. All participants (n=92) in the study were self-selected from charitable organisations that exist to support individuals suffering from OCD. Correlational methods were used to analyse the data from self-completed questionnaire measures of obsessionality, superstitious belief, trait anxiety, locus of control and depression. Findings did not support the main hypothesis for the study: there was no negative association between superstition and trait anxiety. However, the second hypothesis was confirmed in that a strong positive association emerged between superstition and an external locus of control. Results also indicated an absence of support for the exploratory hypothesis in this study: trait anxiety and an external locus of control were not associated with one another. Further analyses showed that depression may be a significant contributory factor in the degree to which superstition, trait anxiety and beliefs about control may be experienced by individuals with OCD, especially for women. The relationship between superstition and situational or 'state' anxiety is discussed along with the clinical implications of the study. Suggestions for future research are given.

1:0 Introduction

1:1 Foreword

The central topic of this research study is superstition and its relationship to the constructs of anxiety and locus of control in men and women with Obsessive Compulsive Disorder. Superstitious beliefs and behaviours are phenomena that can present in both non-clinical and clinical populations (Frost et al, 1993; Vyse, 1997) and are widely thought to function as a way of maintaining an illusion of control in the face of uncertainty (Matute, 1994; 1995). Specifically, it has been argued that some individuals suffering from Obsessive Compulsive Disorder (OCD) evidence thoughts and ritualistic behaviours that are akin to a belief in superstitious ideals (Amir, Freshman, Ramsey, Neary & Brigidi, 2001). Anxiety is also a core feature of OCD, but its relationship with superstitious beliefs and behaviours and perception of control has not been widely studied. Recent research with a non-clinical population suggests that 'superstitiousness is nonspecific and related more to perception of control than any specific form of psychological distress (Zebb & Moore, 2003)'. This raises interesting questions with regard to the effects of superstitious beliefs and behaviours on anxiety within OCD. Consequently, the current study was an attempt to extend the findings of Zebb and Moore in investigating the relationship of superstition to anxiety and locus of control within an OCD population with special reference to any gender differences that presented.

In order to provide a background to the current research, the introduction initially gives a definition of OCD before moving on to outline the severity and frequency of obsessions and compulsions that present in this condition together with a consideration of their gender differences and qualitative differences that may signal belief in superstitious ideals in a sub-set of patients. The aetiology of superstition is then addressed through an exploration of the perceptual and schematic processes implicit to the registering, storage and retrieval of information before moving on to discuss definitions of State and Trait anxiety. Subsequent sections focus on Locus of Control (Rotter, 1966) and its significance in the development of superstitious ideals as a method of coping with threat and uncertainty. A comparison of coping styles in OCD is then explored through a juxtaposition of the perceived passiveness of superstitious beliefs with the more active obsessions and compulsions that may

characterise those individuals who tend towards perfectionism. It is then argued that anxiety may be experienced to differing degrees in these two groups. Particular reference is made to Zebb and Moore (2003) in the final part of the introduction where the specific hypotheses for the current study are stated.

1:2 Obsessive Compulsive Disorder

1:2:1 Definition and diagnostic features of OCD.

Obsessive Compulsive Disorder (OCD) is a condition characterised by persistent and intrusive thoughts that generate intense anxiety in the individual which may or may not necessitate the use of specific behaviours, that is, compulsive behaviours, in order to alleviate or reduce the anxiety (Salkovskis & Kirk, 1989). Wells (1994) and Wells and Morrison (1994) suggest that obsessive thoughts in OCD are different to the kinds of intrusive thoughts experienced in excessive worrying.

Although evidence suggests that obsessions and compulsions present along a continuum and are to some extent present in non-clinical populations (Rachman & de Silva, 1978; Sher, Frost & Otto, 1983; Salkovskis & Harrison, 1984; Sternberger & Burns, 1990), where obsessions and/or compulsions are considered excessive or unreasonable and cause significant distress to the individual then it is likely that a diagnosis of OCD is indicated. The Diagnostic and Statistical Manual, fourth edition (DSM-IV TR), (American Psychiatric Association, 2002) concludes that for OCD to be present obsessions should be recurrent and persistent and experienced by the individual as "intrusive and inappropriate" and cause significant anxiety or distress and that compulsions should be "repetitive behaviours or mental acts that the person is driven to perform...aimed at preventing or reducing distress or preventing some dreaded event or situation" (p.462).

Obsessions may present as thoughts, images, ideas or impulses (Wells, 1997) and most commonly reflect fears about contamination (such as contacting disease through touching door handles etc.), (DSM-IV TR), (American Psychiatric Association, 2002); ordering or arranging objects (e.g. hanging out washing in a strictly predetermined sequence) (ibid); doubts around the completion of tasks (e.g. uncertainty about whether electrical appliances have been switched off or doors locked), (ibid); or doubting whether oneself has injured or intruded upon another person in some way,

for example, knocking someone down when out driving or making spontaneous and unwanted sexual advances to strangers (Salkovskis & Kirk, 1989). In the latter examples the sufferer may be so concerned about their culpability that they may revisit the scene many times, searching for evidence and reassurance that will refute the content of the obsession (personal communication). However, obsessions may or may not lead to compulsive behaviours (Rachman & Hodgson, 1980). Salkovskis (1985; 1989) suggests that it is the degree of significance to the individual of the appraisal and interpretation of obsessive thoughts that is critical in the triggering of heightened anxiety and the evolution of compulsive behaviours. OCD sufferers may be compelled to neutralise their anxiety through engaging in long and repetitive behaviours or mental rituals that may be completely disruptive to their lives (Salkovskis & Kirk, 1989; Steketee, 1997; Wilhelm, Tolin & Steketee, 2004). Often, these mental rituals or behaviours have to be repeated a 'good number of times' or until 'it feels right' (Salkovskis & Kirk, 1989). For example, an individual plagued with contamination fears may repeatedly wash their hands in a particular way (ibid) and then may repeat this sequence many times throughout the day often causing considerable damage to their skin (DSM-IV TR, 2002). Repeated checking in response to intrusive doubts about whether doors have been locked (Wells, 1997) can similarly take over the person's existence causing great disruption to their lives. Distressing thoughts and images about harm occurring to the self or others may precipitate elaborate, covert mental rituals designed to neutralise such intrusions and the accompanying anxiety (Salkovskis et al, 2000; Rachman & Hodgson, 1980; Vyse, 1997). Most typically, covert rituals may involve counting in particular sequences of numbers, either forwards or backwards a set number of times or repeatedly summoning up an image that is the opposite of the intrusive one (Salkovskis & Kirk, 1989; Wells, 1997; DSM-IV-TR, 2002).

A wealth of research has shown that obsessive compulsive phenomena is also widely experienced in non-clinical populations albeit at a less intense level (e.g. Salkovskis & Harrison, 1984; Sternberger & Burns, 1990; Rachman & de Silva, 1978). Consequently, those processes are often investigated in non-clinical samples (e.g. Zebb & Moore, 2003; Sica, Novara & Sanavio, 2002; Frost, Sher & Green, 1986; Freeston, Ladouceur, Thibodeau & Gagnon, 1992.

1:2:2 Gender differences in OCD

In adults, the incidence of OCD is equally common in men and women (American Psychiatric Association, 2002; Karno & Golding, 1991; Rasmussen & Eisen, 1992). However, gender may influence other demographic factors and the expression of OCD phenomena (Lensi et al., 1996). OCD onset tends to occur later in women than in men (Rasmussen Eisen, 1992; Castle, Deal & Marks, 1995; Noshirvani, Kasvikis & Marks, 1991; Flament & Rapoport, 1984; Lensi et al., 1996) and to be more often associated with depression (Noshirvani et al., 1991; Juang & Liu, 2001) and eating disorders (Fahy, Osacar & Marks, 1993). Women with OCD are more likely to present with a higher frequency of contamination fears and cleaning and avoidant behaviours (Lensi et al., 1996; Matsunaga et al., 2000; Marks, 1987), whereas in men a prevalence of social phobia (Marks, 1987), obsessive slowness (Roy, 1979), sexual obsessions (Castle et al., 1995; Lensi et al., 1996; Matsunaga et al., 2000) and need for symmetry (Rasmussen & Tsuang, 1986; Leckman, Grice & Boardman, 1997; Juang & Lui, 2001; Lensi et al., 1996) have been demonstrated. Using a non-clinical population Zebb and Moore (2003) also found that women had higher levels of contamination fears and cleaning behaviours than men but comparable levels of obsessive slowness. Dowson (1977) suggested that gender differences in frequency of contamination and cleaning symptomatology may particularly reflect sociocultural roles of men and women in western society.

In an Italian sample of two hundred and sixty three OCD patients, Lensi et al (1996) found that more males than females had suffered perinatal trauma and early onset OCD and were less likely to have ever married. Just under half the sample reported suffering co-morbid depression although no gender difference was found. Interestingly, females in this study had higher levels of co-morbid panic attacks and more aggressive obsessions than men. However, a Japanese study (Matsunaga et al., 2000) found a higher level of aggressive obsessions in males compared to females and may, according to the authors, reflect the cultural landscape of Japan in its emphasis on interpersonal sensitivity and the tendency for males to be more frequently exposed to social gatherings where such processes are evoked. Women by way of contrast are more likely to experience aggressive obsessions in domestic situations, such as fears of harming their newborn baby (Matsunaga et al., 2000; Lensi et al., 1996).

1:2:3 Qualitative differences in the content of obsessions and compulsions in OCD

Although a common theme in obsessions and compulsions is the threat of and warding off of future harm, the expression of those fears may differ widely in OCD. One major difference may be that some obsessions and compulsions conform to laws of cause and effect whereas others do not. As Einstein and Menzies (2004) suggest, contamination fears and excessive cleaning (for example) do not require the suspension of scientific laws in order to maintain the beliefs; it is after all perfectly possible that some germs will remain however long an individual engages in cleaning behaviours. Although cleaning behaviours may be excessive in OCD sufferers they are often linked in a concrete fashion to the content of the obsessional thought. In contrast, mental rituals and overt compulsive behaviours that have superstitious content cannot be related in any possible rational sense to those events or phenomena which they are designed to obstruct from happening and do require the individual to suspend, or not acknowledge, scientific reasoning. For example, some individuals may have to count whilst walking through a door or close the door a set number of times either until they feel 'complete' or 'just right' and threat of future harm has been repelled (patient communication to author; Summerfeldt, 2004). There is no rational basis for believing these behaviours can affect the course of or prevent events happening in the external world. In support of this observation, Tobacyk and Milford (1983) found a significant positive correlation between superstitious beliefs and responses on the Irrational Belief Questionnaire (Newmark, Frerking, Cook & Newmark, 1973) in a student sample. Similarly, a later study found a positive association between superstition and irrational beliefs in a large sample of undergraduate students (Roig, Bridges, Renner & Jackson, 1998).

Superstitious obsessional thoughts and behaviours have also been linked in the literature to the processes which are thought to underlie Thought Action Fusion (TAF) (Rachman, 1993). Briefly, TAF refers to the process by which an individual is troubled with intrusive thoughts such as 'I might have harmed my children' and is then driven to either repeatedly check that they haven't (overt behavioural response) or engage in some kind of mental ritual such as counting in predetermined groups of numbers a set number of times in order to neutralise the thought (covert behavioural response). Critically, in TAF the thought is experienced as being almost as bad as the

event actually happening either through the 'badness' of the individual for having the thought in the first place or by the thought itself actually increasing the risk of the event happening. Wells (1997) suggests that TAF reflects 'a general purpose belief that intrusive thoughts reflect reality' and that the mechanism of TAF 'blurs important boundaries between internal (cognitive) and external events' (p.240).

In OCD the differentiation between beliefs and behaviours that either conform or do not conform to scientific laws is striking in that it suggests distinct aetiological sub-groupings of patients may exist under the umbrella of OCD. There has been no research to date that has investigated the determinants of the specific content of obsessions and compulsions in OCD and it is not currently known if specific beliefs or behaviours influence the course and severity of anxiety in OCD.

2:0 Superstition

2:1 Definition of superstition

Writing in the 1700's Voltaire (cited in Jahoda, 1969) supposed that regarding something as a superstitious belief was to some extent relative to its social context and the degree to which the beliefs had gained credence among the population. In a similar vein, Marmor (1956) defined superstition as 'beliefs or practices groundless in themselves and inconsistent with the degree of enlightenment reached by the community'. Other writers acknowledge the contribution of theology and religious practice in types of belief that could be evaluated as synonymous with superstitious thinking (Vyse, 1997; Jahoda, 1969; Reber 1995). One such example from theology was a belief that the left side of the body was unfavourable; omens appearing on the left side of the body were considered as warnings of evil (Reber, 1995). Modern psychological literature however tends to draw on empirical science to aid a more concise definition of superstition and one that is rooted in the assumption that the established laws of cause and effect are currently absolute and universal. Thus Keinan (2002) defines superstitious belief as belief in an 'ability to achieve certain physical effects in a manner not governed by known principles of transmission of energy or information'. Ciborowski (1997) proposed that superstition invites a causal link

between unrelated events. Such beliefs do not stand up to scientific examination but nevertheless are usually impervious to contradictory evidence (Zebb & Moore, 2003). Similarly, Tobacyk and Milford (1983) suggest that superstitious beliefs violate the principles of science, for example, beliefs that black cats bring good luck or that breaking a mirror invites misfortune (Dudley, 1998). Typically, and as these examples show, superstitious beliefs emphasise the invoking of good luck or the fending off of misfortune Vyse (1997).

2:2 Gender differences in superstitious beliefs

Research suggests that a possible gender difference may exist in superstitious thinking (Clarke, 1991; Irwin, 1993; Vyse , 1997; Dag, 1999). Zebb and Moore (2003) found that women had significantly higher scores than men on the Superstitiousness Questionnaire (Leonard et al, 1990). Similarly, Wolfradt (1997) reports significantly higher scores for women on the superstition subscale of the Paranormal Belief Scale (PBS-R) (Tobacyk, 1991). Another study (Sica et al., 2002) using a non-clinical Italian sample of college students found that a higher proportion of women, compared to men, were classified as highly superstitious on a questionnaire listing common Italian superstitious beliefs such as 'if you see a black cat are you worried about it?'. There were no differences in education or other demographic characteristics between the low and high superstitious groups suggesting that gender was a significant factor in level of superstitious belief.

The literature appears to reflect both positive and negative interpretations of the utility of superstitious beliefs that could be significant in terms of gender differences found in the studies above. A number of studies indicate that superstitious belief increases under conditions of stress (Gmelch & Felson, 1980; Keinan, 1994; Keinan, 2002; Malinowski, 1954; Padgett & Jorgenson, 1982; McCann & Stewin, 1984) and support the idea that individuals invoke superstitious thinking in response to uncertainty (Dudley, 1999). Superstitious thinking is also associated with social isolation (Tobacyk, 1985). It is possible that stress, uncertainty and social isolation are experienced differently in women than in men. Alternatively, Scheidt (1973) hypothesises that greater belief in superstition and the paranormal in women reflects historical social roles in that men were encouraged to take up scientific thinking whereas women were closely allied to religious issues. However this argument is

weakened when one considers that positions of authority in the church have until very recently been monopolised by men. A more positive view of gender differences in superstitious belief and one that conflicts with the notion of superstitious belief as a response to stress is that women have a richer fantasy life than men which in turn lends itself to a greater belief in superstitious ideals (Blackmore, 1994) and may reflect the significance of personal experience over experimental (scientific) evidence (Randall & Desrosiers, 1980).

2:3 Superstitious beliefs in obsessive compulsive disorder

It has been suggested that for some individuals belief in superstitious ideals is tantamount to a worldview in which omnipotent external forces determine outcome and personal agency is limited (Tobacyk, Nagot & Miller, 1988). However, such beliefs are not exclusive to superstitious individuals (Zebb & Moore, 2003) and may commonly occur in obsessive-compulsive phenomena (Amir, Freshman, Ramsey, Neary & Brigidi, 2001; Frost et al., 1993; Freud, 1914; Salzman, 1968). Nevertheless the relationship between the two has not been extensively investigated (Vyse, 1997; Zebb & Moore, 2003). Indeed, there is scant research evidence to arrive at any unifying hypothesis with regard to how superstitious beliefs or tendencies may impact upon and mediate the co-existence, content and severity of more concrete obsessions and behaviours in the same individual. More importantly perhaps there has been no systematic study of superstitious ideals and the degree to which they may or may not be associated with anxiety in the OCD sufferer. Superstition itself is an elusive concept, one that has not traditionally been a favourite of psychologists, being difficult to measure accurately and viewed as a close relative of magical ideation (Amir et al., 2001) that is more characteristic of some psychotic states. Its status as a worthy research topic is further hindered by its sometimes mythical origins and the value and interpretation of such collective beliefs by more traditional societies that have not, historically, been the subject of psychological investigation. However, many writers have hypothesised a relationship between superstition or 'magical thinking' and a reduction in anxiety in OCD (A. Freud, 1966; S. Freud, 1913/1966; Rachman & Hodgson, 1980; Pitman, 1993).

2:4 Aetiology of superstition

2:4:1 Perceptual illusion and bias in the development of superstitious beliefs

One possible theoretical framework for understanding the evolution of superstitious beliefs focuses on the processes of learning and perception. Vyse (1997) suggests that the processes of contiguity and perception are highly significant in the development of superstitious beliefs and builds his argument upon the early experiments of the Gestalt school of psychology that began around 1910. The main protagonists of the Gestalt school, among them Max Wertheimer (1880-1943), discovered that the presentation and contiguity of stimuli can make us perceive something that is not really there. This phenomenon where the whole or the *Gestalt* is greater than or different to the sum of its constituents parts has at its core the principles of perceptual organisation. Wertheimer and his colleagues hypothesised that discrete and specific differences in the spatial configuration and temporal contiguity of stimuli influence our eventual perception of that stimuli. A classic demonstration of what Wertheimer termed the *phi phenomenon* is an experiment where two images are projected in succession onto a screen. The first image is projected as a line on the left hand side of the viewing area whilst the second image shows a line on the right side of the screen. Particular combinations of spacing and timing of the projected images will create an illusion whereby motion is perceived around and between the two lines even though the two lines themselves appear fixed in their left and right positions. Vyse (1997) describes a similar experiment with flashing dots and perceived motion between the fixed position of the dots and concludes that the critical time for the illusion to occur is a delay of one tenth to a quarter of a second between the presentation of images. Too long, and there is no movement, just two distinct images presented separately. Too short, and the two images appear simultaneously on the screen. The suggestion from these and similar studies is that the primary perceptual illusion has the potential to build in error and/or bias to information processing and that an eventual psychological analogue could possibly be a belief in superstition.

2:4:2 Schemas, bias and superstition

The laboratory studies of perceptual illusion discussed above illustrate how bias in the processing of stimuli can occur at a primary level and perhaps lead to inaccurate

beliefs about the stimuli. It follows that the selection, processing and organisation of more complex information may be subject to the same or greater degree of error/bias and lead to inaccurate interpretation and retrieval. However, despite the cost of error, humans seem fundamentally driven to schematise in order to unify that which to them appears fragmented and inconsistent. Jahoda (1969) terms this as 'active construction, not merely passive reception' and suggests that superstitious beliefs may arise not just from the 'loopholes....of first-hand sense impressions' but as a result of constructions on both real and abstract information that we receive from others.

2:4:3 Bias in story-recall

The processes of recall and active construction of information are illustrated very well through studies of story- recall. Kashima (2000) found that subjects who were asked to memorise and then reproduce a short story through a chain of five or six people tended to reproduce familiar and gender stereotype-consistent information more accurately than that which was unfamiliar and stereotype-inconsistent as the number of reproductions increased. Examples of gender stereotype-consistent and gender stereotype-inconsistent propositions from the story used in the study were 'This particular Saturday is extremely important because they are entertaining James's employer' and 'Sarah tells James that she had so much fun drinking with the girls' respectively. Interestingly, gender stereotype-inconsistent information was reproduced as often and as accurately as gender stereotype-consistent information at the beginning of the chain but tailed off as the number of reproductions increased. This result supports an earlier study looking at cultural stereotypes by Allport and Postman (1947) who found that a story about a well-dressed black man standing next to a white man with a razor gradually transformed from a cultural stereotype-inconsistent story (for that particular historical period) into a stereotype-consistent story, resulting in the black man holding the razor in just under half of the reproduction chains. These studies give interesting insights about how gender and culture may privilege certain, and perhaps inaccurate, social constructions of memory, information and ideals, including superstitious thinking.

3:0Anxiety

Charles Darwin writing in 1872 considered that anxiety was both a universal and adaptive process in man and other animals and could range from slight discomfort to extreme 'terror'. Darwin described the observable physiological manifestations of fear as including increased perspiration, dilation of the pupils, trembling and changes to facial expression. Later, Freud (1924) referred to anxiety as being an unpleasant emotional state, as being 'something felt' that had physiological, experiential and behavioural aspects. Freud emphasised the adaptive function of anxiety as a necessary motivator to avoid or respond to danger and in this regard his Danger Signal Theory (1936) was in keeping with Darwin's evolutionary conceptualisation. Importantly, Freud differentiated between experiencing anxiety in response to a real and objective threat and *neurotic* anxiety which he regarded as a disproportional emotional response to a perceived threat. Similarly, Basowitz, Persky, Korchin and Grinker (1955) conceptualised neurotic anxiety as 'intense dread and foreboding...internally derived and unrelated to external threat'.

3:1 State and Trait anxiety

Cattell and Scheier (1963) used factor analytic techniques that consistently yielded two separate and independent conceptualisations of anxiety (Cattell, 1966). They found that loadings on the two factors largely differentiated between the fluctuating physiological arousal symptoms of anxiety and the more stable and enduring personality traits tapped by psychometric measures of anxiety, and labelled these state and trait anxiety respectively. Thus Spielberger, Sydeman, Owen and Marsh (1999) suggest that Catell's (1963) research identified these two separate anxiety constructs as being 'an unpleasant emotional state or condition that varies in intensity and fluctuates over time [state anxiety], and relatively stable individual differences in anxiety proneness as a personality trait [trait anxiety]' (p.32).

State anxiety is most often described as an unpleasant conscious awareness of feelings of apprehension, tension and worry (Calvete, Estevez, Lopez de Arroyabe & Ruiz,

2005) accompanied by increased arousal of the autonomic nervous system signalled through physiological-behavioural changes and verbal self-report (Spielberger, 1972; Spielberger, Sydeman, Owen & Marsh, 1999; Krause, 1961). In developing an operational measure of anxiety and building on Freud's (1936) Danger Signal Theory and Catell's definition of anxiety (Catell, 1966; Catell & Scheieer, 1958, 1961, 1963), Spielberger, Gorsuch and Lushene (1970) further defined state anxiety as a 'temporal cross-section in the emotional stream-of-life of a person' and emphasised its fluctuation in response to perceived threat.

Trait anxiety is invariably defined in terms of disposition and 'anxiety proneness', that is, the degree to which an individual may consistently 'perceive a wide range of situations as dangerous or threatening, especially situations that involve....threats to self-esteem' (Spielberger et al, 1999). This is consistent with Catell and Scheier's (1963) original concept that trait anxiety reflected an individual's 'relatively permanent personality characteristics' (Spielberger & Rickman, 1991). Although conceptually discrete from state anxiety, individuals high in trait anxiety tend to experience more frequent and raised levels of state anxiety than those low in trait anxiety (Spielberger, 1972; Spielberger et al, 1970; Spielberger et al, 1999). There is some evidence that levels of trait anxiety are associated with the quality of early parent-child interactions and negative evaluation by teachers or peers, the suggestion being that individuals with high trait anxiety tend to lack confidence and have low self-esteem (Purdue & Spielberger, 1966; Spielberger & Rickman, 1991).

3:2 Gender-related issues in anxiety

Epidemiological studies indicate that women tend to suffer higher rates of anxiety disorders compared to men (Kessler et al., 1994; Regier et al., 1988) although a more recent study (Carter et al., 1999) found equal distribution across genders of anxiety disorder conditions comorbid with depression. An extensive literature search yielded only one German study that has investigated gender differences in anxiety conditions comorbid with OCD and subclinical OCD (Grabe et al., 2001). This study revealed that women with OCD were more likely than men with OCD to suffer from comorbid social and specific phobias. The authors report that in most cases social and specific phobias pre-dated the onset of OCD symptoms and hypothesise a 'predisposition for excessive anxiety responses' in individuals with OCD. One potential avenue for such

a predisposition has been investigated in an interesting study of children who have a parent with OCD (Black, Gaffney, Schlosser & Gabel, 2003). The study reported that they were 'fearful, anxious children' and that they were more likely than controls to be suffering from impaired social functioning, poor sleep and somatic complaints. Interestingly, children were more likely to have a diagnosis of broadly defined OCD at follow-up (2 years after baseline assessment of functioning) if their OCD parent was female. These results are consistent with an earlier study (Black, Noyes, Goldstein & Blum, 1992) that found OCD sufferers were more likely to have a mother with obsessional symptoms than a father with obsessional symptoms. Whilst there is no evidence to indicate whether male or female children experience or model anxiety differentially in relation to their same/opposite sex parent, the findings of these studies may have implications for the social and gendered construction of anxiety in children and the later development of anxiety-related disorders.

4:0 Locus of Control

4:1 Definition of Locus of Control

Locus of Control (LOC) refers to the beliefs that a person may have about the perceived influences that shape events and outcomes in their lives (Rotter, 1966; Levenson, 1981). The concept of Locus of Control (LOC) was originally conceived and defined by Rotter (1966) in his two-dimensional Internal-External Scale (I-E) to reflect belief about outcomes as being dependent either on one's own behaviours (Internal) or subject to the actions of other people and/or events that were beyond the individual's control (External). However, many authors have commented that beliefs or expectancies about the forces of control in one's life are more complex than Rotter's internal-external divide would suggest and should be considered as a multi-dimensional construct (Berrenburg, 1987; Levenson, 1973; Harper, Oei, Mendalgio & Evans, 1990; Klockars & Varnum, 1975). Accordingly, Levenson (1973) separated Rotter's (1966) single construct of externality into two separate scales of belief in Chance factors and belief in Powerful Others. Levenson (1981) asserts that the former reflects a belief that events in a person's life are contingent upon the 'basic unordered and random nature of the world' whereas a belief in Powerful Others, although still

externally oriented, is open to manipulation:

> *"a person... may perceive enough regularity in the actions of such people [powerful others] as to believe that he or she can obtain reinforcements through purposeful action". (p.15)*

In a further reformulation of Rotter's (1966) original LOC construct the Spheres of Control Scale (SCS) (Paulhus, 1983) reflects LOC again as a multi-dimensional construct comprising three potential spheres or dimensions that may operate in an individual's life: Personal Efficacy, Interpersonal Control and Socio-political Control. According to Paulhus (1983) belief in Personal Efficacy refers to the non-social environment and the level of personal achievement that is attained whereas the construct of Interpersonal control reflects the degree to which the individual believes he/she has succeeded or failed in developing familial, social and intimate relationships. Paulhus (1983) suggests that the dimension of Socio-political Control reflects how much one may believe in the efficacy of the individual in fighting for causes and shaping policy in the systems that govern us. Paulhus (1983) points out that the SCS should be thought of as complementary to rather than superseding earlier LOC conceptualisations as it taps into areas of control not previously explored but at the same time does not deny the philosophical and theoretical reality of other constructs such as the Chance and Powerful others scales of Levenson's (1973) multi-dimensional LOC scale.

4:2 Gender differences in Locus of Control

Research has emphasised the assumption that individuals with an internal focus are characterised by positive health maintenance behaviours and increased psychological well-being relative to those individuals who tend towards external attributions (Wallhagen, Strawbridge, Kaplan & Cohen, 1994). Further, evidence suggests that women are more likely than men to attribute outcomes in their lives to external causes, that is to people or events that are not within their control (e.g. Deaux & Emswiller, 1974; Randall & Desrosiers, 1980; Zebb & Moore, 2003). Over forty years ago Janis and Field (1959) asserted that due to gender- role stereotypes, women were 'creatures of culture' and less in control of 'their own beliefs'.

However, in Levenson's (1972) initial validating study of the Multi-dimensional LOC scale, there were no differences between men and women in the degree to which they attributed outcomes in their lives as being either due to their own agency or chance factors, although men did have significantly higher scores on the Powerful Others scale than did women. This is puzzling but may reflect the social and demographic trends of the time in that men were still higher wage earners than women, and more often exposed to situations where powerful others in the workplace, such as managers, had the potential to considerably impact on their earning power and/or effect their chances of promotion. In contrast Mahler (1974) found that Japanese women had a greater perception than Japanese men that events in their lives were contingent on the actions of powerful others, and suggest that the concerns of women in such a traditionalist society as it was then may have been quite different to their western counterparts. Levenson (1981) suggests that Mahler's findings were consistent with the poor status of women in Japanese society at that time. However, other studies from the 1970's found no evidence to suggest a gender difference on these scales (Hall, Joesting & Woods, 1977; Zukotynski & Levenson, 1976 (cited in Levenson, 1981)). More recently, the focus in research has shifted to the role that perception of diminished control may have for women in the etiology and maintenance of emotional illness (Barlow, 2002; Breslau, Davis, Andreski, Peterson & Schultz, 1997; Barlow, Chorpita, & Turovsk, 1996). Current conceptualisations (e.g. Barlow, 2002; Mineka, Watson & Clark, 1998; Zvolensky, Lejuez & Eifert, 2000) hypothesise that perceived limited control 'represents a shared psychosocial diathesis for anxiety and depression' (Brown, White, Forsyth & Barlow, 2004) and that women may be at greater risk than men of developing emotional distress because of their differential response to similar stressors (Nolen-Hoeksema, 2001). However, research findings are equivocal. Heubeck, Tausch and Mayer, 1995 investigated perceived control over mental health in young unemployed males and females and found no gender differences in domains of control.

4:3 Methodological difficulties

There are not very many studies that have investigated the relationship between superstitious beliefs and locus of control (LOC) although those that have tend towards finding an externalised LOC for superstitious individuals (e.g. Peterson, 1978; Randall & Desrosier, 1980; Scheidt, 1973). Belief in superstitious ideals is also thought to be

greater in females than it is in males (Zebb & Moore, 2003) and there is some support for this position in the findings of the studies below. However a definitive conclusion as to the relationship between superstition and LOC is problematic in that, as discussed above, the conceptualisation of LOC varies between studies either as a uni-dimensional or multi-dimensional construct. Thus the studies themselves are fairly heterogenous through the use of different measuring scales in each, and more importantly, there are no studies that look at the impact of LOC and superstition exclusively in OCD subjects.

Although there is an absence of empirical research to refer to, it would seem that superstitious individuals rarely attribute their beliefs and the dire consequences thereof to people they don't know and yet by their reckoning the external forces they believe in are all-powerful and non-discriminatory. The superstitious individual appears resigned and to have delegated responsibility for outcomes to an external force. The paradoxical nature of belief in a force that on the one hand can provide an illusion of control (Matute, 1994; 1995) but is not related to the efforts of the individual is puzzling. In contrast, religious beliefs also violate scientific laws but tend to focus on the contribution of the self in achieving personal growth and provide a degree of social support that appears to be lacking for the superstitious individual (Tobacyk, Nagot, Miller, 1988). The externality of superstition appears to imply that personal control or efficacy is problematic. In this regard, superstition and its relationship with personal and external control are reviewed below.

4:4 Research studies of superstition and LOC

Scheidt (1973) found that subjects who were classified as externals on the Rotter Internal-External Control Scale (Rotter, 1966) held more positive attitudes toward superstitious and supernatural beliefs than subjects classified as internals. However, regardless of internal-external status, female subjects tended toward holding these beliefs more than males. Schiedt (1973) urges caution however in interpretation of these results as sample size was small (n=43). Similarly, Peterson (1978), found that in a sample of Australian female trainee teachers (n=62) an external locus of control on Rotter's scale was significantly positively correlated with self-oriented superstitious beliefs. A later study found a significant positive correlation between an external LOC (as measured by Rotter's (1966) I-E scale) and belief in the supernatural

(n=147) for both men and women (Randall and Desrosiers, 1980).

In further support of an external focus for superstitious individuals, Tobacyk, Nagot and Miller (1988) found a significant inverse correlation between the personal efficacy subscale of the SCS and the Superstition subscale of the Paranormal Belief Scale (Tobacyk & Milford, 1983) in a sample of college students (n=349). Finally, Zebb and Moore (2003) found a significant negative correlation (in females) between belief in superstitious behaviour and perception of anxiety control. This study used the Anxiety Control Questionnaire (AxCQ) (Rapee, Craske, Brown & Barlow, 1996) as it was conceptualised to embrace perception of 'control over anxiety-related symptoms, reactions, and external problems and threats' (p.289) rather than a more generalised LOC and as such represents a construct that straddles both LOC and related anxiety. The study showed that females both had higher levels of superstitious beliefs than males and evidenced stronger inverse associations between superstition and perception of control over anxiety related events. Zebb and Moore (2003) conclude that historically, societal factors may have contributed to a perceived reduction of control over the environment for females, prompting the development of superstitious beliefs in order to convey the illusion of control.

5:0 Superstition and perfectionism

Superstitious beliefs and perfectionist tendencies both in the OCD and non-clinical populations are of interest to this study because of the differential relationships they may hold with LOC and anxiety. On the one hand superstition is conceptualised as a powerful force external to the individual whilst perfectionism signals a high degree of personal responsibility and activity in affecting outcomes. They appear to oppose one another in the demands they make on the individual but are nonetheless both common to OCD. Since the time of Janet in the early 1900's perfectionism has long been recognised as a core feature of OCD. Janet (cited in Pitman, 1987) suggested that feelings of uncertainty (arising in early childhood) about performing one's actions in exactly the correct way triggered the need to develop perfection in perception and behaviour in order to reduce uncertainty and the accompanying anxiety. Mallinger

(1984) emphasised that perfectionism in OCD functions as a means by which the sufferer can exert complete control over events that have the potential to harm them or others. Similarly, Frost and Di Bartolo (2002) propose that by adopting a perfectionist style mistakes are eliminated and the risk of criticism is obviated, or at the very least significantly reduced.

Anxiety about the risk of not attaining perfection in a changing and sometimes uncertain environment may be continually present in some OCD sufferers which may make them ever more vigilant and vulnerable to developing cognitive distortions, and according to Frost (ibid), superstitions, so that at least an *illusion* of control is possible. However, evidence to link perfectionism with sub-sets of OCD type beliefs and behaviours including superstition is equivocal. Sica, Novaro and Sanavio (2002) found in a non-clinical sample of Italian students that those individuals who scored highly on superstitious beliefs also scored more highly on the cognitive domains of greater overestimation of threat, impaired mental control, contamination and worry, but were not characterised by perfectionist tendencies. Conversely, in a sample of female college students Frost et al (1993) found higher levels of perfectionism and checking but not cleaning in superstitious subjects than in those who were not superstitious.

Unfortunately there have been no further studies on non-clinical or clinical populations which could help to clarify and delineate the OCD sub-symptom clusters most commonly associated with superstitious beliefs. However the conflicting results of the two aforementioned studies are puzzling. Perfectionism and superstition *per se* appear to be naturally diametrically opposed in the sense that they present as two qualitatively different strategies in response to an uncontrollable environment. Perfectionism manifests as a very active and pervasive strategy in attempts to control, whereas superstition is often passive and is at best an inexact and risky strategy. As Sica et al (2002) point out, the expression of perfectionism is linked more to actual behaviours (Frost & Steketee, 1997) whereas superstition is more likely to be associated with obsessional thoughts. Frost et al (1993) found that superstitiousness had a stronger correlation with the Obsessive Thoughts Questionnaire (OTQ) (Bouvard, Mollard, Cottraux & Guerin, 1990) than with the Maudsley Obsessional-Compulsive Inventory (MOCI) (Rachman & Hodgson, 1977). Whereas the MOCI

focuses on both obsessive thoughts and compulsive behaviours, the OTQ focuses solely on unwanted obsessional thoughts and how distressing or disturbing they may be. The difference between the intense involvement of a perfectionist style compared to the passiveness of the superstitious individual may have respective implications for the level of anxiety experienced. This is discussed below.

5:1 Anxiety and perfectionism

Evidence suggests that certain aspects of perfectionism, most notably the social and maladaptive evaluation aspects correlate strongly with measures of trait anxiety. In a student cohort Deffenbacher, Zwemer, Whisman, Hill and Sloan (1986) found significant positive correlations for trait anxiety and the Demand for Approval and Personal Perfection item subscales of the Irrational Beliefs Test (Jones, 1969). Similarly, in subjects with a social phobia, Juster et al (1996) found a significant positive correlation between trait anxiety and two subscales of the Multi-dimensional Perfectionism Scale (MPS) (Frost et al, 1990) that measure evaluative concerns, that is, Concern Over Mistakes and Doubt About Actions. In another study, Flett, Hewitt and Dyck (1989) found a significant positive correlation between the Burns Perfectionism Scale (BPS) (Burns, 1980) and trait anxiety. There is some debate as to what dimensions of perfectionism are reflected in the items of the BPS but Frost and Di Bartolo conclude that as the BPS correlates strongly with items on the Concern Over Mistakes subscale of the MPS then it is more analogous to concerns about the social evaluative aspects of perfectionism. More specific forms of anxiety have also demonstrated an association with perfectionism. Frost and Roberts (cited in Frost et al., 2002) found significant and positive correlations between scores on the Penn State Worry Questionnaire (PSWQ) (Meyer, Miller, Metzger & Borkovec, 1990) and items on the MPS subscales of Concern Over Mistakes, Personal Standards, Doubts About Actions and Parental Criticism.

The association with anxiety for these perfectionism scales is interesting in that the constructs being measured tap into areas of functioning such as responsibility and accuracy that are unlikely to concern superstitious individuals (Sica, Novara & Sanavio, 2002) who, from the studies already reviewed, tend to attribute responsibility for outcomes to external forces. The interesting question here is that as perfectionism represents such an active coping strategy and is consistently linked to high levels of

trait anxiety and to other more specific forms of anxiety, to what extent would superstition, given that it is linked more to beliefs than behaviours and may be conceptualised as a somewhat inexact and passive strategy, mediate or attenuate trait anxiety? In OCD, if superstitious beliefs have become extreme and more or less globally present as a coping strategy in the believer, then it follows that in such individuals anxiety may not be experienced to the intense level of that typified by someone with more perfectionist tendencies who, at all costs, has to be actively engaged in the behaviours that reduce their anxiety and is therefore more or less continuously hyper-vigilant and physiologically aroused.

5:2 Superstition and anxiety

In line with the above hypothesis, Zebb and Moore (2003) doubt whether superstitiousness is a predisposing factor in the development of anxiety per se although they conclude 'superstitiousness may be a predisposing factor for psychological distress in general, but not for anxiety in particular' (p.127). They found in a non-clinical sample that superstitious beliefs evidenced a strong association with symptoms of agoraphobia and social phobia as well as obsessive-compulsive symptoms. They explain these results by suggesting that the common factor to both superstitious individuals and those experiencing psychological distress is a 'perceived inability to control the environment around them'. Zebb and Moore suggest that it is perception of control or lack of it which mediates the development of various anxiety-disorder symptoms and thus may determine specific coping strategies. Their study shows some support for this position in that partial correlations (in males) attributed more unique variance to perception of control in obsessive-compulsive symptoms and other anxiety-disorder symptoms and general psychological distress than did superstitiousness. In females however, although perception of control again accounted for more unique variance in measures of general psychological distress (anxiety, depression & stress) and symptoms of agoraphobia and panic attacks, it was superstitiousness rather than perceived control that accounted for more unique variance in the checking factor on both the MOCI and PI obsessive-compulsive scales.

In the above study, at least in males, perception of control rather than superstition has a close, perhaps causal, relationship with the symptoms of anxiety disorders. But

perhaps the most interesting finding of this study was the relationship it revealed between superstition, perception of control and *general* anxiety as measured by the anxiety subscale of the Depression Anxiety Stress Scales (DASS) (Lovibond & Lovibond, 1995). In males, once the effects of perception of control were partialled out there was no relationship at all between anxiety and superstition. In females although there was initially a significant positive correlation between the anxiety subscale of the DASS and superstition, the strength of the correlation was reduced after controlling for perception of control but was still stronger than the correlation for these variables in males. However, in both males and females there was a highly significant inverse correlation between anxiety on the DASS and perception of control when superstition was partialled out. Thus, when superstition was controlled for, individuals who perceived themselves as having little control over aversive events experienced higher levels of anxiety.

Conversely, Wolfradt (1997) found a positive correlation between trait anxiety and the superstition subscale of the revised Paranormal Belief Scale (PBS-R, Tobacyk, 1991) in a sample of German students (n=269). This was an interesting study in that it also yielded a significant correlation between superstition and the absorption/amnesia subscale of the Dissociative Experiences Scale (DES, Bernstein & Putnam, 1986) which in turn showed a significant association with trait anxiety.

Finally, in terms of the relationship that anxiety has with superstition and LOC, Dudley (1999) found that exposure to an unsolvable word puzzle showed that individuals high on superstitious belief scored significantly higher than individuals low on superstitious belief on a subsequent task in which they were required to solve anagrams. It may be that attributing failure on the unsolvable task to internal rather than external factors yielded a resultant rise in anxiety and interfered with performance on the anagram task for the individuals who were low on superstitious beliefs. Unfortunately there was no anxiety measure included in the Dudley study but it is interesting to consider the possibility that in some instances, superstitious beliefs function to allow the individual to evade perception of failure thereby maintaining control and may mediate or even reduce the accompanying anxiety. This study suggests that in attributing control to external forces the superstitious individual can then function as optimally as is possible for them.

6:0 Rationale for proposed research

The studies reviewed above show a complex relationship between anxiety, LOC and superstition in the non-clinical population and suggest a gender difference may exist in the strength of the relationship between superstition and anxiety and superstition and LOC (Zebb & Moore, 2003). Whilst OCD itself appears to be distributed equally across gender (Karno & Golding, 1991; Rasmussen & Eisen, 1992; American Psychiatric Association, 2002), previous research suggests that women evidence higher levels of superstitious beliefs than men (Clark, 1991; Sica et al., 2002; Vyse, 1997, Zebb & Moore, 2003) and are more likely than men to attribute event outcomes to external causes that are not within their control (Deaux & Emswiller, 1973; Randall & Desrosiers, 1980; Zebb & Moore, 2003). There are no studies as yet that have investigated if women with OCD are more anxious than men with OCD but the higher rate of comorbid anxiety disorders in females found by Grabe et al (2001) suggests that gender may be a significant factor.

The theoretical review and research studies outlined in the introduction also suggest that superstitious beliefs have a central role in the attempt to retain control over anticipated threat or uncertainty in the environment (Keinan, 2002; Dudley, 1999; Keinan, 1994; Zebb & Moore, 2003; Malinowski, 1954). It may be that the use and function of those beliefs in reducing anxiety becomes even more critical in OCD (Freud, 1913/1966; Pitman, 1987; Rachman & Hodgson, 1980; Pitman, 1993). If a person perceives or learns through past experience that outcomes are not contingent upon their response, they may adopt superstitious beliefs (unconsciously or consciously) as a global and dominant way of coping in attempts to attain an illusion of control over events. Such beliefs may assume huge importance as an anxiety reducing strategy within OCD and may reflect the termination, early on in development, of any logical attempts to deconstruct cause and effect. To date, these constructs have not been studied extensively, either in non-clinical or OCD populations.

Zebb & Moore (2003) investigated superstition and anxiety in a non-clinical population and found that these constructs were not specifically associated with one

another. Although there is no empirical evidence to suggest that superstition and anxiety function the same or differently in OCD than in non-clinical populations, OCD symptomatology is thought to present on a continuum (Rachman & Hodgson, 1980; Frost et al., 1993; Rachman & de Silva, 1978; Sher, Frost & Otto, 1983; Sternberger & Burns, 1990) and it is therefore reasonable to suggest that anxiety and superstition might operate in similar ways, possibly to varying degrees, in low and high obsessionality. Alternatively, superstition may function as a coping mechanism in reducing anxiety (Rachman & Hodgson, 1980; Freud, 1913/1966). In addition, previous research suggests that superstitious individuals may have an externally oriented LOC (Scheidt, 1973; Peterson, 1978; Randall & Desrosiers, 1980; Tobacyk, Nagot & Miller, 1988; Zebb & Moore, 2003). Accordingly, the current study was an attempt to further investigate the relationships between superstition, anxiety and LOC in an obsessional population, and to examine whether these relationships manifest differentially according to gender.

6:1 Hypotheses

Based on the reviewed literature the specific hypotheses for the current study were:-

1 Building on previous theory and research (Keinan, 2002; Freud, 1913/1966; Rachman & Hodgson, 1980; Zebb & Moore, 2003) superstition may function in OCD as a global way of coping with uncertainty and reducing anxiety such that there will be an inverse association between superstitious beliefs and trait anxiety.

2 In an obsessional population, and in accordance with previous research (e.g. Tobacyk, Nagot & Miller, 1988; Zebb & Moore, 2003) there will be a positive relationship between superstition and an external LOC.

3. An additional *exploratory* hypothesis to the study was that if the hypothesised relationships above (1 & 2) had validity, then an external LOC by virtue of its association with superstitious beliefs would show a negative association with trait anxiety.

In addition and in accordance with past research (Clark, 1991; Sica et al., 2002; Zebb

& Moore, 2003) that has found superstition, anxiety and LOC to vary by gender, it was intended that all results would be explored in terms of possible gender differences.

7:0 Method

7:1 Design

A correlational design was used in the study in order to explore the hypothesised relationships between the constructs of superstition, trait anxiety and LOC in obsessional men and women and also to make comparisons with the findings from previous research that have used this design.

7:2 Ethical approval

Ethical approval for the study was obtained from the Central and South Bristol Research Ethics Committee and from the University of Surrey Ethics Committee (see appendix 1).

7:3 Procedure

All volunteers were recruited from charitable organisations that exist to support individuals with OCD. Advertisements (please see appendix 2 for a copy) for participants were placed on the websites of those OCD organisations and also in christmas cards that were sent out to members by the organisations themselves. Interested individuals responded to the advertisement for volunteer participants by contacting the researcher either by telephone, letter or email. These individuals were then sent an information pack about the study plus a set of questionnaires. Please see appendix 3 for a copy of the information pack. The questionnaires are listed separately below.

A power analysis indicated that a sample size of 128 would be adequate in terms of a reliable and valid analysis of the data. However, approximately 190 potential participants initially contacted the researcher, resulting in 165 sets of questionnaires being sent out. Ninety-two of these were completed and returned to the researcher in

the freepost envelope provided. Informed consent was obtained from all participants. Please see appendix 4 for a copy of the proposal submitted to the ethics committees.

7:4 Participants

A total of 92 people took part in the study, 35 men and 57 women. The sample had a mean age of 40.44 years (s.d 13.40) with a range of 60 years, the youngest participant being eighteen and the oldest seventy eight.

The mean age of onset of OCD for the participants was 16.36 years (s.d. 9.71, median age =14, n=85). The mean number of years the participants had suffered from OCD was 25.01 years (s.d. 15.47, median =24, n=85).

In an additional form (see appendix 5) participants were asked if they had received a formal diagnosis of OCD either from a medical or psychological practitioner. Only eighty four participants responded to this question, seventy three said yes and eleven said no. Although it would have been more satisfactory to be completely sure of a diagnosis of OCD for all participants it was considered that some of the people taking part may have their own reasons for not wanting to pursue a diagnosis or were unaware that they could access help and support through a diagnosis from health professionals, especially those individuals who had only recently recognised the extent of their difficulties.

7:5 Questionnaire measures

7:5:1 Padua Inventory (Sanavio, 1988).

The Padua Inventory (PI) (see appendix 6) consists of 60 statements that reflect obsessional thoughts and behaviours. Factor analyses both during and post-development suggest four component scales of Impaired Control Over Mental Activities, Becoming Contaminated, Checking Behaviours, and Urges and Worries of Losing Control over Motor Behaviours (Sanavio, 1988). Examples of questions from these scales respectively are; 'I find it difficult to make decisions, even about important matters'; 'I feel my hands are dirty when I touch money'; 'I have to do things several times before I think they are properly done'; 'I sometimes feel the need to break or damage things for no reason'. Sternberger & Burns, (1990) retained Sanavio's (1988) four factor solution and have shown that the PI can transfer

successfully from a romanic culture to an anglo-american one.

The PI has good internal consistency (coefficient $\alpha = .94$) and good convergent and divergent validity in that it has a significant correlation ($r = .66$) with the obsessional subscale of the Symptom Checklist-90 revised (SCL-90) but not with the other SCL-90 subscales. The subscales of the PI also show significantly stronger correlations with the corresponding subscales of the Maudsley Obsessive Compulsive Inventory (MOCI), (Hodgson & Rachman, 1977), for example, .68 for the checking subscales (Sternberger & Burns, 1990), than with the noncorresponding subscales. Sanavio (1988) achieved a test-retest correlation of .78 for men and .83 for women. Sanavio (1988) found that PI scores discriminate between OCD and 'neurotic' patients and suggest therefore that the PI can be used with both normal and clinical populations.

7:5:2 Obsessive Belief Questionnaire – 44 item version (OBQ-44)
(Obsessive Compulsive Cognitions Working Group(OCCWG), in press).

The OBQ-44 is a recently developed measure of obsessions and compulsions and was obtained by the author through personal communication with the OCCWG.

The OBQ-44 (see appendix 7) was originally comprised of 87 theoretically derived items that were considered to reflect obsessive thinking but in response to its length and high intercorrelations among some of the subscale items the OCCWG conducted factor analyses of the OBQ which yielded a 44-item scale, comprised of three factors subsequently labelled as Responsibility/Threat Estimation, Perfectionism/Certainty and Importance/Control of Thoughts. Examples of items from the three respective subscales are 'I often think things around me are unsafe', 'even minor mistakes mean a job is not complete' and 'for me, having bad urges is as bad as actually carrying them out'. Items are scored on a 7-point Likert-type rating scale from 'disagree very much (1) to agree very much (7).

Initial findings for the OBQ-44 show that Internal consistency is high in an OCD sample with Cronbach alpha coefficients of .93 for Responsibility/Threat Estimation, .93 for Perfectionism/Certainty, .89 for Importance/Control of Thoughts and .95 for the total score. The subscales of the OBQ-44 show good convergent validity with the subscales of the PI (Washington State University revision, Burns, Keeortge, Formea &

Sternberger, 1996) (OCCWG, ibid). A recent study (Wood, Tolin & Abramowitz, 2004) supports the three factor structure of the OBQ-44.

7:5:3 Obsessive-Compulsive Inventory-Revised (OCI-R, Foa, Huppert, Leiberg, Langner, Kichic, Hajcak & Salkovskis, 2002).

The OCI-R (see appendix 8) is an eighteen-item measure of obsessional beliefs and behaviours that has demonstrated its usefulness in differentiating between obsessional patients as distinct from patients with other anxiety disorders or non-anxious controls (Foa et al., 2002). Responses to the items on the OCI-R are scored on a five point Likert-type scale, signalling level of agreement, and range from 0 (not at all) to 4 (extremely).

A principal components analysis yielded a six-factor structure of Washing, Obsessing, Hoarding, Ordering, Checking and Neutralising (Foa et al., 2002). An example from each of these subscales consecutively is as follows: 'I sometimes have to wash or clean myself simply because I feel contaminated'; 'I find it difficult to control my own thoughts'; 'I collect things I don't need'; 'I need things to be arranged in a particular order'; 'I repeatedly check gas and water taps and light switches after turning them off'; 'I feel compelled to count while I am doing things'.

With obsessional subjects the OCI-R has been shown to demonstrate good internal consistency with a coefficient value of .81 for the total score and coefficients ranging in value from .82 to .90 for the six subscales. Similarly, excellent test-retest reliability has been found for the total and subscale scores of the OCI-R with spearman's coefficient values ranging from .74 to .91 (Foa et al., 2002).

The OCI-R also shows good convergent validity with the original 42-item OCI (Foa, Kozak, Salkovskis, Coles & Amir, 1998), with a coefficient for total scores of .98, and moderate to high correlations with other measures of obsessional symptoms ranging from .53 with the Yale-Brown Obsessive-Compulsive Scale (Goodman et al., 1989) to .85 with the MOCI (Foa et al., 2002).

7:5:4 Lucky Beliefs Questionnaire (Frost et al., 1993)

The Lucky Beliefs Questionnaire (LBQ) is a 30-item scale scored on a five point Likert scale that measures superstitious beliefs such as 'fortune tellers can predict the future' and 'picking up a penny brings good luck'. Items were generated from an earlier measure of superstition (see below) developed by Leonard, Goldberger, Rapport, Cheslow and Swedo (1990) and from the Encyclopedia of Superstitions (Radford & Radford, 1969). The LBQ has strong internal consistency ($\alpha = .95$) (Frost et al, 1993). A copy of the LBQ can be found in appendix 9.

The companion Lucky Behaviours Questionnaire (LbehQ) (Frost et al, 1993) was not used in this study as Frost (ibid) suggested that the high intercorrelation between the LBQ and the LbehQ and an identical pattern of correlations with obsessive-compulsive symptoms indicated a lack of differentiation.

7:5:5 Superstition Questionnaire

(Leonard, Goldberger, Rapoport, Cheslow, Swedo, 1990).

The Superstition Questionnaire (SQ) was originally developed by Leonard et al (1990) and was modified by Zebb and Moore (2003), which is the version used in this study. They changed the original items from questions to statements so that for example 'Do you believe that the number 13 is unlucky?' becomes 'I believe that the number 13 is unlucky'. This change facilitated the use of a six point scale from Strongly disagree (0) to Strongly agree (5).

The modified questionnaire has eighteen statements that reflect common superstitions such as 'I believe that finding a four leaf clover brings good luck' or 'I believe that fortune tellers can predict the future'. Although there are no formal validity or reliability data available, the original use of the questionnaire by Leonard et al (1990) yielded an inter-rater reliability correlation of .94.

Both the LBQ and the SQ were used in this study as although they have items common to both scales they also differ in some of their content. The LBQ has some additional items not covered in the SQ such as 'the seventh child in a family is unlucky' whilst the SQ incorporates behaviours as well as beliefs on some of the items such as 'I believe walking under ladders will bring bad luck' and 'I avoid walking

under ladders'. A copy of the SQ can be found in appendix 10.

7:5:6 Multi-dimensional Locus of Control questionnaire (Levenson, 1972).

This locus of control (LOC) scale (see appendix 11) was derived from Rotter's (1966) original conceptualisation of the internal-external control construct where a person believes events are either contingent upon one's own agency or are attributable to forces external to the self that is, powerful others, fate or chance. Levenson developed the LOC scale to take account of a proposed differentiation between belief in powerful others and the random forces of fate and chance, both having been subsumed into one factor in Rotter's original external construct. Levenson constructed three subscales scored on a 6-point Likert scale from strongly disagree (-3) to strongly agree (+3): belief in personal control (Internal scale), belief in chance (Chance scale) and belief in powerful others (Powerful Others Scale). Examples of respective items from these scales are 'whether or not I get to be a leader depends mostly on my ability', 'to a great extent my life is controlled by accidental happenings' and 'getting what I want requires pleasing those people above me'.

Internal consistency is relatively high. Levenson (1974) found Kuder-Richardson reliabilities of .64 (internal scale), .78 (chance scale) and .77 (powerful others scale). Test-retest reliability ranges between .6 and .79 (Levenson, 1973) over one week and between .62 and .73 over a 7 week interval (Lee, 1976). Factor analyses evidenced the three distinct dimensions of personal, powerful others and chance control (Levenson, 1974).

7:5:7 State-Trait Anxiety Inventory – Form Y (STAI-Y) (Spielberger, 1983)

The STAI-Y measures state and trait anxiety separately on two 20-item self-report scales. Only the trait anxiety scale was used in this study (see appendix 12). Trait anxiety refers to the enduring characteristics of a person's anxiety-proneness and how threatening they perceive stressful situations to be (Spielberger, 1983). The scale asks how subjects generally feel and responses are rated on a four point scale from 1 (not at all) to 4 (very much so). The reader is referred to Spielberger, Sydeman, Owen and Marsh (1999) for a more detailed discussion of the theoretical and conceptual background of Trait anxiety.

Eleven of the trait anxiety scale's items are worded such that a higher score indicates greater anxiety and nine items are worded in the opposite direction so that a high score indicates low anxiety. These latter items are reverse scored when calculating the total score. Examples of such items are 'some unimportant thought runs through my mind and bothers me' and 'I am calm, cool and collected'.

Test-retest coefficients for the trait anxiety scale are reported from .73 to .86 (Spielberger, Sydeman, Owen, Marsh, 1999). Spielberger et al (1999) report high internal consistency of the scale with independent samples of military recruits, adults and students achieving a median coefficient of .90 (Cronbach's alpha). They also found good concurrent validity with correlations ranging from .73 to .85 between the trait anxiety scale and other measures of trait anxiety.

Higher mean scores for neuropsychiatric patients and lower scores for personality disordered patients on the anxiety scale provide evidence of construct and discriminant validity (Spielberger, 1983).

7:5:8 Beck Depression Inventory – II (BDI-II, Beck, Steer & Brown, 1996)

The BDI-II is a self-report measure of depressive symptoms in adolescents and adults that was specifically designed to reflect DSM-IV criteria for diagnosis of the depressive disorders (Beck, Steer, Ball & Ranieri, 1996). The BDI-II is a widely used established and reliable tool for use in clinical and normal populations. One-week test-retest reliability has been found as high as .93 in depressed outpatients (Beck et al., 1996). Beck et al, (ibid) report convergent validity with the Hamilton Psychiatric Rating Scale (Riskind, Beck, Brown & Steer, 1987) as r =.71, n=87, and discriminant validity with the Hamilton Rating Scale for Anxiety (Riskind et al., 1987) as r =.47, n = 87,(Beck et al, 1996).

The BDI-II has 21 items that reflect the cognitive, affective and psychomotor aspects of depression. Each item has four statements about one of those components that reflect differing degrees of severity. For example, item three is labelled Past Failure and has four possible responses: 'I do not feel like a failure' (0); 'I have failed more than I should have' (1); 'As I look back I see a lot of failures' (2); 'I feel I am a total failure as a person' (3). The total score on the BDI-II ranges between 0 and 63.

A score of less than 10 on the BDI-II is classified as not depressed, whilst a score between 10 and 19 signals mild depression. Scores between 20-25 indicate moderate depression and a score of 26 or over indicates severe depression. A copy of the BDI-II can be found in appendix 13.

8:0 Results

Before testing the specific and exploratory hypotheses for the study, descriptive statistics for the whole sample data and for men and women separately are presented in section 8:1. The extent to which the sample is representative of the obsessional population is determined through a comparison with non-clinical sample data as there is unfortunately an absence of established clinical cut-off scores on the obsessional measures for a diagnosis of OCD (except for the OCI-R, see section 8:1 below). A preliminary exploration of the differences in men and women's scores on measures of superstition, LOC, anxiety and depression is effected through the application of ANOVA's to the data.

Throughout sections 8:2 to 8:5 each hypothesis is examined in the order presented in the introduction. Initially, in order to examine the validity of the data, scatterplots are conducted between the pairs of variables specified in the hypotheses for the study: superstition with trait anxiety; superstition with LOC and LOC with trait anxiety. Following Zebb and Moore (2003) a series of correlations and partial correlations are then applied to the data in order to facilitate comparison with their findings in regard to the relationship between superstition and anxiety, and also to examine the further hypotheses specific to this study together with any gender differences that may exist.

8:1 Descriptive statistics

8:1:2 Testing data for normality

Before conducting the analysis, data were screened to check for normality. Taking the data as a whole, scores on measures of superstition, LOC, anxiety and depression were all normally distributed. Of the obsessional measures the Contamination and Control

over Motor Behaviours subscales of the PI together with the Washing, Obsessing, Hoarding and Neutralising subscales of the OCI-R were not normally distributed, as measured by the Kolmogorov-Smirnov test (K-S). However, when the sample was split into male and female groups only the Urges and Worries of Losing Control Over Motor Behaviours (UWLMC) subscale of the PI was positively skewed for males whilst for females only the four subscales of the OCI-R (washing, obsessing, hoarding and neutralising) were skewed. However, it was not attempted to statistically transform these skewed sub-scales scores as they were required only for descriptive purposes in determining whether levels of obsessionality in this sample were higher than that of non-clinical samples.

8:1:3 Descriptive statistics for obsessional measures

Table 1a shows descriptive statistics for obsessional measures for the whole sample and for males and females separately. The sample as a whole evidenced higher mean scores on obsessional measures than those obtained from non-clinical populations with the exception of the hoarding subscale of the OCI-R. This is consistent with Foa et al (2002) who found that the hoarding subscale did not differentiate OCD subjects from non-anxious controls. However, the OCI-R is one of the few measures that provides cut-off scores for a diagnosis of OCD. Foa et al (2002) recommend a total score of 21 or above on the OCI-R as an indication of the presence of OCD and an optimal cut-off score of 4 on the obsessing subscale (sensitivity: 74.4%; specificity: 76.1%). Results in table 1 overleaf show that scores were in excess of those recommended by Foa et al (ibid) and therefore suggest that the sample was representative of an OCD population.

Table 1a. Descriptive statistics for obsessional measures

Measure	Total sample		Males		Females		Scores from non-clinical samples*	
Obsessive-compulsive Measures	**Mean**	**s.d**	**Mean**	**s.d**	**Mean**	**s.d**	**Mean**	**s.d**
PI								
Impaired control of mental activity.	31.35	14.71	27.49	12.28	33.72	15.66	13.35	9.51
Becoming contaminated.	14.87	13.73	14.66	14.78	15.00	13.17	8.26	5.66
Checking behaviours.	13.75	8.78	13.00	8.03	14.21	9.24	6.59	5.61
Urges and worries of losing control over motor behaviours.	5.03	4.80	5.26	5.50	4.89	4.36	3.00	3.76
Total PI score	**82.02**	**37.64**	**77.29**	**32.24**	**84.93**	**37.92**	**41.33**	**25.77**
OBQ-44								
Responsibility/ threat estimation.	73.55	24.26	65.41	22.26	78.40	24.29	34.2	13.00
Perfectionism/certainty.	79.33	21.80	72.74	22.95	83.26	20.28	41.4	18.10
Importance/ control of thoughts.	47.91	20.75	41.38	19.52	51.81	20.64	20.5	9.30
Total OBQ-44 score	**200.91**	**56.52**	**179.91**	**52.74**	**213.44**	**55.38**	**96.0**	**35.1**
OCI-R								
Washing.	4.23	4.41	3.86	4.07	4.46	4.63	2.41	2.50
Obsessing.	7.82	3.69	7.06	3.46	8.28	3.79	2.86	2.72
Hoarding.	4.11	4.04	3.63	2.76	4.40	4.65	4.41	2.67
Ordering.	6.10	4.24	5.83	4.15	6.26	4.33	4.40	3.03
Checking.	5.85	4.04	5.83	3.73	5.86	4.25	2.91	2.56
Neutralising.	4.37	4.10	4.60	4.22	4.23	4.06	1.82	2.20
Total OCI-R score	**32.37**	**15.23**	**30.83**	**13.55**	**33.32**	**16.23**	**18.82**	**11.10**

*** source of non-clinical sample scores:**
OBQ-44: Obsessive Compulsive Cognitions Working Group (in Press) n= 86
PI: Sternberger & Burns (1990) n= 678
OCI-R: Foa et al (2002) n=477

8:1:4 Descriptive statistics for superstition, anxiety, LOC and depression

Table 1b shows the mean scores and standard deviations for the total sample and for men and women separately on measures of superstition, LOC, Trait Anxiety and depression. Results indicate that the participants were suffering from depression, with the mean score for men being in the Mildly Depressed range and for women in the Severely Depressed range.

In order to test for gender differences a series of ANOVAs were applied to these measures. Levene's test of equality of error variance was non-significant for each of the ANOVA's. F values and probability levels are also given in table 1b. Results show that women had significantly higher mean scores than men on the SQ, LBQ and the BDI-II.

Table 1b. Descriptive statistics for measures of superstition, LOC, trait anxiety and depression

Superstitiousness measures	Total Sample	males	females	F	Probability
	Mean s.d.	Mean s.d	Mean s.d		
LBQ	66.48 *(24.71)*	58.97 *(22.95)*	71.09 *(24.82)*	5.47	.022*
SQ	32.36 *(22.02)*	26.06 *(21.30)*	36.23 *(21.74)*	4.82	.031*
LOC					
Internality.	7.67 *(6.57)*	6.73 *(6.64)*	8.24 *(6.53)*	1.087	.300
Powerful others.	-.15 *(10.76)*	1.94 *(10.40)*	-1.43 *(10.87)*	2.028	.158
Chance.	-.97 *(9.30)*	-.61 *(9.73)*	-1.19 *(9.12)*	.078	.780
Trait Anxiety	59.18 *(11.22)*	56.37 *(9.72)*	60.91 *(11.80)*	3.65	.059
BDI-1	23.54 *(14.48)*	19.32 *(13.20)*	26.05 *(14.74)*	4.79	.031*

*$P< 0.05$

Total possible scores on questionnaires: LBQ: 150; SQ: 90; LOC: plus or minus 24 for each scale; Trait anxiety: 80; BDI-II: 63.

8:2 Bi-variate correlational analysis – total sample

8:2:1 Preliminary scatterplots of superstition, Trait anxiety and LOC

Each of the pairs of variables specified in the hypotheses (p. 22) were entered into scatterplots in order to check for any outlying scores that could effect the overall trend of the data. Because there were two measures of superstition and two external LOC constructs (chance and powerful others) these are shown as overlay scatterplots with anxiety and with each other. The scatterplots are shown in figures 1-4 and indicate that there are no obvious outliers in the data. Owing to listwise deletion for missing LOC data the sample size is reduced to 87 in the correlational analysis.

Figure 1. Overlay scatterplot of trait anxiety total scores with total scores on the SQ and LBQ for the total sample. n= 92

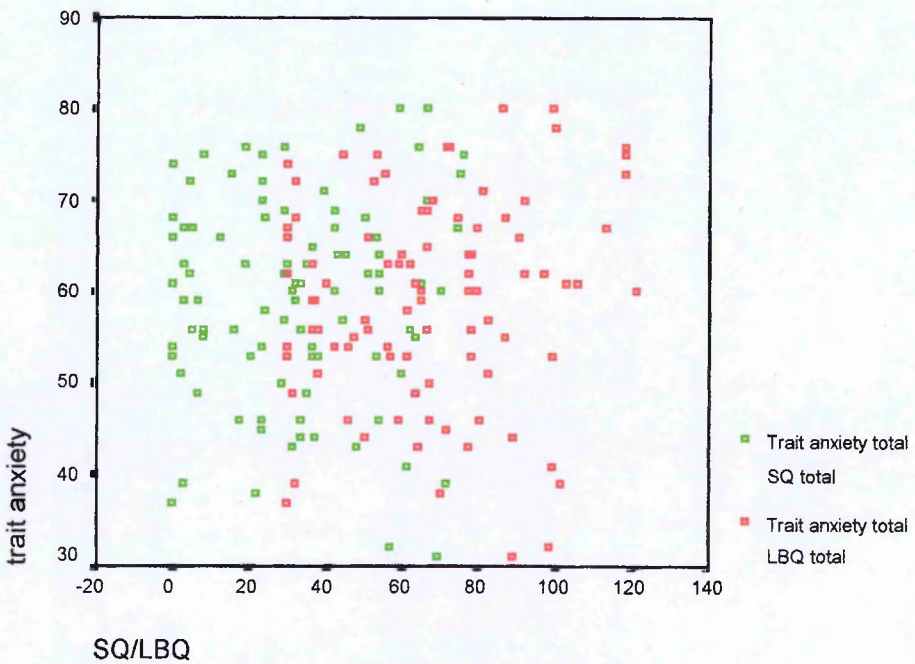


Figure 2. Overlay scatterplot of SQ total scores with LOC Chance/ powerful others total scores for total sample. N=87

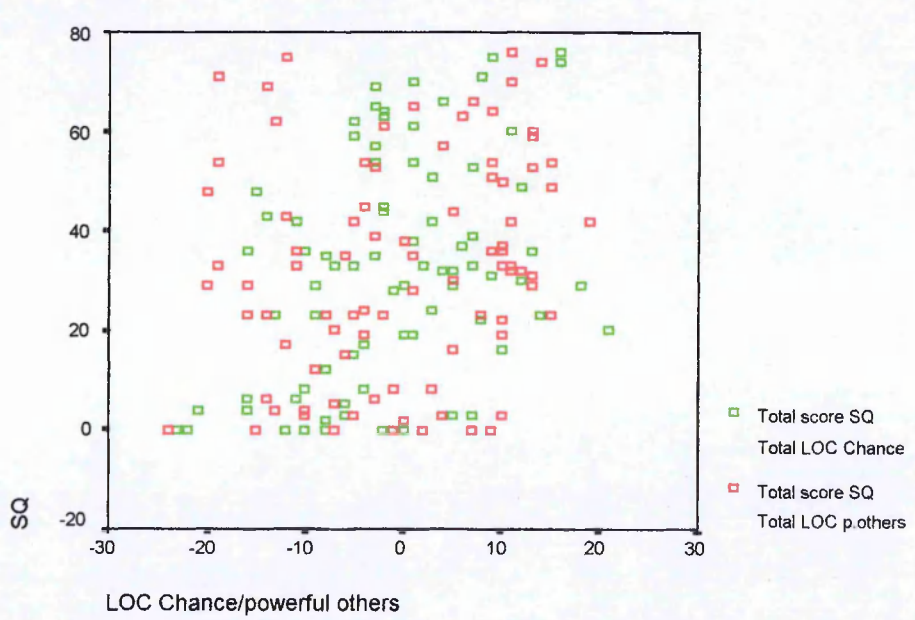


Figure 3. Overlay scatterplot of LBQ total scores with LOC Chance/powerful others total scores for total sample. N= 87

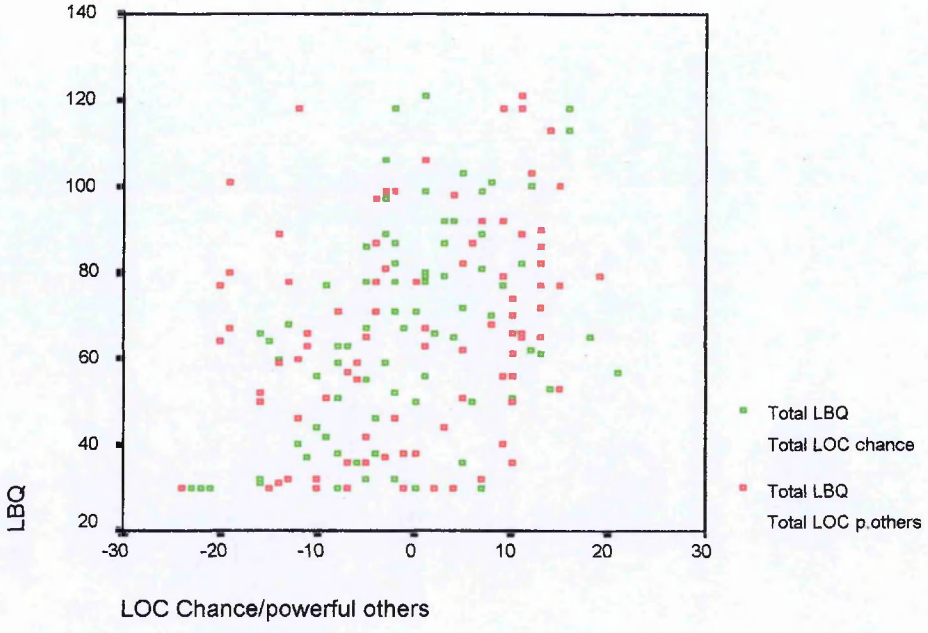
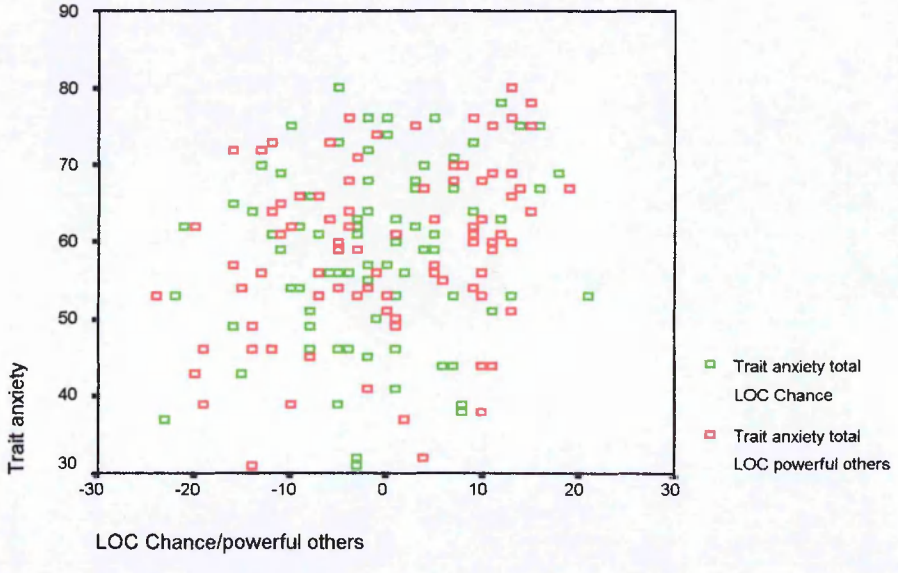


Figure 4. Overlay scatterplot of trait anxiety total scores with LOC Chance/powerful others total scores for total sample. N = 87.



Bi-variate correlations between measures of superstition, Trait anxiety and LOC were carried out on the *total sample* data as shown in table 2a. In addition and in order to justify the inclusion of data from individuals without a formal diagnosis of OCD a separate analysis was carried out which excluded responses from non-diagnosed individuals (table 2b). A comparison of the results show that significant correlations attained between variables for diagnosed individuals are retained when the analysis includes the whole sample data with the exception of the correlations between the BDI-II/LBQ, Powerful Others/superstiousness and Trait anxiety/Chance. However, reductions in the strength of these relationships are so slight as to be negligible. These results indicate that associations between variables are not significantly altered when data from non-diagnosed individuals are included and justify the following analysis of results using data from the whole sample. This topic is addressed further in the discussion.

Table 2a. Bi-variate correlations between superstition, LOC, anxiety and depression for the total sample, n=87

Measure	S/S	LBQ	Trait anx.	LOC		
SUPERSTITION				*Int*	*P.other*	*Chance*
Superstitiousness		.906**	.026	-.022	.207	.410**
LBQ	.906**		.093	.095	.290*	.478**
LOC						
Internality	-.022	.095	-.016		.029	.025
Powerful others	.207	.290*	.316**	.029		.501**
Chance	.410**	.478**	.159	-.025	.501**	
Trait anxiety	.026	.093		-.016	.316**	.159
BDI-II	.134	.223	.811**	.055	.280**	.219*

** Correlation is significant at the .01 level (2-tailed)
*Correlation is significant at the .05 level (2-tailed).

Table 2b **Bi-variate correlations between superstition, LOC, anxiety and depression *for participants who have been formally diagnosed with OCD, n= 73***

Measure	S/S	LBQ	Trait anx.	LOC		
				Int.	*P.other*	*Chance*
SUPERSTITION						
Superstitiousness	-	.901**	.113	-.043	.259*	.488**
LBQ	.901**	-	.220	.076	.296*	.539**
LOC						
Internality	-.043	.076	-.014	-	-.027	.003
Powerful Others	.259*	.296*	.329**	-.027	-	.559**
Chance	.488**	.539**	.251*	.003	.559**	-
Trait Anxiety	.113	.220	-	-.014	.329**	.251*
BDI-II	.152	.269*	.803**	.040	.301*	.264*

** Correlation is significant at the .01 level (2-tailed)
*Correlation is significant at the .05 level (2-tailed).

8:2:2 The relationship between superstition and Trait anxiety – hypothesis 1.

Table 2a shows the results for bi-variate correlations carried out on the *total sample* data between measures of superstition, Trait anxiety, LOC and depression. Results show that contrary to the hypothesis for this study there was no association between measures of superstition and trait anxiety for the total sample data.

8:2:3 The relationship between superstition and an external LOC (Chance and Powerful Others) - hypothesis 2.

Table 2 shows there were particularly significant positive correlations between both measures of superstition, (the SQ and the LBQ) with LOC Chance (Pearson's r = .410 and .478 respectively, $p < .01$). There was also a significant positive correlation between the LBQ and LOC Powerful Others (r = .290 $p < .01$).

As might be expected results show a significant positive correlation between LOC Powerful Others and LOC Chance (Pearson's r = .501, $p < .01$).

8:2:4 The relationship between an external LOC (Chance and Powerful Others) and Trait anxiety – hypothesis 3.

Contrary to the proposed exploratory hypothesis there was a significant positive correlation between LOC Powerful Others and Trait anxiety (r = .316, $p < .01$). There was no association at all between LOC Chance and Trait anxiety.

8:2:5 Effects of depression

Table 2 shows a significant positive correlation between Depression and Trait anxiety, indicating a very strong relationship (r = .811 $p < .01$), and accounting for 65.8% of the variance in these two variables. The effects of depression on the relationships of the other variables is addressed further in section 8:4.

8:3 Further analyses

8:3:1 Bi-variate correlations by gender

Consistent with previous research (Wolfradt, 1997; Sica et al., 2002; Zebb & Moore, 2003) the preliminary analysis reported in section 8:1 indicated that women had significantly higher levels of superstitious belief than men. Consequently, bi-variate correlations between the LBQ, SQ, LOC and Trait anxiety were calculated separately by gender (see table 3).

8:3:2 Superstition and Trait anxiety – hypothesis 1

As expected from the total sample correlations, results in table 3 indicate there was no relationship between both the LBQ and the SQ with trait anxiety for men or women.

8:3:3 Superstition and an external LOC (Chance and Powerful Others) – hypothesis 2

The gender analysis showed that the relationship between superstition (LBQ) and LOC chance is even stronger for the split sample with a coefficient of .508 ($p= .01$) for females and .494 for males ($p=.01$). Scores on the LBQ and LOC Powerful Others were more significantly correlated for men (.452 $p< .01$) than they were for women (.284 $p<.05$).

Table 3. Bi-variate correlations between measures of superstition, LOC, Trait anxiety and depression by gender.

Measure	S/S		LBQ		Trait anx.		BDI-II	
	m	*f*	*m*	*f*	*m*	*f*	*m*	*f*
SUPERSTITION								
SQ	-	-	.924**	.891**	.066	-.058	.307	-.012
LBQ	.924**	.891**			.008	.081	.288	.148
LOC								
Internality	.095	-.137	.179	.005	-.314	.107	-.106	.110
Powerful others	.354*	.190	.452**	.284*	.285	.382**	.274	.345*
Chance	.473**	.399**	.494**	.508**	.149	.177	.235	.228
Trait anxiety	.066	-.058	.008	.081			.679**	.849**
BDI-II	.307	-.012	.288	.148	.679**	.849**		

** Correlation is significant at the .01 level (2-tailed) *m= male; f= female*
Correlation is significant at the .05 level (2-tailed).

8:3:4 External LOC (Chance and Powerful Others) and Trait anxiety – hypothesis 3

As expected from the total sample correlations, there was no correlation between LOC Chance and Trait anxiety in the gender analysis. However, the gender analysis strengthened the significant positive correlation between LOC Powerful Others and Trait anxiety in that it increased from .316 for the total sample to .382 for women (Pearson's r = .382 *p< .01).* There was no significant correlation between LOC Powerful Others and Trait anxiety for men.

8:3:5 Depression

The highly significant positive correlation between depression and Trait anxiety obtained for the total sample was changed by the gender analysis with the significant correlation slightly reduced for males(r=.679 *p= .01*) and slightly increased for females (r=.849, *p=.01*). Similarly, the strength of the significant positive correlation between depression and LOC Powerful Others that had been found in the total sample showed increased for women (r= .345 *p= .05)* and decreased for men (r = .274).

8:4 Partial Correlations by gender

Controlling for depression

The results of the partial correlations shown in table 3 on page 259 suggest a relationship between superstitiousness and LOC Chance, superstitiousness and LOC Powerful Others, LOC Powerful Others and Trait anxiety (for women only), depression and Trait anxiety and lastly depression and LOC Powerful Others. The results also suggest that there is no relationship of any substance between superstitiousness and anxiety.

It was clear from the size of the correlation between depression and Trait anxiety that they accounted for a large amount of the variance in each other. In addition it indicated that the impact of depression on Trait anxiety may have obscured the relationship that Trait anxiety had with superstition and LOC. To help clarify these relationships and the contribution of unique variance accounted for by each of these variables, a series of partial correlations, controlling for depression, were carried out on the data (see table 4). Partial correlations control for the effects of a third variable on both of the other two variables that are put into the analysis (Field, 2000).

Table 4. Partial correlations between trait anxiety, measures of superstition and locus of control with the effects of depression controlled for.

note: probability levels are given in parentheses

	Trait Anx.		SQ		LBQ		LOCchance	
	m	*f*	*m*	*f*	*m*	*f*	*m*	*f*
Trait Anx.	-------		-.209 *(.244)*	-.090 *(.509)*	-.275 *(.118)*	-.086 *(.530)*	-.021 *(.910)*	-.031 *(.824)*
SQ	-.209 *(.244)*	-.090 *(.509)*	--------		.914** *(.000)*	.902** *(.000)*	.435** *(.013)*	.412** *(.002)*
LBQ	-.277 *(.118)*	-.086 *(.530)*	.914** *(.000)*	.902** *(.000)*	--------		.463** *(.008)*	.492** *(.000)*
LOCchance	-.021 *(.910)*	-.031 *(.824)*	.435** *(.013)*	.412** *(.002)*	.463** *(.008)*	.493** *(.000)*	-------	
LOCp.others	.136 *(.457)*	.179 *(.199)*	.299 *(.097)*	.207 *(.136)*	.413** *(.019)*	.250 *(.070)*	.707** *(.000)*	.314* *(.022)*

* $p < .05$ (2-tailed) ** $p < .01$(2-tailed) *m=male f=female*

8:4:1 Superstition and Trait anxiety – controlling for depression

Results in table 5 show that with depression controlled for the coefficient values for partial correlations between Trait anxiety and the SQ and LBQ all became negative (but did not reach significance) for both males and females.

8:4:2 Superstition and LOC Chance and Powerful Others- contolling for depression

The LBQ had shown highly significant correlations with LOC Chance and LOC Powerful Others for both men and women in the bi-variate analysis, as did the SQ (except for SQ/LOC Powerful others for women). The partial correlations retained significance for the LBQ on both LOC Chance and LOC Powerful Others for men but only on LOC chance for women. The SQ retained its significant correlation with LOC Chance for both men and women but not for Powerful Others.

8:4:3 External LOC (Powerful Others) and Trait anxiety- controlling for depression

The one significant relationship that Trait anxiety evidenced in the bivariate correlations (other than with depression) was with LOC powerful others in females. With the effects of depression controlled for on both these variables the correlation lost significance and fell from .382 to .179, the unique variance in Trait anxiety explained by Powerful Others (and vice versa) being reduced from 14.6% to 3.2%.

8:4:4 External LOC (Chance) and Trait anxiety – controlling for depression

In the bi-variate and gender analyses there had been no association between LOC Chance and Trait anxiety. Similarly, results in table 4 show that there was no association between LOC Chance and Trait anxiety after controlling for the effects of depression.

8:5 Summary of results

Participants in the study had higher mean scores on measures of obsessions than those obtained from non-clinical populations. This suggests participants were representative of an obsessional population. The sample as a whole had a mean score on the BDI-II of 23 suggesting they were moderately depressed. Women had significantly higher

mean scores than men on the BDI-II. Results also show that women had significantly higher mean scores than men on measures of superstition.

Results did not support the first hypothesis of the study that superstition and Trait anxiety would be negatively correlated. Nevertheless, in the final analysis when controlling for depression, all of the correlation coefficients for these two variables had negative values although none reached significance.

However, results did support the second hypothesis. Initially, there was a significant positive correlation between superstition and an external LOC (chance and powerful others). The gender analysis showed that the association between superstition and LOC Chance was stronger for women than men, whereas the association between superstition and LOC Powerful Others was stronger for men than it was for women. After controlling for depression the LBQ retained its significant positive correlation with LOC Chance and LOC Powerful Others for men, but only with LOC Chance for women. The SQ also retained a significant positive correlation with LOC Chance but not with Powerful Others (for both men and women).

An additional exploratory hypothesis of the study was that an external LOC would be negatively associated with Trait anxiety but this was not supported by the initial total sample analysis that showed a strong significant positive correlation between LOC Powerful Others and Trait anxiety. The gender analysis confirmed this relationship for women but lost significance for men. However, removing the effects of depression from the analysis revealed that Trait anxiety and an external LOC (chance and powerful others) were not associated at all, either in men or women.

9:0 Discussion

In an extension of previous research, the aim of this study was to investigate the relatedness of superstition and trait anxiety and the relatedness of superstition and an external LOC in men and women with OCD. A third, exploratory, aim of the research was to assess the degree to which an external LOC may be associated with trait anxiety in an obsessional population. An over-arching aim of the study was to explore

the findings in terms of any gender differences that presented.

The discussion will begin in section 9:1 with a brief overview of findings with regard to levels of superstition, obsessionality and depression in the participants. In sections 9:2 to 9:5 a review and interpretation of the main findings for each of the specific hypotheses for the study are given together with a consideration of the relationship between anxiety and superstition in clinical and non-clinical populations. The possible effects on the findings of particular sub-types of OCD symptomatology are discussed in section 9:6. A critique of the study is offered in section 9:7 together with a discussion of cultural issues and a consideration of ethical difficulties pertinent to conducting research with a potentially vulnerable population. Suggestions for future research are given in section 9:7:4. Finally, clinical implications of the main findings of the study are discussed in section 9:8 before giving a concluding summary in section 9:9.

9:1 Participant levels of obsessionality, depression and superstitiousness

Results show that participants demonstrated higher levels of obsessionality than that of non-clinical populations suggesting that they were representative of an obsessional population. In addition, participants were suffering from depression, with women being significantly more depressed than men. This is consistent with studies that have found depression to be co-morbid with OCD (Salkovskis et al., 2000; Millet et al., 2004).

Level of superstitious belief was not particularly high for the sample but above that obtained in a recent study using the LBQ with an obsessional population (Einstein, & Menzies, 2004). Women had significantly higher levels of superstitious beliefs than men and this is consistent with those studies that have researched levels of superstitious beliefs in non-clinical populations and report a gender bias in favour of women (Wolfradt, 1997; Sica, Novara & Sanavio, 2002 ;Zebb & Moore, 2003).

9:2 Hypothesis 1

> *"Building on previous theory and research (Keinan, 2002; Freud, 1913/1966; Rachman & Hodgson, 1980; Zebb & Moore, 2003) superstition may function in OCD as a global way of coping with uncertainty and reducing anxiety such that there will be an inverse association between superstitious beliefs and trait anxiety"*

The first hypothesis was not supported. There was no negative association between superstition and trait anxiety. Although the final analysis (controlling for the effects of depression) showed there was a tendency towards a negative relationship between superstitious beliefs and trait anxiety, for both men and women, this relationship was not significant. Nevertheless, men did show a stronger inverse non-significant relationship between superstitious beliefs and trait anxiety, with correlation values over twice that of the values for women. Of course, an alternative interpretation could be that another factor, related to both but not measured here, could be mediating the effect.

One interpretation of the differences found between males and females in the relationship of anxiety and superstitiousness is that superstitious beliefs in men may function as a more salient and utilitarian force because they are more unusual in men. Thus, superstition may function to mediate anxiety in men with OCD but not in women with OCD. Vyse (1997) points out that although studies have been consistent in finding higher levels of superstitiousness in females, the men that are superstitious in the non-clinical population very often reflect the institutionalised beliefs that develop in response to culturally desired aims, such as winning a race or a football match. It may be that superstition in men and women is differentially perceived and experienced. In addition, the invoking of superstitious beliefs as a possible coping mechanism for anxiety may also be less efficacious in women if they feel less in control of circumstances. As Sica et al (2002) suggest, higher levels of superstitious belief may perpetuate an over-estimation of threat and lack of control. Future research into superstition in men and women in both clinical and non-clinical populations could include an analysis of the content of beliefs and their meaning and function.

Superstition and trait anxiety are discussed in more detail in section 9:5.

9:3 Hypothesis 2

> *"In an obsessional population, and in accordance with previous research (e.g. Tobacyk, Nagot & Miller, 1988; Zebb & Moore, 2003) there will be a positive relationship between superstition and an external LOC"*

Previous research has suggested that superstitious individuals are characterised as having an external locus of control (Peterson, 1978; Vyse, 1997) and this was confirmed by the current study. Scores on the LBQ for both men and women showed strong positive relationships with belief in powerful others and chance factors. This suggests that belief in superstitious ideals is more likely in individuals who believe that events are largely outside of, or beyond, their control. Even after depression was taken into account these relationships retained their significance except for females and powerful others. This may indicate that depression is much more efficacious in women than it is in men in altering beliefs about the self and may lead to an increase in superstitious strategies in order to compensate for perceived threat and lack of control. However, as discussed above, this strategy may be ineffective in reducing distress in OCD and may even paradoxically strengthen the person's belief that they have no control over their lives. Sica et al (2002) suggest that engaging in superstitious behaviours does in itself become a reinforcer of both a sense of threat and absence of personal control. These concerns may be even more significant for the women in the current study given that their higher levels of depression must signal increased isolation and reduced opportunity and motivation to break the cycle of emotional distress. Results suggest that for men, there are other factors influencing the positive relationship between superstition and a belief that one has little personal control over events. Levenson's (1972) suggestion that men, more than women, may focus on the potential that powerful others have in mediating one's success or failure may be significant in interpreting these findings. Expectancies of control may also be mediated by other factors not measured here that have the potential to be differentially experienced by men and women with OCD, such as employment and education. A future study could include these demographic variables in order to assess their

covariance with expectancies of control.

Results for the other measure of superstition, the SQ (a less extensive questionnaire than the LBQ), were slightly different in that after controlling for depression it held onto its positive correlation with believing in Chance factors for both men and women but not to a belief in Powerful Others. Compared to belief in Powerful Others, belief in Chance factors was more strongly correlated with superstitious beliefs both for men and women. In contrast there was no relationship at all between superstition and an internal locus of control.

Using two measures of superstition in the study but treating them as one construct was problematic. These difficulties are discussed in more detail in the critique in section 9:6.

9:4 Hypothesis 3

> *"An additional exploratory hypothesis to the study was that if the hypothesised relationships above (1 & 2) had validity, then an external LOC by virtue of its association with superstitious beliefs would show a negative association with trait anxiety"*

Findings did not support the third, exploratory, hypothesis of this study. Results suggest that holding an externalised locus of control, in terms of belief in chance/fate factors and/or powerful others, is not associated in any systematic way with lower levels of trait anxiety. In part, this is consistent with the findings above that superstitious individuals tend to attribute outcomes in their lives to external causes but do not enjoy lower levels of anxiety.

However, it was interesting that before depression was controlled for there was actually a highly significant *positive* correlation between powerful others and trait anxiety in women. This relationship became non-significant once depression was taken into account. This result suggests that depression impacted substantially on the association between trait anxiety and a belief in powerful others in women but not for men. Without depression, there was no association at all between these two

constructs. This may indicate, at least in women, that depression acts to increase both anxiety and a belief that events are outside of one's own control. This is consistent with the findings in the study thus far that depression is a significant factor in the experience of perceived control for women. It may be that developmental factors are in the first instance driving those beliefs but they become more salient through being depressed, thereby leading to a sense of helplessness and increased anxiety.

9:5 Perceived threat and the function of superstition

This study has shown that trait anxiety is not inversely related to either superstitious beliefs or an externalised LOC. In retrospect it may have been too ambitious to expect such a relationship between superstition and trait anxiety in individuals already suffering from an extreme anxiety-related disorder. Given that superstition is widely accepted as a form of coping and control when all other means of control appear inadequate or beyond the perceived capability of the individual (Jahoda, 1969) it may be that superstitious beliefs only function to reduce the anxiety that is related to an *immediate* sense of perceived threat, but are not related to trait or general levels of anxiety, especially in women. To some extent this answers one of the questions raised by the study, that is, do superstition and trait or general anxiety function in clinical populations in the same way or differently as they do in non-clinical populations? Although this study suggests they do, there are some caveats. Zebb and Moore (2003) found no relationship in males between superstition and anxiety in their non-clinical population once perception of control had been controlled for and a reduced significant relationship for females. The results of the current study evidenced a similar position but only when depression, not an external LOC had been partialled out of the correlation. All relationships between superstition and anxiety became negative once depression was held constant. This could be a differential factor in terms of clinical and non-clinical populations in that depression may be much more central to the person's experience once an anxiety disorder such as OCD and all its implications have developed and taken hold. In contrast, Zebb & Moore found relatively low levels of depression in their non-clinical sample compared to the very high levels in the current study. It may be that depression and perception of control are equally likely to impact on superstition and anxiety. It may also be important to consider whether depression presents as a primary or secondary comorbid condition in an obsessional population with regard to both its impact on other aspects of the

disorder and treatment outcomes. Outcome studies have found that the presence of Major Depressive Disorder in OCD impedes progress on exposure and response treatment approaches (Abramowitz & Foa, 2000; Steketee, Chambless & Tran, 2001). Abramowitz (2004) recommends that both OCD and co-morbid depression should be addressed concurrently in any therapy programme.

In addition, if superstition per se is not related to trait anxiety in either a non-clinical or an OCD population, this may suggest that its relationship with obsessionality as a disorder is not exclusive either, even though they share common characteristics. This raises questions with regard to aetiology and whether superstition is more or less likely to predispose individuals to developing OCD. Whilst many writers presume an association between superstitiousness and OCD (e.g. Salzman, 1968; Amir et al., 2001), Zebb and Moore (2003) found that superstitiousness was just as related to agoraphobic and panic disorder symptoms in their non-clinical sample as it was to obsessional symptoms. Similarly, Sica et al (2002) suggest that superstition may predispose the individual to developing 'any form of psychological disorder that involves the generalized expectations of danger'.

9:6 Sub-types of OCD symptoms

It is possible that levels of particular OCD symptomatology among participants in the study could have impacted on the strength of the observed relationships between superstition, trait anxiety and LOC. For example, participants who held superstitious beliefs but may also have had higher levels of perfectionist tendencies could have experienced higher levels of trait anxiety. Many researchers have commented on the positive association between perfectionism and trait anxiety (Deffenbacher et al, 1986; Juster et al, 1996; Flett et al, 1989). The net effect of such characteristics in superstitious individuals could obscure a relationship between superstition and anxiety. Research suggests that although superstitious individuals tend towards rumination rather than active behaviours (Sica et al, 2002) some studies have found them to be characterised by perfectionism and responsibility (e.g. Frost et al, 1993). In order to add to the growing literature on the heterogeneity of beliefs and behaviours in OCD and the particular associations between sub-sets of symptoms a further study could assess the impact of perfectionism on anxiety in those individuals high and low in superstitious beliefs.

9:7 Critique

9:7:1 Methodological problems

Measures of superstitious beliefs and behaviours

One of the major difficulties for this study was in sourcing a questionnaire that would capture superstitious beliefs and ideals as experienced in a clinical, obsessional population. In the absence of any research that would definitively conclude that the content of superstitious beliefs was the same or different within clinical populations as compared to non-clinical populations, or indeed presented on a unified continuum that tips over into pathology only when increasing conviction in those beliefs begins to seriously impede the everyday existence of the individual, established measures of everyday superstitious beliefs were used. The author decided to use two measures that differed slightly in content in order to maximise the information gathered. However, this proved problematic at the analysis stage as they yielded slightly different associations with the other constructs, making interpretation less clear. In addition the SQ and the LBQ both reflect culturally familiar (to a western european population) superstitious beliefs but do not tap into any of the idiosyncratic beliefs that the individual may hold. Further, some of the items on the LBQ such as 'carrying silver dollars is good luck' are perhaps relevant only to a fairly circumscribed set of individuals and do not maximise the power of the questionnaire in revealing the extent of people's superstitious beliefs. As Zebb and Moore (2003) suggest the development of a valid and reliable questionnaire to measure superstitious beliefs is much needed.

In addition, there is some degree of confusion in the literature and indeed in the scales themselves about the classification of superstition and whether it is subsumed by or qualitatively distinct from magical ideation and/or paranormal beliefs making it difficult to systematically consider its relationship to other constructs. Some authors view them as one and the same construct whereas others say that distinctions may be made between superstition, magical thinking and fantastical thinking (Boyer, 1997; Johnson, 1997). Magical thinking is typically defined as 'belief in forms of causation that by conventional standards are invalid' (Eckblad & Chapman, 1983). However, this description can be equally applied to superstitiousness and indeed some of the items on the LBQ such as 'there is such a thing as the evil eye' seem to straddle the boundary between magical thinking and superstition. One approach to superstition is

that it may possibly be conceived of as a more benign form of magical ideation, at least in the sense that the consequences of belief and/or action are usually confined to the self, that is, the warding off of harm or threat is seen as a personal responsibility even though the potential effects of the belief and/or action may be widespread. Magical ideation on the other hand appears to represent a more global template for the way in which the world might be or is arranged. In western culture, magical ideation typically involves believing in astrology, telepathy, clairvoyance and the like (Chapman, Chapman & Miller, 1982) and appears to encapsulate a sense of 'not knowingness' on the part of the believer. Even more than superstition, magical ideation is defined by thought rather than action and is an indicator of schizotypy (Ecklad & Chapman, 1983). Taken to extremes, magical ideation has the capacity to escalate paranoid tendencies in the individual, in the form of, for example, developing beliefs about global conspiracies in public and corporate institutions. Likewise, superstitious beliefs in OCD can completely debilitate the individual and are often accompanied by behaviours and rituals that can consume the personal life of the individual both mentally and physically. These similarities and qualitative differences between superstition and magical ideation really do invite a thorough exposition in the literature so that some shared agreement about the degree to which they either reflect the same constructs or are theoretically distinct from each other can be reached. This should go some way towards developing questionnaires that operationalize and measure both superstition and magical ideation in a robust manner.

In addition, there may have been some highly superstitious individuals in this study who didn't actually hold many of the culturally recognisable beliefs that make up the questionnaires. Some of the questions on both the LBQ and SQ are open ended such as 'do you do anything special to ward off bad luck' but the other questions may be irrelevant to some individuals thereby reducing the potential of the questionnaire to accurately measure their level of superstitious belief. In a quantitative design these difficulties could be reduced by incorporating a qualitative aspect of measurement that could take account of idiosyncratic beliefs and behaviours. This particular problem was not formulated in enough detail prior to the study and although it may not have any significance as far as anxiety is concerned it precluded the gathering of valuable information about the obsessional population.

Defining and measuring anxiety

Trait anxiety is defined as the enduring characteristics of a person's anxiety-proneness (Spielberger, 1983) in that it remains fairly stable across different contexts. Conceptually, trait anxiety was thought to me more relevant to this study than state anxiety as both trait anxiety and superstitious ideals appear to be driven by developmental, rather than situational factors. However, in the light of the findings of this study, it may be that state/situational anxiety would be a better indicator of the function of superstitious beliefs as a strategy for coping with the distress associated with uncontrollable outcomes. Given the learning/conditioning context of a reduction in anxiety, it may be more likely to reduce *immediately after* superstitious beliefs and behaviours were invoked. Future research in this area could include measures of both state and trait anxiety.

9:7:2 Cultural considerations

Although the original advertisement for the study advised that potential participants should have English as their first language no further attempts were made to screen participants for cultural homogeneity given the time constraints of the study and the difficulties in sourcing a clinical population. However, from the email and letter contact the researcher had with participants it was clear that the sample was highly representative of the dominant White British culture. On the whole, levels of superstitious belief were not particularly high, perhaps for some of the reasons discussed above, but it should be considered that this may also represent cultural differences with regard to the meaning, acceptance and expression of superstitious beliefs. For example, Sternberger and Burns (1990) found a significantly lower mean score on the PI for a sample of American female college students (n=384) compared to Sanavio's (1988) sample of Italian females (n=146) in the 16-20 and 21-25 year old age range. Sternberger and Burns (1990) do not give details about whether participants' scores differed on superstitious items on the PI but it is possible that results reflect cultural variance in expressing superstitious beliefs. Where superstition has a cultural acceptance in its status as a coping strategy in responding to the unknowable or uncontrollable it may be more readily expressed by individuals in that culture and less pathologised (Sica et al., 2002).

9:7:3 Ethical considerations

Placing an advertisement for volunteers in a research study that is seeking to recruit a clinical population always has the potential to invite unrealistic expectations on the part of the participants as to what the study is setting out to investigate and what it can hope to achieve in the short-term. This issue was thought about prior to carrying out the research and made explicit to participants through the information sheet included in the questionnaire pack Briefly, this stated that the research was of an *investigative* nature and that no obvious benefit could be gained through taking part. However, in reality OCD is a debilitating condition which renders many individuals feeling isolated and vulnerable, especially those who have become so disabled that they are no longer employed and may be hyper-vigilant to any research activity that they feel will be sensitive and *interested* in their difficulties in the hope that at some point in the future they are going to experience relief from their symptoms. For the most part, volunteers were very enthusiastic and sometimes philosophical about taking part in the research but it was notable that some individuals who were so overwhelmingly distressed by their symptoms contacted the researcher several times asking for help. In every case they were strongly advised by the researcher to consult with their GP and to seek specialist help. Anyone undertaking research with potentially vulnerable individuals should be mindful of the way in which they may be perceived by respondents and to take account of the power differential which inevitably exists.

9:7:4 Future research

This study used a correlational design in order to be able to make clear comparisons with previous research but as a consequence can only comment and hypothesise about relationships between the various constructs that were measured and as such leaves many questions unanswered with regard to causal factors. A further study could take account of these methodological difficulties and seek to clarify the findings of the current study by using an experimental design to investigate differences in anxiety levels between superstitious and non-superstitious individuals with OCD, and also differences in anxiety between those people having an external LOC compared to those with an internal LOC. However, the conflict between choosing an experimental or correlational design is really an indication of just how complex and broad a topic superstition is. On the one hand and in pursuit of a notional 'truth', is it best to seek a thorough delineation of any unique and 'pure' relationships that may or may not exist

around superstition, or is it better to consider superstition and its effects as the result of a dynamic interaction of multiple factors? As discussed above, these philosophical difficulties are to some extent reflected in the literature in that superstition is clearly not understood or researched as either a distinct category or as a manifestation of some universal process which also takes in magical thinking and belief in the paranormal.

As mentioned in the introduction superstitious obsessional thoughts and behaviours have been linked to processes which are thought to underlie TAF. It was also argued briefly that superstitious beliefs may reflect the termination of logical attempts to deconstruct cause and effect early in development. In contrast ruminating at length on intrusive thoughts is a key feature of TAF that functions to increase anxiety. The use of covert or overt behaviours is reinforced due to a consequent reduction in anxiety. Both superstitious beliefs and TAF appear to have intrusive thought-rumination components about threat of harm but the latter appears to have more intermediary cognitions at least until one strategy or another is adopted to terminate the intrusive thought-rumination cycle. It seems apparent that TAF and superstition obviously share some universal underlying process and it would be interesting for further research to examine how beliefs in essentially the same magical processes (ie. both defy the laws of cause and effect) can, in some individuals, evidence a differential response. It may be that a differential response is linked to a myriad of complex developmental factors that drive an individual's locus of control but this still leaves many interesting questions unanswered about the nature of the beliefs themselves, that is, beliefs that essentially defy scientific laws.

9:8 Clinical implications

One of the findings of this and previous studies is that superstitious beliefs show a strong association with belief in an externalised LOC such that the individual comes to be defined by and experiences life through an acceptance of events being beyond their control. This helplessness may be one of the factors implicated in the apparent resistance to treatment for some individuals with OCD and one that is not usually considered in cognitive and behavioural treatments for the disorder. Treatment for obsessional beliefs and behaviours typically focuses on challenging the content of thoughts and encourages the individual to engage in their own hypothesis testing by

observing and noting the outcome of not engaging in thoughts/rituals designed to ward off harm or threat. Wells (1997) suggests that it is not clear how much the cognitive component adds to treatment success whereas other authors report that cognitive therapy for OCD is as beneficial as exposure and response prevention methods (Cottraux et al., 2001; Wilhelm, Steketee, Fama & Golan, 2003). Despite these inconsistencies in the literature, OCD is a heterogenous disorder in terms of clinical characteristics and comorbid symptoms and it seems sensible to favour an eclectic and pragmatic (in terms of the patient's history) approach to treatment. Indeed recent developments in the literature favour a pluralism in treating OCD which embraces psychoeducational, cognitive, behavioural and pharmacological approaches (Wilhelm, Tolin & Steketee, 2004). However, these same authors state that 'conspicuous by their absence are psychodynamic, humanistic and family systems treatments for OCD' and attribute this absence to a lack of research on their efficacy and a consensus among workers in the field that OCD is best treated through the approaches cited above. Unfortunately such models do not take account of the wider experience of the client. It may be beneficial to take a developmental approach towards an exploration of factors impacting on a patient's attributions in order to encapsulate and facilitate a broader understanding of their difficulties, especially in those cases resistant to change and in which frequent relapse has occurred. In support of a developmental perspective to treatment, superstitious beliefs have been found to be more prevalent in early onset OCD (Millet et al., 2004) and evidence suggests that early onset OCD is more resistant to successful treatment outcome (Campos, 2001). Future research could attempt to clarify if obsessions with superstitious content are more resistant than non-superstitious obsessions to successful treatment outcomes.

9:9 Summary and conclusion

Previous research by Zebb and Moore (2003) found that superstitious beliefs in a non-clinical population were not specifically related to levels of general (or trait) anxiety. The current study hypothesised that superstitious beliefs in a clinical population with OCD may be negatively associated with trait anxiety as they may have come to represent a global way of coping with threat and uncertainty such that threat was perceived as being generally less salient and present in the more superstitious individual's environment. However this hypothesis was not supported by the data generated by this study. Although superstitious beliefs and trait anxiety were inversely

related, this relationship was not significant. Nevertheless, this inverse relationship was stronger in men than in women. Results confirmed the findings of previous research in that women had significantly higher levels of superstitious beliefs than men. It was suggested that as superstition is less common in men it may be more salient and have more utility than it does for women. Women in the study were also significantly more depressed than men.

In line with previous research, a second hypothesis stated that belief in superstition would be strongly associated with an externalised LOC. Results confirmed this. There was a particularly strong relationship between superstitious beliefs and a belief in chance/fate factors for both men and women. Additionally, in men there was a strong positive association between superstitiousness and a belief that powerful others control events. Depression was considered to be associated with and a significant factor in control expectancies for women.

An additional and exploratory hypothesis to the study was that trait anxiety would be inversely related to an externalised LOC. However, results of the study did not support this hypothesis. There was no association between trait anxiety and an external LOC. However an additional finding was that depression was very strongly correlated with anxiety, (these two constructs evidenced the highest positive correlation of all the variables measured) and may have obscured the relationship between anxiety and an external LOC. In support of this, an initial positive relationship between anxiety and Powerful Others (externalised LOC) in women was reduced to a non-significant relationship once depression was controlled for, suggesting that depression was driving the initial association of these two constructs. Results suggest that depression was especially significant for women in their experience of distress and beliefs about personal control.

It was also considered that future research should take account of both developmental and situational constructs in defining and measuring anxiety as they may be differentially associated with superstitious beliefs and behaviours.

In conclusion, this study has shown that the area is under researched and as yet little understood but may yet yield interesting and useful therapeutic tools if extended and

modified appropriately.

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Appendix 1.

Ethics approval

Central and South Bristol Ethics Committee

University of Surrey Ethics Committee

Central & South Bristol Research Ethics Committee
UBHT Headquarters, Marlborough Street, Bristol BS1 3NU

Administrator: Mrs Naaz Nathoo
Tel: 0117 928 3613
Email: naaz.nathoo@ubht.swest.nhs.uk

14 September 2004

Mrs Vanessa Bryant
Trainee Clinical Psychologist
University of Surrey
Guildford
Surrey GU2 7XH

Dear Mrs Bryant,

Full title of study: The relatedness of superstitious beliefs to Locus of Control (LOC), gender and anxiety in individuals suffering from Obsessive Compulsive Disorder (OCD)
REC reference number: 04/Q2006/76
Protocol number:

Thank you for your letter of 02 September 2004, responding to the Committee's request for further information on the above research

The further information was considered at the meeting of the Sub-Committee of the REC held on 8 September 2004. A list of the members who were present at the meeting is attached

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.

Conditions of approval

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

Approved documents

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

Document Type: Application
Dated: 28/06/2004
Date Received: 05/07/2004

Document Type: Investigator CV
Version: unreferenced, undated
Date Received: 05/07/2004

Document Type: Protocol
Dated: 02/05/2004
Date Received: 05/07/2004

Document Type: Covering Letter
Dated: 28/06/2004
Date Received: 05/07/2004

Document Type: Letter from Sponsor
Version: undated
Date Received: 05/07/2004

Document Type: Copy of Questionnaire
Version (Various questionnaires, undated)
Date Received: 05/07/2004

Document Type: Copies of Advertisements
Version: 2
Dated: 02/09/2004
Date Received: 06/09/2004

Document Type: Letters of Invitation to Participan
Dated: 01/05/2004
Date Received: 05/07/2004

Document Type: Participant Information Sheet
Version: 2
Dated: 02/09/2004
Date Received: 06/09/2004

Notification of other bodies

We shall notify the research sponsor that the study has a favourable ethical opinion

Statement of compliance ***(from 1 May 2004)***

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.

REC reference number: 04/Q2006/76	**Please quote this number on all correspondence**

Yours sincerely,

Dr David Grier
Chairman

UniS
Ethics Committee

12 November 2004

Ms Vanessa Bryant
Trainee Clinical Psychologist
Department of Psychology
School of Human Sciences

Dear Ms Bryant

The relatedness of superstitious beliefs to locus of control, gender and anxiety in individuals suffering from Obsessive Compulsive Disorder (EC/2004/106/Psych) - FAST TRACK

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: **12 November 2004**

The list of documents reviewed and approved by the Committee under its Fast Track procedure is as follows:-

Document Type: Application
Version: 1
Dated: 25/10/04
Received: 04/11/04

Document Type: Research Proposal
Version: 2
Dated: 05/04
Received: 04/11/04

Document Type: Information Sheet
Version: 2
Dated: 09/04
Received: 04/11/04

Document Type: Consent Form
Version: 1
Dated: 05/04
Received: 04/11/04

Document Type: Letter to Participants
Version: 1
Dated: 05/04
Received: 04/11/04

Document Type: Advertisement for Participants
Version: 2
Dated: 09/04
Received: 04/11/04

Document Type: Approval Letter form the Central & South Bristol REC
Version: 1
Dated: 14/09/04
Received: 04/11/04

Document Type: Application to the Central & South Bristol REC
Version: 1
Dated: 28/06/04
Received: 04/11/04

This opinion is given on the understanding that you will comply with the University's Ethical Guidelines for Teaching and Research.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected with reasons.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
Dr S Thorpe, Supervisor, Psychology

Appendix 2

Advertisement for participants in study

Invitation to take part in OCD research

I am a third year student at the University of Surrey studying for a doctorate in Clinical Psychology. I am currently undertaking research with individuals suffering from Obsessive Compulsive Disorder in which I will be investigating how levels of anxiety and control may differ in OCD sufferers according to the kinds of belief they may have, and whether there are any variations between men and women. Understanding this relationship may go some way towards helping patients and professionals alike in developing more effective methods of treatment for OCD. I would be most grateful if anyone who is interested in taking part in the study and would like further information on how to do so, could contact me via email or my university address, details of which are given below:-

Email address: psm2vb@surrey.ac.uk

Postal address: Vanessa Bryant
Department of Clinical Psychology
University of Surrey
Guildford
Surrey
GU2 7XH

The study will involve completing postal questionnaires and returning to the researcher in the provided stamped addressed envelopes. The study is completely confidential and no identifying details will appear anywhere on the questionnaires.

Appendix 3

Information pack, letter of introduction and consent forms sent to interested participants

UniS

University of Surrey
Guildford
Surrey GU2 7XH, UK
Telephone
+44 (0)1483 300800
Facsimile
+44 (0)1483 300803
www.surrey.ac.uk

School of Human Sciences
Department of Psychology
Facsimile
+44 (0)1483 689553

3rd December 2004

Information Sheet

Study title:

The relatedness of superstitious beliefs to anxiety, perception of control and gender in individuals suffering from Obsessive Compulsive disorder.

Invitation to take part in the study:

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

Thank you for reading this.

What is the purpose of the study?

The study is hoping to find out whether superstitious beliefs in OCD sufferers are related to perception of control and more or less anxiety than those sufferers who don't hold superstitious beliefs. For example, would an individual who engages in rituals (such as saying a rhyme a set number of times) in order to ward off any harm occurring to his/her family be likely to appraise events in their life as being more or less outside of their control and experience more or less anxiety compared to an individual who engages in continuous hand-washing to prevent contamination? The study will also assess if male and female OCD sufferers differ in their level of superstitious beliefs and perception of control.

The study is expected to be completed by July 2005.

The Queen's Anniversary Prizes 2002

Why have I been approached to take part?

The researcher has advertised the research project to several recognised organisations that exist to support OCD sufferers. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will taking part involve?

The research project is a questionnaire study. Participants will be given several questionnaires which they should complete and return to the researcher in a stamped addressed envelope that will be supplied. It will take approximately one hour to fill in the questionnaires.

What are the advantages of taking part in the study?

The research is seeking to contribute towards an improved understanding of the relationship between beliefs, anxiety and perception of control in OCD and may help sufferers and professionals to collaborate in developing more effective treatments for this distressing condition.

It is unlikely that individual participants will derive any personal benefit from taking part in the study.

What are the disadvantages of taking part in the study?

None except for the time it takes to fill in the questionnaires.

However, as a result of focussing on and completing the questionnaires it may be that some participants experience an increase in their anxiety. Should any participants become distressed they are urged to contact the researcher by post or email who will supply information on how to access psychological help for their difficulties. The address is at the end of this information sheet.

What happens after the research study finishes?

The information collected by the researcher will be used in her research thesis which will then be kept in the library at the University of Surrey. In addition it is hoped that *the study will be published in a peer reviewed journal.*

Will my taking part in this study be kept confidential?

Yes, taking part in the study is strictly confidential. You will not have to put your name on any of the questionnaires and cannot therefore be identified by any of the details you supply.

Should I inform my GP about my participation in the study?

Although the study is confidential you are encouraged to inform your GP about your participation in the study. However, it is your decision as to whether you wish to do this or not.

Who is organising and funding the research?

The University of Surrey and the researcher jointly.

Who has reviewed the research?

The Central and South Bristol Research Ethics Committee and the University of Surrey Ethics Committee.

Contact for further information

If you require further information please contact:

By post: Vanessa Bryant
Department of Clinical Psychology
University of Surrey
Guildford
Surrey
GU2 7XH.

Email address: psm2vb@surrey.ac.uk

Thank you very much for agreeing to take part in this study. Please return one copy of the signed consent form with your completed questionnaires and keep the other copy for your own records.

(on university headed paper)

17th January 2005

Dear Mr

Re: Research project investigating the relatedness of anxiety, locus of control and superstitious beliefs in individuals suffering with Obsessive Compulsive Disorder.

Thank you very much for replying to my advertisement with regard to the above research project. I am sorry that it has taken so long to send out the questionnaires to you but setting up the project took much longer than I thought it would!

I enclose an information sheet, consent form and questionnaire pack for you to look at and decide whether or not you wish to take part in the study. If you would like to take part please sign both copies of the consent form and return one copy to me with the completed questionnaires in the enclosed stamped addressed envelope. Also, please don't forget to fill in the form that asks about age etc. As there are rather a lot of questionnaires it may be a good idea to do half of them on one day and the other half another day. Hopefully, they shouldn't take more than about one hour to complete. I would be most grateful if you could check carefully to make sure that all items on the questionnaires have been answered before you send them back to me.

With regard to confidentiality please do not write your name on the questionnaires.

Should you require any further information please don't hesitate to contact me at the address given below.

Thank you again for your interest in the study.

Yours sincerely,

Vanessa Bryant
Department of Clinical Psychology
University of Surrey
Guildford
Surrey
GU2 7XH email: psm2vb@surrey.ac.uk

(on university headed paper)

CONSENT FORM

Title of Project:

The relatedness of superstitious beliefs to anxiety, perception of control and gender in individuals suffering from Obsessive Compulsive disorder.

Name of Researcher:

Vanessa Bryant

Please initial box

1. I confirm that I have read and understand the information sheet dated for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐
3. I agree to take part in the above study. ☐

4. Please indicate whether you are currently taking part in any other research studies:

(please tick) Yes No

Name of Participant	Date	Signature
Researcher	Date	Signature

Appendix 4

Research proposal

Name of researcher: **Vanessa Bryant**

University address: **Department of Clinical Psychology**
University of Surrey
Guildford
Surrey.
GU2 7XH.

Project Title:

The relatedness of superstition to Locus of Control (LOC) gender and anxiety in individuals suffering from Obsessive Compulsive Disorder (OCD).

Theoretical Rationale:

Research into the role of superstitious beliefs in either preventing disaster or inviting a positive outcome suggests a link with the individual's perceived level of control over external events (Jahoda, 1969; Peterson, 1978). It is also suggested gender differences exist, with females having significantly more superstitious beliefs than males (Zebb & Moore, 2003). It is possible that both OCD and superstition represent an adaptive anxiety-reducing strategy whereby individuals engage in behaviours intended to ward off external events they perceive to be beyond their control. Historically, females may have perceived themselves to be less in control of the environment than males. There have been no studies to date that have examined the relationship between superstition, OCD, LOC, anxiety and gender.

Objectives:

To assess whether higher levels of superstitious beliefs in OCD sufferers are associated with more of an externalised LOC and less anxiety than those sufferers who show lower levels of superstitious beliefs. For example, would an individual who engages in a variety of rituals throughout the day (such as saying a rhyme a set number of times) in order to ward off any harm occurring to his/her family be more likely to hold an externalised locus of control and experience lower levels of anxiety compared to an individual who engages in continuous hand-washing to prevent contamination? The study will also assess if male and female OCD sufferers differ in their level of superstitious beliefs, LOC and anxiety.

Design and statistical analyses

The study will be a mixed design, between and within groups. All variables except gender will be continuous. A between groups analysis using ANOVA will test for differences between men and women on LOC, anxiety and level of superstitious belief. A correlational analysis (a series of bi-variate and partial correlations) will look at relationships within each of the two groups on all of the above variables.

Participants:

Unfortunately there are no estimates of the frequency of superstitious beliefs in the OCD population and in effect, this is what the study is setting out to achieve. This is problematic when deciding on sample size, but a power analysis where alpha is set at .05 and power at .80 with an effect size of .25 yields a sample size of 128.

Participants will be recruited from OCD self-help groups.

Procedures

Participants will be recruited through advertisements placed in the newsletters and websites of the OCD self-help groups. Questionnaires will be posted to potential participants by the researcher.

Main hypotheses:

OCD sufferers who are characterised by high levels of superstitious belief will be more likely to have an externalised locus of control and lower levels of anxiety than OCD sufferers who have fewer superstitious beliefs.

Main outcome measure:

Participants will complete established measures of obsessive beliefs, superstitious beliefs, anxiety and Locus of Control.

Ethical considerations: Submission of proposal to University and NHS multi research ethics committee.

Confidentiality of and potential distress to participants are the main ethical issues of this study.

Confidentiality will be addressed through the use of unique identifying numbers on questionnaire packs. No personal details will appear anywhere on questionnaires.

Some participants may experience an increase in their anxiety when completing questionnaires that focus on their difficulties. The information sheet accompanying the questionnaires will advise participants on what they should do if this happens (see information sheet).

University supervisor: Dr. S. Thorpe

Name of ethics committee(s) to which project will be submitted: University of Surrey Ethics Committee and NHS multi research ethics committee.

Background

Obsessive Compulsive Disorder is a severe and debilitating condition characterised by recurrent obsessions and compulsions that cause significant distress and impairment to sufferers. Obsessions may be thoughts, ideas, impulses or visual images that are persistent, unwanted and intrusive. The individual may view the content of their intrusions as strange and abnormal, being completely incongruent with his/her normal thought processes (American Psychiatric Association, 2000). Compulsive behaviours may arise through attempts to neutralise obsessions, thereby reducing anxiety. For example, someone obsessed with contamination fears may engage in repetitive hand-washing. Alternatively, compulsive behaviours may not be connected in a concrete way with the obsession they are seeking to neutralise and may tend towards superstition, such as placing items in a particular order in an attempt to prevent harm occurring to family members.

OCD sufferers are characterised by high levels of anxiety and feeling responsible for preventing some feared harm or events. They may also hold strong superstitious beliefs. However, although Zebb & Moore (2003) found a strong relationship between superstitiousness and obsessive-compulsive behaviour in a non-clinical sample, the relationship between superstition and anxiety was less well-defined. The study showed that in females, but not in males, superstitious beliefs were significantly correlated with measures of other anxiety disorders such as social phobia and agoraphobia. The authors point out that superstition is also related to depression and stress and as such may not be a specific pre-disposing factor for anxiety. In addition, the study found that in females superstitious beliefs are strongly related to compulsive behaviours such as checking but not to cleaning, doubting or slowness. It may be that the latter require more intermediary cognitions than checking and are prompted by continuous and high levels of anxiety and arousal. This may suggest that superstition to a certain extent acts as a container for the individual's anxiety when compared to other OCD sufferers whose anxiety is demonstrated through more controlling

behaviours such as obsessive slowness, doubting or cleaning. Interestingly, a study by Sica, Novara and Sanavio (2002) found a negative correlation between superstition and perfectionism whilst Frost et al (1993) found a strong link between superstition, checking, perfectionism and responsibility. These conflicting results with regard to the relationship between superstition and responsibility may reflect different methods of analysis and require clarification. Nevertheless, as perfectionism requires controlling behaviours and hence continuous arousal, it is unlikely that compulsive behaviours such as excessive cleaning would manifest in OCD sufferers who have strong superstitious beliefs and a hypothesised external locus of control. To a certain extent, belief in superstitious ideals may be seen as a relinquishing of responsibility and control.

Although individuals with superstitious beliefs may indeed be anxious, it is not clear from the Zebb and Moore (2003) study if anxiety varies with type of belief i.e. it may be that anxiety reduces somewhat through superstitious beliefs and ideals. Could OCD sufferers without superstitious beliefs be more anxious than those with superstitious beliefs? The profile of an OCD sufferer who holds superstitious beliefs may be one of an individual who surrenders their anxiety to an external force rather than the OCD sufferer who is continually 'on guard' and needs to keep track of his/her anxieties through pro-active and overt behaviours that exert a real and concrete effect on his/her environment.

The study predicts that OCD sufferers characterised by higher levels of superstitious belief will demonstrate lower levels of anxiety and more of an externalised LOC than those sufferers who have lower levels of superstitious belief.

Appendix 5

Additional information about participants and a diagnosis of OCD

Additional Information

Please supply the following information about yourself:

1. **Age:**

2. **Sex : Male ☐ Female ☐ (please tick)**

3. **How old were you when you or others around you noticed your Obsessive Compulsive Disorder symptoms?**

4. **Approximately how long have you been suffering from Obsessive Compulsive Disorder symptoms?**

5. **Have you ever received a diagnosis of Obsessive Compulsive Disorder from a medical/psychological practitioner?**

   Yes ☐ No ☐ (please tick)

6. **Please list below any medications that have been prescribed for you and that you are *currently* taking for Obsessive Compulsive Disorder symptoms:**

Thank you very much.

Appendix 6

The Padua Inventory

PADUA INVENTORY

Date: _____

Instructions: The following statements refer to thoughts and behaviours which may occur to everyone in everyday life. For each statement, choose the reply which best seems to fit you and the degree of disturbance which such thoughts or behaviors may create.

0 - not at all
1 - a little
2 - quite a lot
3 - a lot
4 - very much

___ 1. I feel my hands are dirty when I touch money.
___ 2. I think even slight contact with bodily secretion (perspiration, saliva, urine, etc.) may contaminate my clothes or somehow harm me.
___ 3. I find it difficult to touch an object when I know it has been touched by strangers or by certain people.
___ 4. I find it difficult to touch garbage or dirty things.
___ 5. I avoid using public toilets because I am afraid of disease or contamination.
___ 6. I avoid using public phones, because I am afraid of contagion and disease.
___ 7. I wash my hands more often and longer than necessary.
___ 8. I sometimes have to wash or clean myself simply because I think I may be dirty or 'contaminated.'
___ 9. If I touch something I think is 'contaminated' I immediately have to wash or clean myself.
___ 10. If an animal touches me, I feel dirty and immediately have to wash myself or change my clothes.
___ 11. When doubts and worries come to my mind, I cannot rest until I have talked when over with a reassuring person.
___ 12. When I talk I tend to repeat the same things and the same sentences several times.
___ 13. I tend to ask people to repeat the same things to me several times consecutively, even though I did understand what they had said the first time.
___ 14. I feel obliged to follow a particular order in dressing, undressing, and washing myself
___ 15. Before going to sleep I have to do certain things in a certain order.
___ 16. Before going to bed I have to hang up or fold my clothes in a special way.
___ 17. I feel I have to repeat certain numbers for no reason.
___ 18. I have to do things several times before I think they are properly done.
___ 19. I tend to keep on checking things more often than necessary.
___ 20. I check and recheck gas and water taps and light switches after turning them off.
___ 21. I return home to check doors, windows, drawers, etc., to make sure they are properly shut.
___ 22. I keep on checking forms, documents, checks, etc. to make sure I have filled them in correctly.
___ 23. I keep on going back to see that matches, cigarettes, etc. are properly extinguished.
___ 24. When I handle money, I count and recount it several times.
___ 25. I check letters carefully many times before posting them.
___ 26. I find it difficult to make decisions, even about important matters.
___ 27. Sometimes I am not sure I have done things which in fact I know I have done.
___ 28. I have the impression that I will never be able to explain things clearly, especially

when talking about important matters that involve me.

___ 29. After doing something carefully, I still have the impression I have either done it badly or not finished it.

___ 30. I am sometimes late because I keep on doing certain things more often than necessary.

___ 31. I invent doubts and problems about most of the things I do.

___ 32. When I start thinking of certain things, I become obsessed with them.

___ 33. Unpleasant thoughts come into my mind against my will and I cannot get rid of them.

___ 34. Obscene or dirty words come into my mind and I cannot get rid of them.

___ 35. My brain constantly goes its own way and I find it difficult to attend to what is happening round me.

___ 36. I imagine catastrophic consequences as a result of absent-mindedness or minor errors that I make.

___ 37. I think or worry at length about having hurt someone without knowing it.

___ 38. When I hear about a disaster, I think it is somehow my fault.

___ 39. I sometimes worry at length for no reason that I have hurt myself or have some disease.

___ 40. I sometimes start counting objects for no reason.

___ 41. I feel I have to remember completely unimportant numbers.

___ 42. When I read I have the impression I have missed something important and must go back and reread the passage at least two or three times.

___ 43. I worry about remembering completely unimportant things and make an effort not to forget them.

___ 44. When a thought or doubt comes into my mind, I have to examine it from all points of view and cannot stop until I have done so.

___ 45. In certain situations I am afraid of losing my self-control and doing embarrassing things.

___ 46. When I look down from a bridge or a very high window, I feel an impulse to throw myself into space.

___ 47. When I see a train approaching I sometimes think I could throw myself under its wheels.

___ 48. At certain moments I am tempted to tear off my clothes in public.

___ 49. While driving I sometimes feel an impulse to drive the car into someone or something.

___ 50. Seeing weapons excites me and makes me think violent thoughts.

___ 51. I get upset and worried at the sight of knives, daggers, and other pointed objects.

___ 52. I sometimes feel something inside me which makes me do things which are really senseless and which I do not want to do.

___ 53. I sometimes feel the need to break or damage things for no reason.

___ 54. I sometimes have an impulse to steal other people's belongings' even if they are of no use to me.

___ 55. I am sometimes almost irresistibly tempted to steal something from the supermarket.

___ 56. I sometimes have an impulse to hurt defenseless children or animals.

___ 57. I feel I have to make special gestures or walk in a certain way.

___ 58. In certain situations I feel an impulse to eat too much, even if I am then ill.

___ 59. When I hear about a suicide or a crime, I am upset for a long time and find it difficult to stop thinking about it.

___ 60. I invent useless worries about germs and diseases.

___ Total

Sanavio, E. (1988). Obsessions and compulsions: The Padua Inventory. Behavior Research and Therapy, 26, 169-177.

Appendix 7

The OBQ-44

Obsessional Beliefs Questionnaire (OBQ-44)

This inventory lists different attitudes or beliefs that people sometimes hold.
Read each statement carefully and decide how much you agree or disagree with it.

For each of the statements, choose the number matching the answer that *best describes how you think.*
Because people are different, there are no right or wrong answers.

To decide whether a given statement is typical of your way of looking at things, simply keep in mind what you are like *most of the time.*

Use the following scale:

1	2	3	4	5	6	7
disagree very much	disagree moderately	disagree a little	neither agree nor disagree	agree a little	agree moderately	agree very much

In making your ratings, try to avoid using the middle point of the scale (4), but rather indicate whether you usually disagree or agree with the statements about your own beliefs and attitudes.

1. I often think things around me are unsafe.	1 2 3 4 5 6 7
2. If I'm not absolutely sure of something, I'm bound to make a mistake	1 2 3 4 5 6 7
3. Things should be perfect according to my own standards.	1 2 3 4 5 6 7
4. In order to be a worthwhile person, I must be perfect at everything I do.	1 2 3 4 5 6 7
5. When I see any opportunity to do so, I must act to prevent bad things happening.	1 2 3 4 5 6 7
6. Even if harm is very unlikely, I should try to prevent it at any cost.	1 2 3 4 5 6 7
7. For me, having bad urges is as bad as actually carrying them out.	1 2 3 4 5 6 7
8. If I don't act when I foresee danger, then I am to blame for any consequences.	1 2 3 4 5 6 7
9. If I can't do something perfectly, I shouldn't do it at all.	1 2 3 4 5 6 7
10. I must work to my full potential at all times.	1 2 3 4 5 6 7
11. It is essential for me to consider all possible outcomes of a situation.	1 2 3 4 5 6 7
12. Even minor mistakes mean a job is not complete.	1 2 3 4 5 6 7
13. If I have aggressive thoughts or impulses about my loved ones, this I may secretly want to hurt them.	1 2 3 4 5 6 7
14. I must be certain of my decisions.	1 2 3 4 5 6 7
15. In all kinds of daily situations, failing to prevent harm is just as bad as deliberately causing harm.	1 2 3 4 5 6 7

16. Avoiding serious problems (for example, illness or accidents) requires constant effort on my part. 1 2 3 4 5 6 7

17. For me, not preventing harm is as bad as causing harm. 1 2 3 4 5 6 7

18. I should be upset if I make a mistake. 1 2 3 4 5 6 7

19. I should make sure others are protected from any negative consequences of my decisions or actions 1 2 3 4 5 6 7

20. For me, things are not right if they are not perfect. 1 2 3 4 5 6 7

21. Having nasty thoughts means I am a terrible person. 1 2 3 4 5 6 7

22. If I do not take extra precautions, I am more likely than others to have or cause a serious disaster. 1 2 3 4 5 6 7

23. In order to feel safe, I have to be as prepared as possible for anything that could go wrong. 1 2 3 4 5 6 7

24. I should not have bizarre or disgusting thoughts. 1 2 3 4 5 6 7

25. For me, making a mistake is as bad as failing completely. 1 2 3 4 5 6 7

26. It is essential for everything to be clear cut, even in minor matters. 1 2 3 4 5 6 7

27. Having a blasphemous thought is as sinful as committing a sacrilegious act. 1 2 3 4 5 6 7

28. I should be able to rid my mind of unwanted thoughts. 1 2 3 4 5 6 7

29. I am more likely than other people to accidentally cause harm to myself or to others. 1 2 3 4 5 6 7

30. Having bad thoughts means I am weird or abnormal. 1 2 3 4 5 6 7

31. I must be the best at things that are important to me. 1 2 3 4 5 6 7

32. Having an unwanted sexual thought or image means I really want to do it 1 2 3 4 5 6 7

33. If my actions could have even a small effect on a potential misfortune, I am responsible for the outcome. 1 2 3 4 5 6 7

34. Even when I am careful, I often think that bad things will happen. 1 2 3 4 5 6 7

35. Having intrusive thoughts means I'm out of control. 1 2 3 4 5 6 7

36. Harmful events will happen unless I am very careful. 1 2 3 4 5 6 7

37. I must keep working at something until it's done exactly right. 1 2 3 4 5 6 7

38. Having violent thoughts means I will lose control and become violent. 1 2 3 4 5 6 7

39. To me, failing to prevent a disaster is as bad as causing it. 1 2 3 4 5 6 7

40. If I don't do a job perfectly, people won't respect me. 1 2 3 4 5 6 7

41. Even ordinary experiences in my life are full of risk.	1	2	3	4	5	6	7
42. Having a bad thought is morally no different than doing a bad deed.	1	2	3	4	5	6	7
43. No matter what I do, it won't be good enough.	1	2	3	4	5	6	7
44. If I don't control my thoughts, I'll be punished.	1	2	3	4	5	6	7

questionnaire developed by:

Obsessive Compulsive Cognitions Working Group. (2001). Development and initial validation of the Obsessive Beliefs Questionnaire and the Interpretations of Intrusions Inventory. *Behaviour Research and Therapy,* **39,** 987-1006.

Appendix 8

The OCI-R

Obsessive-Compulsive Inventory – Revised

The following statements refer to experiences that many people have in their everyday lives. Circle the number that best describes **HOW MUCH** that experience has **DISTRESSED or BOTHERED you during the past month.** The numbers refer to the following verbal labels:

0	1	2	3	4
Not at all	A little	Moderately	A lot	Extremely

1.	I have saved up so many things that they get in the way.	0 1 2 3 4
2.	I check things more often than necessary.	0 1 2 3 4
3.	I get upset if objects are not arranged properly.	0 1 2 3 4
4.	I feel compelled to count while I am doing things.	0 1 2 3 4
5.	I find it difficult to touch an object when I know it has been touched by strangers or certain people.	0 1 2 3 4
6.	I find it difficult to control my own thoughts.	0 1 2 3 4
7.	I collect things I don't need.	0 1 2 3 4
8.	I repeatedly check doors, windows, drawers, etc.	0 1 2 3 4
9.	I get upset if others change the way I have arranged things.	0 1 2 3 4
10.	I feel I have to repeat certain numbers	0 1 2 3 4
11.	I sometimes have to wash or clean myself simply because I feel contaminated.	0 1 2 3 4
12.	I am upset by unpleasant thoughts that come into my mind against my will.	0 1 2 3 4
13.	I avoid throwing things away because I am afraid I might need them later.	0 1 2 3 4
14.	I repeatedly check gas and water taps and light switches after turning them off.	0 1 2 3 4
15.	I need things to be arranged in a particular order.	0 1 2 3 4
16.	I feel that there are good and bad numbers.	0 1 2 3 4
17.	I wash my hands more often and longer than necessary.	0 1 2 3 4
18.	I frequently get nasty thoughts and have difficulty in getting rid of them.	0 1 2 3 4

Appendix 9

The LBQ

Lucky Beliefs Questionnaire (Frost et al., 1993)

Please indicate the extent to which you disagree or agree with each of the following statements.

		Strongly disagree				**Strongly agree**
1.	Some numbers are lucky.	1	2	3	4	5
2.	Seeing a cat brings bad luck.	1	2	3	4	5
3.	Walking under ladders is bad luck	1	2	3	4	5
4.	The number 13 is unlucky.	1	2	3	4	5
5.	Opening an umbrella inside is bad luck.	1	2	3	4	5
6.	Stepping on cracks in the pavement brings bad luck.	1	2	3	4	5
7.	Finding a four leaf clover brings good luck.	1	2	3	4	5
8.	Picking up a penny brings good luck.	1	2	3	4	5
9.	Rabbits' feet are lucky.	1	2	3	4	5
10.	Some objects are lucky.	1	2	3	4	5
11.	Wishes made at a well or while tossing coins into a fountain will come true.	1	2	3	4	5
12.	Knocking on wood will prevent the undoing of something good you have just said.	1	2	3	4	5
13.	There are such things as haunted houses and ghosts.	1	2	3	4	5
14.	Fortune tellers can predict the future.	1	2	3	4	5
15.	Some sayings are lucky.	1	2	3	4	5

		Strongly disagree				Strongly agree
16.	It is bad luck for the groom to see the bride in her gown before the ceremony.	1	2	3	4	5
17.	Wishes made on a star will come true.	1	2	3	4	5
18.	Friday the 13th is an unlucky day.	1	2	3	4	5
19.	Breaking a mirror will bring seven years bad luck.	1	2	3	4	5
20.	Hanging a horse-shoe ends up will bring good luck.	1	2	3	4	5
21.	Killing a spider is bad luck.	1	2	3	4	5
22.	The 7th child in a family is lucky.	1	2	3	4	5
23.	Astrology can predict the future.	1	2	3	4	5
24.	Crystals have a special power.	1	2	3	4	5
25.	There is such a thing as the evil eye.	1	2	3	4	5
26.	Crossing your fingers can bring good luck.	1	2	3	4	5
27.	Hanging gifts of money in new businesses will bring good luck.	1	2	3	4	5
28.	Bad luck comes in threes.	1	2	3	4	5
29.	Throwing change in the back seat of a new car will bring good luck.	1	2	3	4	5
30.	Carrying silver dollars is good luck.	1	2	3	4	5

Appendix 10

The SQ

Superstitiousness Questionnaire (**Leonard et al., 1990**)

Listed below are a number of statements. Please read each statement carefully and indicate, according to the scale given below, how much you think each statement applies to you.

Strongly disagree	= 0	Slightly agree	= 3
Moderately disagree	= 1	Moderately agree	= 4
Slightly disagree	= 2	Strongly agree	= 5

1	I have a lucky number	_____
2	I believe that seeing a black cat brings bad luck	_____
3	I believe that walking under ladders will bring bad luck.	_____
4	I avoid walking under ladders.	_____
5	I believe that the number 13 is unlucky.	_____
6	I believe that opening an umbrella indoors is bad luck	_____
7	I avoid opening an umbrella indoors.	_____
8	I avoid stepping on cracks in the pavement for fear of bringing bad luck.	_____
9	I believe that finding a four leaf clover brings good luck	_____
10	I believe that picking up a penny brings good luck.	_____
11	I believe that wishes made in a well or while tossing coins in a fountain will come true	_____
12	I believe that knocking on wood will prevent the undoing of something good I just said.	_____
13	I knock on wood to prevent the undoing of something good I just said.	_____
14	I believe that fortune tellers can predict the future.	_____
15	If I went to a fortune teller and that person predicted something, it would come true for me.	_____
16	I do something special to bring good luck.	_____
17	I do something special to prevent bad luck	_____
18	I have a superstition not listed here	

Appendix 11

LOC questionnaire

		Strongly disagree	Disagree somewhat	Slightly disagree	Slightly agree	Agree somewhat	Strongly agree
1.	Whether or not I get to be a leader depends mostly on my ability.	-3	-2	-1	+1	+2	+3
2.	To a great extent my life is controlled by accidental happenings.	-3	-2	-1	+1	+2	+3
3.	I feel like what happens in my life is mostly determined by powerful people.	-3	-2	-1	+1	+2	+3
4.	Whether or not I get into a car accident depends mostly on how good a driver I am.	-3	-2	-1	+1	+2	+3
5.	When I make plans, I am almost certain to make them work.	-3	-2	-1	+1	+2	+3
6.	Often there is no chance of protecting my personal interests from bad luck happenings.	-3	-2	-1	+1	+2	+3
7.	When I get what I want, it's usually because I'm lucky.	-3	-2	-1	+1	+2	+3
8.	Although I might have good ability, I will not be given leadership responsibility without appealing to those in positions of power.	-3	-2	-1	+1	+2	+3
9.	How many friends I have depends on how nice a person I am.	-3	-2	-1	+1	+2	+3
10.	I have often found that what is going to happen will happen.	-3	-2	-1	+1	+2	+3
11.	My life is chiefly controlled by powerful others.	-3	-2	-1	+1	+2	+3
12.	Whether or not I get into a car accident is mostly a matter of luck.	-3	-2	-1	+1	+2	+3

		Strongly disagree	Disagree somewhat	Slightly agree	Slightly agree	Agree somewhat	Strongly agree
13.	People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure groups.	-3	-2	-1	+1	+2	+3
14.	It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune.	-3	-2	-1	+1	+2	+3
15.	Getting what I want requires pleasing those people above me.	-3	-2	-1	+1	+2	+3
16.	Whether or not I get to be a leader depends on whether I'm lucky enough to be in the right place at the right time.	-3	-2	-1	+1	+2	+3
17.	If important people were to decide they didn't like me, I probably wouldn't make many friends.	-3	-2	-1	+1	+2	+3
18.	I can pretty much determine what will happen in my life.	-3	-2	-1	+1	+2	+3
19.	I am usually able to protect my personal interests.	-3	-2	-1	+1	+2	+3
20.	Whether or not I get into a car accident depends mostly on the other driver.	-3	-2	-1	+1	+2	+3
21.	When I get what I want, it's usually because I worked hard for it.	-3	-2	-1	+1	+2	+3
22.	In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.	-3	-2	-1	+1	+2	+3
23.	My life is determined by my own actions.	-3	-2	-1	+1	+2	+3
24.	It's chiefly a matter of fate whether or not I have few friends or many friends.	-3	-2	-1	+1	+2	+3

Appendix 12

The STAI – Form Y

MATERIAL REDACTED AT REQUEST OF UNIVERSITY

Appendix 13

The BDI-II

MATERIAL REDACTED AT REQUEST OF UNIVERSITY

MATERIAL REDACTED AT REQUEST OF UNIVERSITY

LOG OF RESEARCH EXPERIENCE

Research Skill/Experience	Description of how research skill/experience acquired	Date research skill/experience acquired
Conduct a literature search	Conducting literature searches has been a continuous part of my work throughout the entirety of the training course. This has been done using author and keyword searches via online electronic databases such as Psychinfo and Medline and the electronic journal database at the University of Surrey.	Continuously from 2002.
Critically review the literature	I have carried out critical analyses of the literature for academic, research and clinical work. This has been demonstrated through written essays, case reports and three research projects as well as discussions in lectures and informally with colleagues.	Continuously from 2002

Research Skill/Experience	Description of how research skill/experience acquired	Date research skill/experience acquired
Formulate a specific research question	I formulated specific research questions for the Service Related Research Project (SRRP) and the Major Research Project (MRP). In addition, as part of a group of five trainees I contributed to the formulation of a research question for a joint qualitative project. The SRRP research question was formulated in consultation with the service providers in an Adult Community Mental Health Team. This process revealed that research into assessing outcomes for a new clinic the team had opened the previous year would be very useful information for the future direction of their service. I formulated the research question for the MRP after developing an interest in Obsessive Compulsive Disorder and treating several clients in my clinical placements who were suffering from the disorder.	October –November 2002 (SRRP). 2003 (qualitative research). January 2004 (MRP)
Write a brief research proposal	I wrote a brief research proposal for the SRRP according to guidelines provided by the University of Surrey Clinical Psychology course.	November 2002 (SRRP)
Write a detailed proposal/protocol	I wrote a detailed proposal for the MRP after considering the strengths and limitations of the research question. This included thinking about the validity of the research question, the overall design of the study, the availability of the target population and the time available to carry out the data collection and analysis.	December 2003
Obtain appropriate supervision/collaboration for research	I obtained collaborative support for the SRRP from the service in which I was working and conducting the study. For the MRP I liaised with OCD self-help organisations and worked closely with them for the duration of the study. I received appropriate supervision from my supervisor at the University of Surrey for both the SRRP and the MRP projects. I did not need an external supervisor for either of these studies.	October 2002 – March 2003 (SRRP). January 2004 – July 2005 (MRP).

Research Skill/Experience	Description of how research skill/experience acquired	**Date research skill/experience acquired**
Write a participant information sheet and consent form	I wrote a participant information sheet and consent form for the MRP using the Department of Health's (DOH) recommended format which is available on the DOH website. I adopted the template accordingly to take account of the specific requirements of the MRP.	January 2004
Judge ethical issues in research and amend plans accordingly	The participants in the MRP were from a vulnerable population suffering from a debilitating anxiety disorder. I discussed a strategy with my clinical tutor that could help and support participants if they sought advice from me about their difficulties. Any potential participant who did contact me was advised in the first instance to visit their GP and if required, to ask for a referral to a specialist mental health service.	August 2004
Obtain approval from a research ethics committee	I obtained ethical permission to carry out the MRP from the NHS Multi Research Ethics Committee in Bristol. I attended a meeting of all the committee members and answered their questions about the study as they arose. They approved the study after I amended my personal contact details on the information forms.	July-september 2004
Collect data from research participants	I collected questionnaire data from participants face to face (in the service setting) for the SRRP, by postal questionnaires for the MRP and by interview for the Qualitative research project. I have also collected data face to face for research projects that I was involved in prior to commencing clinical psychology training.	January – April 2002 (SRRP). November 2004 – May 2005 (MRP).
Set up a data file	I used the SPSS computer programme to set up a data file for the MRP.	December 2004
Analyse quantitative data	I have carried out statistical analysis on the data collected for the MRP. This involved Descriptive, Multiple Analysis of Variance and Correlational methods. Due to small sample size for the SRRP the data was subjected to a frequency analysis.	May – July 2005 (MRP) April 2003 (SRRP).
Analyse qualitative data	As part of a group of five trainees, I contributed to the qualitative analysis of recorded transcripts of interviews conducted by each member of the group.	September 2004
Summarise results in figures/graphs	I have summarised research findings for the SRRP and the MRP in charts and tables in the results section of each report.	2003-2005

Research Skill/Experience	Description of how research skill/experience acquired	**Date research skill/experience acquired**
Interpret results from data analysis	I have interpreted results from the analysis of data collected for the SRRP and the MRP in the discussion section of each report.	May – July 2003
Present research findings/plans to an audience	I presented the findings of the SRRP to the service in which the project was conducted. I presented the proposal and rationale for the MRP to an audience of clinical psychology trainees at the University of Surrey prior to carrying out the study.	August 2003
Produce a written report on a research project	I wrote both the SRRP and the MRP research reports in their entirety. I collaborated with my fellow trainees in the writing up of the qualitative research project.	2002 and 2003
Defend research project at an oral examination	I will be defending the MRP research project in an oral examination in August 2005 at the University of Surrey.	August 2005
Submit research report for publication in a journal/book	I will be continuing to collect data after my thesis is handed in. It is then intended to submit the MRP as a paper for publication.	
Apply research findings to clinical practice (give examples of 3 papers published during your training which influenced your practice).	**Holmes, J.** (2004). Disorganised attachment and Borderline Personality Disorder: A clinical perspective. *Attachment and Human Development,* **6,** (2) 181-190 **Vas Dias, S.** (2004) Cumulative phobic response to early traumatic attachment: Aspects of a developmental psychotherapy in midlife. *Attachment and Human Development,* **6,** (2), 165-179. **Touyz, S., Thornton, C., Rieger, E., George, L. Beumont. P.** (2003) The incorporation of the stage of change model in the day hospital treatment of patients with anorexia nervosa. European Child and Adolescent Psychiatry, **12,** 65-71.	