Weight Changes,
The Meaning of Food &
Eating Behaviours
Amongst Women in
Recovery From Substance Addiction

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<u>PREFACE</u>

For the past two years of my doctorate I have worked for a community adult substance misuse service as a key-worker and group facilitator. I have also worked with various different populations including service users and carers, students, health care and welfare professionals.

The misuse of alcohol and drugs by adults has risen over the past two decades and there has been an increase in individuals entering substance misuse treatment services in the UK. Alcohol and drugs can take a heavy toll on the human body and causes a range of health complications. Alcohol and drugs can have a physical dependency, but have a psychological dependency as well, in which it affects ones ability to function and think. The range of problems that develop as a result of alcohol and drug addiction can affect every area of one's life, including family and relationships, emotional health, employment and finances, legal status and personal development. Alcohol is the third leading cause of disease and injury worldwide.

My main role within the service is to deliver psycho-social, educational interventions in a group setting, based on CBT principles. CBT has been proven to be effective in reducing distress and facilitating lifestyle change. I have a case load of clients whom I key-work by assisting in goal setting. I also support clients from a health psychology perspective by encouraging them to make multiple lifestyle changes, such as giving up smoking, taking up more exercise and changing their diet. The service however provides a range of other therapeutic approaches, including one-to-one counselling, therapeutic group sessions, key-work, drama therapy, and complementary therapies including: acupuncture and life coaching. The service also provides support with general life skills such as housing advice, benefits information, education/employment guidance/signposting and referral to other services, as appropriate. Clients accessing the service have mainly drug and alcohol problems, some still misusing these whilst others in recovery. Most of the clients are unemployed, have low education and are on government income assistance. It is

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important to highlight that all the clients accessing the service are there because they choose to and not due to court orders.

RESEARCH

The research element of this professional doctorate involved a qualitative study exploring weight changes, the meaning of food and eating behaviours amongst women in recovery from substance addiction. Recovery from drug and alcohol misuse is seen as a behaviour-change process whereby the person starts to move gradually away from former habits and patterns of thinking whilst learning new skills, however returning to a normal diet can be challenging for many recovering substance misusers. Studies involving substance misuse have mainly focused on weight changes and eating behaviours during active substance addiction, whilst research on how substance misusers experience weight changes and how they describe the functions and meaning of food and eating behaviours in recovery from substance addiction is scarce.

This is a qualitative study using a constructivist grounded theory approach which aimed to explicate the experiences of food, eating and weight changes from eight women in different stages of recovery (ranging from early, mid and late recovery) from drug and alcohol addiction. The areas identified from 'the meaning of food' included: *substituting alcohol with food*, *structure* and *social benefits*. The areas identified from 'weight changes' included: *weight gain* and *weight loss*, and the areas identified from 'eating behaviours' included: *distorted eating* and *dieting*. The findings lead to an emerging theory that indicated: *'Food during recovery involved providing structure to the day, enjoyment of social eating and substituting alcohol with food, particularly sugar rich foods during early recovery to 1. Replace the substances by filling a void, 2. Satisfy the cravings and urges experienced from the substances and 3. Experience a change in mood. The excessive intake of sugar rich food caused weight gain and in turn resulted in dieting and distorted eating behaviours later in recovery'.*

The theory that emerged from this research should prove useful to substance misuse facilities in order to enhance and incorporate nutrition education into treatment programmes to address food, eating and weight issues faced by women in recovery from substance addiction.

SYSTEMATIC REVIEW

A systematic review was carried out to describe the effectiveness of interventions aimed at promoting healthy eating within a substance misuse sample. Healthy eating is fundamental in preventing a number of chronic conditions and crucial for individuals suffering drug and alcohol problems due to the lack of nutritional deficiencies. An increasing number of reviews have been conducted on healthy eating amongst other populations (children, the elderly, pregnant women, ethnic minority groups), but no reviews addressing the substance misusing population have been found. Multiple electronic databases were searched. Journals were hand searched and references of eligible studies were checked for further relevant publications. Seven studies targeting healthy eating and nutrition for substance misusers met the inclusion criteria, including a RCT and before-and-after studies. The interventions were part of substance misuse treatments and ranged from one-to-one counselling sessions to intensive group-based interventions, including didactic lessons, group discussions, interactive learning activities and weekly assignments. Six of the seven studies reported positive outcomes regarding increasing healthy eating and nutritional knowledge during and after the interventions. Three of the studies included follow-ups, ranging from four weeks to six months. There is however, little evidence to determine long-term sustained behaviour change within this population. The importance of incorporating a healthy eating plan within drug and alcohol treatment facilities are discussed.

PROFESSIONAL PRACTICE:

<u>Consultancy</u>

The case study in this portfolio provides a detailed reflective account on a consultancy agreement I undertook with a mental health service user involvement project, which aims to voice people's views regarding their experiences of mental health services they have accessed, and offer various courses for service users to promote well-being. However, individuals with mental health conditions have the highest rates of morbidity and mortality, associated with lifestyle and social factors, including, smoking, substance misuse, inactivity and diet. Taking into consideration the lack of lifestyle interventions offered to individuals suffering mental health problems, I undertook this consultancy in order to bring a health psychologist's perspective in an

effort to raise awareness of the importance of a healthy lifestyle. I faced a range of barriers during the consultancy project, however it provided a good opportunity for me to learn about managing these barriers. Despite some of the barrier's I faced, the case study discusses the experience of setting up the consultancy, monitoring, evaluating and reflecting on the consultancy project, which acquired new experiences and was proven to be a rewarding undertaking.

Intervention to Change Health Related Behaviour

This case study provides a detailed description of the design, development and delivery of a smoking cessation intervention for a socially disadvantaged population. The literature suggests that unhealthy lifestyle choices such as destructive habits have been evident amongst social disadvantaged groups, such as inactivity, poor diet, drug use, excessive alcohol intake and high rates of tobacco smoking. Smoking rates have been particularly high for this group, which indicates that the most deprived and vulnerable members of society are the ones that may be more prone to smoking and would be regarded as a high-risk group of developing smoking related diseases. As there seems to be are a variety of factors influencing smoking and smoking cessation for lower socioeconomic groups, interventions tailored specifically to this group are highly recommended. Using services that these groups already access are regarded as suitable settings for reaching vulnerable groups. Based on the evidence of high smoking rates amongst this population, a smoking cessation intervention was carried out within a community drug and alcohol service. The case study provides an example of efforts to bring health psychology research into practice and includes an evaluation of the outcome of the intervention.

Teaching and Training

The aim of the teaching and training was to develop and demonstrate competence as a teacher and trainer in health psychology through the application of educational principles and good practice. I undertook two teaching sessions and five training sessions. The training sessions were delivered to tenants from supported living, suffering mental health conditions and learning disabilities. The training sessions included nutrition and healthy eating, calories and physical activity, stress, relationships/social support and, anger and resentment. The training sessions were

delivered through a group context based on evidence on how to improve their skills and knowledge around each topic.

The teaching sessions were delivered to MSc students on a health psychology and addictions course. The lectures taught were on 'Childhood Obesity' and 'Substance Misuse & The Stages of Change'. As I work in the substance misuse field the latter lecture was an advantage to me, as it allowed me to promote health psychology to the students by describing how I was able to use theories and models based on health psychology evidence into my workplace, and how health psychology could be applied to promote behaviour change in clients. Both the teaching and training sessions required me to take into account the learning needs of the audience, and accordingly plan and design the sessions, plan and implement procedures for assessment and evaluate the sessions.

Professional Skills

The reflective commentary in this portfolio highlights my experiences and learning as a trainee health psychologist and outlines how I have worked through to meet the professional competence within the discipline of health psychology. I have demonstrated how I have used my professional skills to practise within the legal ethical boundaries, the strategies I have employed to engage in continuous professional development, and how I have used concepts and evidence derived from health psychology within my personal and professional development as a health psychologist.

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<u>ABSTRACT</u>

During the period of recovery from drug and alcohol misuse the individual starts to move gradually away from former habits and patterns of thinking whilst learning new skills, however returning to a normal diet can be challenging for many recovering substance misusers. Studies involving substance misuse have mainly focused on weight changes and eating behaviours during active substance addiction, whilst research on how substance misusers experience weight changes and how they describe the functions and meaning of food and eating behaviours in recovery from substance addiction is scarce.

This is a qualitative study using a constructivist grounded theory approach which aimed to explicate the experiences of food, eating and weight changes from eight women in different stages of recovery (ranging from early, mid and late recovery) from drug and alcohol addiction. The areas identified from 'the meaning of food' included: *substituting alcohol with food*, *structure* and *social benefits*. The areas identified from 'weight changes' included: *weight gain* and *weight loss*, and the areas identified from 'eating behaviours' included: *distorted eating* and *dieting*. The findings lead to an emerging theory that indicated: *'Food during recovery involved providing structure to the day, enjoyment of social eating and substituting alcohol with food, particularly sugar rich foods during early recovery to 1. Replace the substances by filling a void, 2. Satisfy the cravings and urges experienced from the substances and 3. Experience a change in mood. The excessive intake of sugar rich food caused weight gain and in turn resulted in dieting and distorted eating behaviours later in recovery'*.

The theory that emerged from this research should prove useful to substance misuse facilities in order to enhance and incorporate nutrition education into treatment programmes to address food, eating and weight issues faced by women in recovery from substance addiction.

CHAPTER 1

INTRODUCTION

This chapter consists of a review of the existing literature on addiction, nutrition, weight changes and eating patterns during active substance addiction and during recovery from substance addiction. This chapter will aim to orient the reader to the theoretical context of the existing literature.

1.1 Models of Addiction

Addiction can be defined as a "primary, chronic, neurobiologic disease with genetic, psychosocial and environmental factors that influence its development and manifestations" (Centre for Addiction and Mental Health, 2009, p.1). Typical characteristics include loss of control over the behaviour, continued use despite negative consequences and compulsive use and craving (CAMH, 2009). Over the years, two types of addictions have been identified: substance addictions (such as smoking, alcoholism and drug misuse) and process addictions (such as eating, shopping and gambling). Addiction to more than one substance or process, or a combination of both has been on the rise in recent years (Gale Encyclopedia of Medicine, 2008). Over the past 300 years many questions have been raised to explain the reasons behind such self-destruction. The causes of addiction can be addressed through various theoretical perspectives including the moral models, which see addiction to be a result of weakness and lack of moral fibre; biomedical models which regard addiction as a disease; and social learning theories which consider addiction behaviours to be learned.

During the seventeenth century, drinking alcohol was regarded as an acceptable behaviour, and drinking large quantities of it was seen as a result of free choice and personal responsibility. Treatment was therefore not seen as an option, rather, punishment was considered as a consequence for choosing to behave inappropriately (Ogden, 2012). During the nineteenth century, perspectives towards addictions, especially alcohol changed. Alcohol was seen as a strong, damaging substance and alcoholics were seen as victims of the substance. The first disease concept of

addiction was formed, which was the earliest form of a biomedical approach to addiction in the sense that it suggested that alcoholism could be an illness. This disease concept acknowledged treatment and viewed the substance as the main problem. During the beginning of the twentieth century the study of human behaviour changed, which in turn influenced theories of addiction. The second disease concept of addiction was formed, which moved away from seeing the substance as the problem, but rather placed the blame on the individuals who drank excessively and became addicted to it. Though alcohol consumption at this point became socially acceptable again, the second disease model still recognised that certain individuals potentially developed alcoholism as an illness and needed some form of treatment. It regarded addiction as irreversible, which meant that treatment through complete sobriety was the only option (Ogden, 2012: West, 2006).

During the late twentieth century the rise of behaviourism changed how addiction was viewed. Social learning theories were developed, which viewed addiction as a conditioned response to the environment and other individuals, and was therefore a learned behaviour (Fraser, 2007). From a social learning viewpoint, addictive behaviours are learned through the processes of classical conditioning, operant conditioning, observational learning and cognitive processes (Bandura, 1977). Ogden (2012) explains that the notion behind classical conditioning is that behaviours are acquired through associative learning. For instance, an unconditioned stimulus (e.g. going to the pub) may educe an unconditioned stimulus (e.g. feeling relaxed). If the unconditioned stimulus is associated with a conditioned stimulus (e.g. a drink), then ultimately this will educe the conditioned response (e.g. feeling relaxed). Ogden (2012) further explains that there are external cues (e.g. the pub) and internal cues (e.g. mood) that can be paired with the conditioned response. For example alcohol consumption may be associated with external cues (e.g. associating with a particular group of friends) or with internal cues (e.g. excitement/depression). However, according to the model pairing with an internal cue is more difficult, as such cues are hard to avoid. Moreover, internal cues may also increase the issue of generalization, which occurs when the withdrawal symptoms from abstaining from a substance act as cues for further behaviour. Operant conditioning on the other hand is the likelihood of behaviour to happen, depending on whether it is positively reinforced by the existence of a positive event, or negatively reinforced by the nonexistence or elimination of a

negative event. For example the likelihood of drinking may be enhanced by feelings of confidence and social acceptance (positive reinforcement), and elimination of withdrawal symptoms (negative reinforcement). The social learning model also discusses observational learning/modelling, which are behaviours that are learnt through observing others engaging in the behaviour. Lastly, the social learning model additionally includes cognitive factors such as problem-solving, coping skills and self-esteem. For example an individual who may find it difficult to solve problems and has low self-esteem, may be at greater risk of developing an addictive behaviour (Ogden, 2012; West & Brown, 2013).

Strengths & Weaknesses of the Models

The various theoretical explanations shape addiction behaviours each in their own way in terms of methods, theory and interpretation. For instance professionals from a medical background give emphasis to addiction as an illness, whilst professionals from a behavioural background give emphasis to addiction as a learned behaviour. Although there are professionals that utilise a disease model of addiction, there are a number of weaknesses in this approach. If addiction is viewed as an illness, it may take away the responsibility from the individual, and instead portray them as victims, which could create a sense of learned helplessness. If the individual believes that there is no cure for addiction, they may further believe that resistance to substances is ineffective and therefore continue with the behaviour (Schaler, 1991; Wilbanks, 1989). The disease model additionally promotes treatment through lifelong abstinence and does not take into account relapse (though AA does recognise relapse part of their programme), which may lead to an individual to set unrealistic targets of abstinence (Ogden, 2012). Like the disease model, the social learning theory also has its weaknesses. As it is a purely environmental model, it does not consider the individuals' biological or physiological states. For example Anderson (2007) suggests that there may be genetic aspects, particularly neurotransmitter activities that cause Type II alcoholism, which is strongly linked to a family history of alcoholism and violence. Genetics may therefore be one of the reasons why some individuals are more predisposed to becoming addicted to substances than others. It may be argued that addiction develops because some substances are addictive, however it can also be argued that it is a learned behaviour. Ogden (2012) explains that individuals need exposure and reinforcement to make, for example, drinking enough to develop

tolerance. She further explains that the concept of tolerance may be part of the disease model, but it is also partially dependent upon social learning theory for it to function. Similarly, the idea that individuals might consume large quantities of alcohol because they have learned that it relieves withdrawal symptoms, is an association that has been drawn from a social learning perspective (conditioning), however it also utilises a disease model in the sense that it entails the existence of physical withdrawal symptoms. Both the disease and social learning models have their own weaknesses and strengths, however it appears that the interaction between the two models should be acknowledged, as they both have important traits of influences. The current research will take a biopsychosocial stance, by drawing upon both disease and social learning models of addiction. The approach was chosen as it offers a multidimensional perspective of substance addiction. The model includes variables that are both in and out of one's control including genetic factors, predisposition and environmental influences, which are all important variables to consider when assessing and evaluating substance addiction. By adopting a biopsychosocial model it is possible to identify both internal and external issues associated with biological, psychological and social factors.

1.2 The Rise of Substance Misuse

The use of alcohol and drugs by adults has risen over the past two decades. A large amount of the adult population misuse alcohol and drugs in North America and Europe (Canadian Centre on Substance Abuse, 2011; European Monitoring Centre for Drugs and Drug Addiction, 2011), and the misuse of drugs is also becoming a problem in non-Western countries (Islam, Hossain, Ahmed & Ahsan, 2002; World Health Organisation [WHO], 2011). There has been an increase in individuals entering substance misuse[1] treatment; approximately four million individuals in the USA and one million Europeans receive treatment at specialist dependency services annually. According to the National Drug Treatment Monitoring System (NDTMS, 2013) 39,273 females over the age of 18 were in effective treatment for alcohol abuse

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[1] Substance misuse is defined as intoxication by- or regular excessive consumption of and/or dependence on legal and illegal drugs, including alcohol despite social, occupational, psychological or physical consequences (NICE, 2007).

and 51,454 females were in effective treatment for drug dependency during 2012-13 across England. Women make up over half the adult population, however only a quarter of the adults attending substance treatment services are women. It has been reported that women who misuse substances are hesitant to ask for help, due to the risk of their children being taken into care (The National Treatment Agency for Substance Misuse [NTA], 2010).

1.3 Recovery from Substance Addiction

Although the use of alcohol and drugs by adults has risen over the past two decades, individuals seeking recovery has also risen (NDTMS, 2013). Recovery is a word with many meanings and has been applied throughout health care. In this study, the term recovery will be referring to recovery from drug and alcohol addiction. Recovery is a process of change that allows the person to be able to make positive and healthy choices by overall improving their quality of life (Center for Substance Abuse Treatment [CSAT], 2005a). Generally, recovery from drug and alcohol addiction is a dynamic and complex process including many positive changes to a person's mental, physical and social health (Schwarzlose & McLellan, 2007). There are some common themes that have been identified by individuals in recovery including that recovery involves developing a new meaning and purpose in life, taking responsibility for their illness, managing symptoms, renewing hope, overcoming stigma, getting support from others and believing in themselves (Deegan, 2003; Corrigan & Ralph, 2005; Roberts & Wolfson, 2006).

The recovery process from drug and alcohol addiction has been looked upon as a behaviour-change process whereby complete abstinence from drugs and alcohol is achieved (Flores, 2001; Gorski, 1990). There are various classification systems used to describe individuals in recovery. These include being in early, middle, or late recovery, also known as early sobriety, sustained sobriety and stable sobriety (CSAT, 2005b: Schwarzlose & McLellan, 2007). The stages of recovery also aid recovering substance misusers and professionals to evaluate progress and identify suitable treatment goals (Gorski, 1990). During early recovery the individual may be receiving

some form of treatment, where the primary focus is on becoming abstinent and then on staying sober. At this stage the individual is often fragile and may be vulnerable to relapse. The early stage of recovery is considered to last from 1 month to 1 year (CSAT, 2005b). During mid recovery the individual may start to feel more secure with abstinence. Cravings can still occur during this stage, but are often recognised by the individual. However, the chance of relapsing can still occur. At this stage the individual will start to make significant lifestyle changes. This stage lasts between 1-5 years (CSAT, 2005b: Schwarzlose & McLellan, 2007). Some individuals do not move towards late recovery. They may relapse and go back to early recovery. The final stage, late recovery, is where the individual is maintaining abstinence. During this stage the individual will make other changes that are not associated with their addiction, and may additionally work through psychological issues unrelated to their addiction, that may have occurred during abstinence. The individual enters this stage when they have 5 or more years of recovery. This stage has no end to it, as the maintenance stage is seen as ongoing (CSAT, 2005b; Schwarzlose & McLellan, 2007).

The change process from substance addiction can also be examined through the Transtheoretical Model (TTM), which is designed to assess readiness to change. The model has been presented as an integrative framework for understanding, measuring and intervening in behaviour change and is specifically designed to foster interventions based on an individual's psychological and behavioural needs (Prochaska & DiClemente, 1983; 1985; Prochaska, DiClemente, Velicer, Rossi, 1993). The model describes how people cycle through a series of five stages in an effort to change behaviour. The five stages of change have been outlined as precontemplation (PC- no intention to change behaviour in the next six months), contemplation (C- considering changing behaviour in the next six months), preparation (PR- serious intention to change in the next 30 days), action (A- successfully changed their behaviour less than 6 months ago) and maintenance (M- maintaining behaviour change six months or more). Progression through the stages is not viewed as a linear process, as the model recognises that individuals may need to cycle through the stages several times before maintenance is sustained. The strength of the model is its recognition of relapse, where relapse is not seen as failure, but rather as an opportunity to learn from previous attempts to change (Prochaska &

DiClemente, 1983).

To further understand health behaviour change Bandura's Social Cognitive Theory (SCT) includes environmental and social factors that may help or prevent a person from changing. The theory has been used to explain health behaviours in terms of health promotion, prevention and changes of unhealthy lifestyles. SCT examines the thinking process and how an individual's thinking may affect his or her own behaviour (Baranowski, Perry & Parcel, 1997). An important concept of the SCT is the interaction between the individual, the behaviour and the environment. Once there has been a change in one of these aspects, the other two aspects may be influenced (Bandura, 1977). SCT emphasises that the majority of behaviours are learned and can be changed and that learning behavioural and cognitive skills are both essential when coping with situations in order to make changes. For example, a person who wishes to become alcohol-free but lacks the behavioural and cognitive skills to cope with a stressful situation without resorting to alcohol, will be less likely to succeed in changing their behaviour despite the motivation (Bandura, 1977). There are several concepts in SCT; the self-efficacy concept is one of Bandura's most recognised and important in the field of behaviour change, which involves a person's judgment regarding their ability to successfully carry out a behaviour (Bandura, 1982; 1986). The more the individual believes in their ability to change, the greater the probability for success in changing (Brantley et al., 1999). Framing services in terms of the SCT and TTM have a significant impact on the way that substance misuse is understood and treated.

1.4 Substance Addiction & Distorted Eating Patterns

There are various reasons why individuals begin to abuse alcohol and drugs. According to The National Center of Addiction and Substance Abuse (CASA) women may experience more life events that trigger substance abuse than men (CASA, 2003). One of the reasons women engage in substance misuse is related to weight concerns, where it has been reported that women increasingly use both legal and illegal drugs for weight loss (Brecht, O'Brien, von Mayrhauser & Anglin, 2004;

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Greenfield, Brooks, Gordon, Green, Kropp & McHugha, 2007; Office of National Drug Control Policy [ONDCP], 2008). A study exploring the reasons behind methamphetamine use in a sample of 350 adults revealed women were five times as likely to initiate drug use as a desire to lose weight when compared with the men in the study (Brecht et al., 2004). Research suggests that there is a stronger relationship between substance misuse and weight-related concerns in treatment facilities than amongst the general public (CASA, 2003), with recent research showing high prevalence rates of the existence of both substance misuse and eating disorders for women in treatment settings (Krug et al., 2009; Cohen, Greenfield, Gordon, Killeen, Jiang & Zhang, 2010; Greenfield, Back, Lawson & Brady, 2010). In particular it appears that women misusing substances who show weight-related concerns may also experience high body dissatisfaction and may also demonstrate more severe eating disorder symptoms such as binge eating, extreme dieting, laxative use, purging and excessive exercise (Stice & Shaw, 2003; Parkes, Saewyc, Cox & MacKay, 2008; Stice, Ng & Shaw, 2010; Warren, Lindsay, White, Claudat & Velasquez, 2013). Additionally, it has been suggested that women misusing substances with weight-related concerns may be more prone to subscribe to dominant Western cultural values and ideals of appearance promoted in the media (Harrison, 2003; Levine & Murnen, 2009; Lopez-Guimera, Levine, Sanchez-Carracedo & Fauquet, 2010). Furthermore it appears that women with weight-related concerns may actively use substances, as they believe that such use will enhance their appearance and make them lose weight (Warren et al., 2013).

1.5 Food Choice During Substance Addiction

Food consumption plays an important role in health, and understanding the process of food choice is central to health promotion. A person's life-course transitions and trajectories are fundamental influences on the development of his or her personal system for making food choices (Devine, Connors, Bisogni & Sobal, 1998). Although food consumption is a basic human response to satisfy hunger, it also serves many other roles such as providing comfort, pleasure and social interaction (Sobal & Nelson, 2003; Wanksink, Cheney & Chan, 2003). For substance misusers their

relationship with food is somehow different.

The majority of substance misusers are at in increased risk of malnutrition (Himmelgreen, Pérez-escamilla, Segura-Millan, Romero-Daza, Tanasescu, 1998; Islam, Hossain, Ahmed & Ahsan, 2002), as their diets are often unstable with major changes in food and fluid consumption, modulated by substance misuse (Mohs, Watson & Leonard-Green 1990; Nolan & Scagnelli 2007; Himmelgreen et al. 1998). Their diets normally consist of a low intake of fruits, vegetables and grain nutrients, and a high intake of food containing fat and sugar (Zador, Wall & Webster 1996; Noble & McCombie 1997). Some of these diets have been associated with greater risk for chronic food-related diseases such as cardiovascular diseases and diabetes Howard, Arnsten & Gourrevitch, 2004; Poilkolainen, 1998; Rehm, Gmel, Sempos & Trevisan, 2002; Sutter & Vetter, 1999; van de Weil, 2004). Vitamin deficiency and liver disease are the two health problems that are commonly experienced with alcoholism (Oscar-Berman, Shagrin, Evert & Epstein, 1997). It has been pointed out that substance misusers are nutritionally deficient regardless of whether they consume healthy foods or not, as the use of substances causes the liver to focus on getting rid of toxins from the body, before it is able to work on any digestive and nutritional processes. This therefore influences the liver's ability to use any nutrition that has been ingested, and therefore hinders adequate absorption of nutrients into the blood (Lieber, 2003). The absorption of nutrients requires the digestive system to be working properly in order for the nutrients to be absorbed through a normal liver function. The misuse of substances affects this process and results in any benefit from nutrition that has been digested being lost (Taylor, 2010). Another complication that may affect the user's health is tooth decay and tooth loss, making the consumption of basic food, especially chewy foods problematic (Rees, 1992; Roy, Haley, Leclerc, Cedras, Blais & Boivin, 2003).

A study conducted by Baptiste & Hemelin (2009) found that 20 substance misusing women consumed half of the recommended number of servings of each of the four food groups (vegetables and fruits, grain products, milk and alternatives, and meat and alternatives) according to Canada's Food Guide To Healthy Eating (CFG) (Health Canada, 2007). Four servings of fruit and vegetables were on average consumed in comparison to the six or seven servings recommended by CFG. Interestingly, only

three out of the 20 women consumed this, in which the intake was in the form of juice as opposed to whole fruits and vegetables. Half of the women reported consuming only one meal during a 24-hour period, nine women had eaten two meals and just one woman had eaten three meals during the 24-hour period. The study revealed just over half of the foods consumed by the women were not included in the CFG groups. These foods included mainly sweets 41% (particularly chocolate), soft drinks and alcohol 37%, snacks 9% in the form of chips and popcorn, fats 11% and supplements 2%. Other studies reveal similar poor dietary intake of fruits and vegetables, but high consumption of drinks and sugars, which account for their main source of energy (Forrester, 2006; Nolan & Scagnelli, 2007).

The use of substances not only interferes with regular meals, but may also result in a person fasting for several days at a time and the use of some substances may also mean staying awake for several consecutive days (O' Connor, 2007). Depression, anxiety and stress are widely experienced by substance misusers and many suffer mental health problems (Turner et al., 2001). These symptoms influence the quality and quantity of their food consumption (Polivy & Herman, 2005). For instance in Baptiste & Hemelin (2009) study a woman substance misuser claims: "Because, sometimes I become a bit depressive then I don't eat" (Baptiste & Hemelin, 2009, p. 84). These symptoms may not only reduce their appetite for foods, but may also develop an increased desire to consume high calorie foods. For example studies have indicated that where chronic stress is evident, individuals are more likely to increase their intake of comfort foods that contain high amounts of fat and sugars (Dallman et al., 2003). Furthermore, Baptiste & Hemelin (2009) observed in their study that the women reached out for comfort foods when they experienced isolation and loneliness. A woman describes how food can be used as comfort: "It's like a way for me to ventilate shame...Like food has come to compensate drugs and food are my friends" (Baptiste & Hemelin, 2009, p. 85). Eating alone and eating late at night have also been associated with substance addiction (Noble & McCombie, 1997), which is often associated with a chaotic lifestyle including little organisation and daily structure (Ferguson, 2009).

1.6 Food Choice During Recovery

Recovery from substance addiction is viewed as the time where the addicted individual starts to move gradually away from former habits and patterns of thinking whilst learning new skills (Gorski, 1990; McDuff, Solounias, RachBeisel & Johnson, 1994), however returning to a normal diet can be challenging for many substance misusers. Years of substance misuse harms the body, via the effects of the substance itself as well as the negative lifestyle practices, resulting in an imbalance in their eating patterns (O' Connor, 2007). As substance misusers' diet is poor in nutritional value, it is essential to understand how these eating patterns are treated in recovery, particularly in treatment facilities.

A study in the United States conducted by Emerson and colleagues (2009) on 52 Latina and African American women attending residential treatment for substance abuse aimed to evaluate the residents' interest in nutrition, diet and exercise as an element of their treatment programme (Emerson, Amaro, Glovsky & Nieves, 2009). The study also aimed to establish weight gain concerns via interviews and by weighting 10 of the women weekly to capture any weight gained over a 12-week period. The women were in different stages of their recovery, ranging from 1 to 11 months. The residents were very interested in healthy eating and physical activity, but identified barriers to eating nutritious foods, such as the need to change shopping habits, menus and the snacks provided during their sessions within the treatment facilities. According to the U.S Department of Agriculture (USDA) the recommend total fat calorie intake is 20%-35% (USDA, 2005). Emerson and colleagues (2009) pointed out that meats purchased by the treatment centre were high in fat content and were less expensive, and many of the meals were cooked with oils. Though the ingredients purchased by the treatment centre did not help with healthy food choices, the women still overate on these high calorie foods, evident through their weekly food diaries. Most of the residents expressed frustration with not knowing how to eat well, for instance a woman pointed out: "In my experience all the ones I have met as addicts have never had healthy eating habits; we live our lives in the direction the wind blows" (Emerson et al., 2009, p. 1559). The women in the study also stated that they had no time to carry out physical activity, still, they expressed a desire to

incorporate exercise regimes as part of their treatment stay. They pointed out how the treatment centre could help facilitate this, by providing an exercise leader, a place to exercise and a timetable assigned to physical activities (Emerson et al., 2009). Interestingly, the study conducted director and staff interviews where it was reported that weight monitoring was not part of the treatment programme, although they recognise that unhealthy weight gain is very common in women attending treatment for substance misuse. The directors acknowledged that the meals provided could be healthier, and stated that budget and convenience were the main obstacles for changing the menus. They further highlighted that exercise was not part of the programme due to lack of trained staff to carry out exercise groups, lack of space, equipment and busy schedules (Emerson et al., 2009).

Although Emerson et al., (2009) conducted an important piece of research by evaluating the women's interest in nutrition and exercise, Badger, Reel, Leopardi, Durrant & Prosperco (2012) developed the Inside-Out-Health education programme, which actually aimed to raise awareness and improve health-related behaviours of women attending a substance misuse treatment centre. The overall aim of the programme was to prevent distorted eating behaviours through weekly sessions on nutrition, physical activity and body-image. Through this integrative approach, the women learned how to eat healthier meals and become more in tune with their bodies. Working on the women's self-esteem and confidence was an important goal, in order to help develop healthier behaviours. A number of the women pointed out that the programme helped them become more aware of their intentions behind their food choices and learn to differentiate between emotional and physical hunger cues. One woman attending the programme stated: "We've always used something to throw in our body whether it was a substance or food. When we would have a bad day, it was just something you did. After a hard day in therapy I would just always think I'm hungry… Now I'm starting to eat intuitively and pay attention to my emotions" (Badger et al., 2012, p. 156). The women emphasised that health education is not normally part of their treatment and how important and useful they found taking care of their health in recovery. Additionally, the women particularly enjoyed the physical activities they were taught in order to improve their fitness, as their treatment always involved sitting down for one-to-one or group therapy sessions (Badger et al., 2012). Although physical activity is beneficial for health-related reasons, it also provides

mental health benefits, including addressing body-image issues, during a crucial time where the individuals body shape may change (Reel et al., 2007).

1.7 Weight Gain in Recovery

The most important goal of substance-misuse treatment facilities is for individuals entering treatment to become abstinent from drugs and alcohol. Although substantial effort and time is devoted to helping recovering substance misusers maintain sobriety in their lives, not much focus has been given towards dietary behaviours and weight management, despite concern about these behaviours (Cowan & Devine, 2012).

Weight gain is partially due to the weight-loss side effects of the drug being removed from the body, as well as the association with the excess sugar intake during recovery (Brecht et al., 2004). Emerson and colleagues (2009) found that women attending treatment for substance misuse, gained an average of 6.5 lb within the first 12 weeks of treatment. More interestingly, 80% of the women were overweight or obese from the start of them entering the treatment progamme and carried on gaining weight during the study period. Though the women explained using drugs and alcohol helped them to lose weight and control their weight, their weight did not decrease to the extent that they were underweight or even of normal weight with regard to their BMI. According to Emerson et al., (2009) this suggests that the increased weight gain may be associated with overeating and physical inactivity, rather than an attempt to reinstate normal weight.

Hodgkins, Frost-Pineda & Gold (2007) found similar results in their study on nutrition and exercise where all participants attending substance misuse treatment, regardless of the intervention received, gained weight during the 8-week intervention. Although both groups gained weight, the control group, who did not receive any exercise or nutrition education, gained most weight (Hodgkins et al., 2007). Another two studies demonstrated weight gain during treatment from drug and alcohol use; in a treatment centre for adolescents, significant weight gain during the first 60 days of treatment was evident (Hodgkins, Cahill, Seraphine, Frost-Pineda & Gold, 2004), and a study examining the effects of diet on weight and liver function in 264 drug-

dependent patients, found that 69% of the patients increased their weight (Fontaine, Cheskin, Carriero, Jefferson, Finley & Gorelicket, 2001). The excess weight increase in treatment and recovery may contribute to health problems, as obesity may play a key role in increasing chronic conditions (Howard, Arnsten & Gourrevitch, 2004; Sutter & Vetter, 1999).

1.8 Preference for Sweet Tastants During Recovery

Alcohol dependent people in early recovery have been recommended to consume sweet-tasting foods to help with the alcohol cravings, for instance in the 12-step programme of Project MATCH, clinicians advise clients to follow recommendations found in 'Living Sober', which point out: "We can only pass on the word that thousands of us - even many who said they had never liked sweets - have found that eating or drinking something sweet allays the urge to drink" (Nowinski, Baker & Carol, 1995, in Krahn et al., 2006, p. 623). The lesson in 'Living Sober' further indicates that some alcohol dependent individuals may be at increased risk of becoming 'sweet addicts' (Krahn, Grossman, Henk, Mussey, Crosby & Gosnell, 2006, p. 623).

Some studies have proposed a link between a preference for sweet foods and drug and alcohol intake. For example Kampov-Polevoy, Garbutt & Janowsky (1997) revealed in their study that detoxified alcoholics favoured very sweet sucrose solutions, in contrast to the control subjects, and Janowsky, Pucilowski & Buyinza (2003) observed a similar sweet desire by cocaine users. Krahn et al. (2006) conducted a Randomized Controlled Trial (RCT) study exploring the use and avoidance of sweet food in alcohol dependent patients attempting to become abstinent from alcohol. Krahn and colleagues (2006) found whilst in the first month of recovery alcohol dependent (AD) patients reported highly pleasant reactions to the sweetest tastant more regularly than the control (C) patients. Hence, when the retests where carried out at 1 and 6 months, the results indicated that the AD patients favouring the highest concentration of sucrose declined after a while. The 6 months retest confirmed that the sweetest tastant amongst the AD patients had declined by 50% and was now

at a similar level to the C patients. The study revealed that AD individuals who were in recovery for 6 months were less likely to favour the sweetest tastant when compared to the AD individuals who did not sustain abstinence from alcohol. This suggests that there is an association between sugar preferences in the early stages of recovery, with a decline of sugar preference through longer periods of recovery. Additionally, Krahn and colleagues (2006) reported that the AD patients gained weight during the first 6 months of recovery, compared to the non-abstinent group. Their findings support other research on weight gain, particularly during the early stages of recovery (Emerson et al., 2009; Hodgkins et al., 2007).

1.9 Food & Brain Chemistry

It is well known that the misuse of substances increases dopamine levels in the brain (Wise, Leone, Rivest & Leeb, 1995), and likewise the consumption of sugar-rich foods also elevates the release of dopamine (Fortuna, 2010). Carbohydrate cravings have been referred to a serotonin craving, which functions as the main anti-depressant neurotransmitter and plays its part in modulating pain and controlling sleep. Sugar rich foods lift serotonin levels, which also mean that they lift a person's mood and help with pain. It has been identified that individuals with obesity, bulimia, binge eating disorders, stimulant drug misusers, alcohol misusers and smokers show signs of chronic carbohydrate craving (Fortuna, 2010). Consuming sugar rich foods after binging on alcohol or when trying to abstain from alcohol, substitutes the alcohol, by producing the same effects on the brains neurotransmitters. Brain chemistry for individuals with alcohol dependence and other addictive behaviours including binge eating disorders, bulimia and obesity has been linked with a defective endorphin system (Fortuna, 2010). For some individuals food plays a central role in the release of beta-endorphin (Gianokolakis, Angelogianni, Meaney, Thavundayll & Tawar, 1990), where sweet preference is seen as a compensatory behaviour for a deficient beta-endorphin system. Fortuna (2010) states that sweet preference or 'sugar addiction' may be "another form of self medication to correct a neurobiological deficiency" (Fortuna, 2010, p. 149).

The Relevance of This Study

There is a vast amount of literature on weight changes and eating behaviours for women during active substance addiction, however little is known about these processes during the recovery phase. Weight changes, the meaning of food and eating amongst *women* in recovery from substance addiction have not been studied in one single study previously, though a study carried out in the United States exploring the roles that food plays during the recovery process amongst *men* have been identified (Cowan & Devine, 2008). It is important to gain an understanding of behaviour associated with food choices among substance misusers in recovery, in order to decrease disease and promote improved well-being and health. Additionally, by gaining an in depth understanding of the experience of food, eating and weight concerns, it may be possible to address the issues faced by women in recovery settings. Improvement of polices or programmes regarding nutrition education in recovery facilities may be enhanced and further incorporated into treatment programmes, addressing specific needs at each stage of the recovery process.

The aim of this study is to understand how women in recovery from substance addiction experience weight changes, and how they describe the functions and meaning of food and eating behaviours. The study additionally aims to develop a theory to explicate their experiences from these processes.

CHAPTER 2
METHODOLOGY

The current chapter will aim to explore the adoption of a qualitative approach for this research. The first section of this chapter will discuss the general features of qualitative approaches, alongside a detailed description of the qualitative method selected for the data collection and analysis. The second section aims to outline the specific recruitment strategies, data collection and analysis. The last section of this chapter will highlight ethical considerations.

2.1 Design

2.1.1 Qualitative research

The current study is an exploratory study aiming to understand the multiple experiences, meanings, and functions of weight change, food and eating from the perspective of women in recovery from substance addiction. It also aims to develop a model of these processes, through an explanatory framework to help enhance our understanding of these experiences. A qualitative research design is considered the most appropriate method to suit the aims of this study. Qualitative research is an extensive field and there are a number of qualitative methodologies, which have been emerged from a range of philosophical beliefs (Patton, 1990; Willig, 2008). They also share multiple common characteristics and are considered better suited to specific research enquiries. The suitability of such a design for the current study is outlined below.

Qualitative research is a form of social inquiry that tends to focus on how people interpret and make sense of their experiences and the world they live in. Qualitative approaches can be used to explore and understand what it means and how it feels to experience a certain condition, and how a person may cope with a particular situation (Willig, 2008). This kind of research can include broad enquiries about human realities and experiences researched via contact with individuals within their natural

surroundings, generating rich data to aid the researcher in understanding the lived experience of the individual (Boyd, 2001). Thus, qualitative designs in that aspect are naturalistic, they attempt to understand phenomena as they happen naturally in the world, free of projection of research outcomes. This differs extensively from quantitative experimental designs, where hypotheses are generated and variables are controlled and manipulated to test the outcome predictions. Such control and manipulation creates a context that is unnaturally constructed and therefore does not take into account everyday social reality (Patton, 1990). Qualitative methods, in contrast, seek to uncover subjective meanings derived from the data and deepen the understanding of the specific phenomenon being studied. Utilising a qualitative design is recommended when the main aim of the study is to explore and develop an insightful understanding of the person's behaviour, feelings, perspectives and experiences within their own territory (Flick, 2002).

Within qualitative research, it is important for the researcher to build rapport with the participants, by interacting with them and their reality. This develops a deep understanding of the participant's experiences and the meanings they apply to these particular experiences. Therefore one of the main strengths of qualitative research is the close contact with the participant, the environment and data to influence the researcher's interpretation of the phenomenon studied. Though the data is based on the participant's meanings and experiences, the positioning of the researcher is to constantly reflect on the data and analysis. The reflections of the researcher are seen as an additional source of data, in which the reflections are incorporated into the interpretation. This stance is excluded in quantitative designs (Flick, 2002). The reflection process allows the reader to assess how much the of the researcher's interpretations of the data has changed or influenced their knowledge of the study topic.

Qualitative methodologies are iterative in the sense that data collection and analysis are linked, each informing the other. Therefore, the designs are generally flexible where the study's aims direct the initial sampling, data collection and type of analysis. These elements however, could change as a result of new understandings evolving, and consequently shape the final research design (Patton, 1990).

A qualitative design was considered most suited to meet the primary aims of this research by developing an in-depth understanding of the women's experiences with weight changes, and the meanings of food and eating during their recovery process from substance addiction. This type of methodology allows specific and detailed descriptions of the subjective meanings of the women's experiences, and also allows the experience to be reflected upon by the researcher. Seeing that the current study has an exploratory aspect to it, a flexible design is considered important, in order to move from analysis to a general theory. One type of such qualitative method is grounded theory method (GTM).

2.1.2 Grounded Theory Methodology

Grounded theory methodology was devised in 1967 by two social psychologists, Glaser and Strauss, as a way of generating theory or developing explanatory models of people's social processes from the data collected (Eaves, 2001). Since the discovery of grounded theory method, four main approaches were evaluated including Glaser & Strauss (1967), Glaser (1992; 1999; 2004), Strauss & Corbin (1990; 1998) and Charmaz (2006). All versions of grounded theory methodology discuss the key principles of 'symbolic interactionism, 'pragmatism', 'open mind' and 'theoretical sensitivity', but with different epistemological and philosophical standpoints in relation to these key components. The approach incorporates underlying components throughout the research process referred to 'constant comparative methods', 'theoretical sampling' and 'theoretical saturation' and uses systematic procedures and constant comparative methods of data analysis in order to develop a theory. The approach represents a bottom-up method whereby theory emerges from a step-by-step analytic process of data collection, coding and analysis (Speziale & Carpenter, 2003). Grounded theory methodology is exploratory where the researcher generally starts the study with a broad unstructured topic and often narrows the topic as the study progresses. The data collected becomes increasingly more focused as the study goes on because the researcher is undertaking analysis and data collection concurrently, allowing the topic to become more focused. Participants are selected based on a process known as theoretical sampling, in which participants are selected based on

theoretical relevance. This process involves choosing new participants to compare with the ones that have been already studied, or going back to previous participants to explore and investigate further (Strauss & Corbin, 1990). Data collection and analysis are continually evaluated and revised in order to identify patterns, similarities and differences emerging from the research, to finally construct a theory grounded in the data (Glaser & Strauss, 1967). The strength of grounded theory methodology is that it is not pre-conceptualised by a theoretical framework. As with other, inductive techniques, the literature review is delayed in order to avoid any preconceived ideas, as carrying out a major literature review in the beginning may force the data into pre-existing categories. By delaying the literature review the researcher can explore their own ideas, rather than imposing them on the data based on previous research. Though it is recommended to delay the literature review, familiarity with the literature around the research topic is suggested, as it provides a starting point open to further exploration (Charmaz, 2006).

Why constructivist grounded theory methodology

Within the Glaserian approach it is pointed out that with an 'open mind' alongside 'theoretical sensitivity' the theory is naturally allowed to emerge, rather than forcing meaning into the data. 'Open mind' refers to entering the research without any fixed ideas, whilst 'theoretical sensitivity' allows the researcher to differentiate between important and less important data (Holloway & Wheeler, 2002). Glaser (2004) strongly believes that patience is needed, but with perseverance the theory will emerge. However, one could argue that the discovery of theory is not a simple open-ended psychological process as Glaser (2004) proposes, but a self-conscious and intentional search for the logic on how one arrives at theory development. Therefore, the researcher did not apply this version of grounded theory methodology to the current study, as the theory that emerged may be influenced by the researcher's own beliefs.

Strauss and Corbin (1998) have lightly focused on the issue of the reliability and validity of theory development during analysis. They propose certain techniques to help the researcher in maintaining the balance between sensitivity and objectivity, including thinking comparatively and triangulation of data using various methods of

data collection. However, their inflexible procedural techniques have been challenged by a number of researchers, highlighting that the techniques used in the analysis could consequently lead to meanings being driven by the researcher or forced onto the data by researcher (Glaser, 1992; 2004; Heath & Cowley 2003; Dick, 2005). The researcher in the current study agreed with the researchers and also believed that utilising such rigid techniques, would mirror a positivist approach.

Since the inception of grounded theory methodology, a number of researchers have adapted the approach, moving away from its positivistic assumptions in both Glaser's and Strauss and Corbin's versions of the method, which aimed to discover causal explanations and make predictions about the world and its surroundings. Positivist methods assumed a passive observer who collected facts, but did not participate in collecting them, remaining separate and distant from the research participants and their realities (Glaser, 1992; 2004; Strauss & Corbin, 1990; 1998 & Charmaz, 2006). Though there are several versions of grounded theory, researchers can still adapt the basic grounded theory guidelines, such as comparative methods, memo-writing, sampling for theory development and coding in a neutral way (Charmaz, 2006). The current study will follow the basic grounded theory guidelines, and adopt Charmaz's (2006) constructivist approach to grounded theory, which emphasises reflexivity and flexibility throughout, in contrast to objectivist grounded theory, which resides in the positivist tradition. Both the founders (Glaser & Strauss 1967), Glaser (1992; 1999; 2004) and Strauss & Corbin (1990; 1998) have given little attention to the relationships between participants. Charmaz's version of grounded theory highlights the importance of the researcher's role regarding their interpretation of the data via their interaction with the participants and the data during the research process. In the classic work of Glaser and Strauss, they talk about how emerging theories are discovered separate from the researcher, whereas Charmaz assumes that:

> *"Neither data nor theories are discovered. Rather, we are part of the world we study and the data we collect. We construct our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices"* (Charmaz, 2006, p. 10)

As the researcher already works with women in recovery from substance addiction, utilising a constructivist grounded theory approach presented numerous advantages. It would allow the researcher for this study to stay as close as possible to the data: analytic methods such as line-by-line coding and constant comparative analysis, characteristic of this approach, would enable the researcher to bring in their interpretations of the data in at the later stages of the analysis, once categories had been drawn out from the texts (Dallos & Vetere, 2005). Constructivist grounded theory method also views reflexivity and the researcher's role during the formation and analysis phase as central (Charmaz, 2006). The approach would therefore allow the researcher for this study to decrease the influence of their biases and preconceptions regarding the emerging theory by reflecting on these processes. This procedure will enable the reader to assess the influence of the researcher's own biases and preconceptions on collecting the data and interpreting the results.

The researcher felt that the methodology of constructivist grounded theory would provide a systematic approach that would lead to theory development, which is useful when the subject area has been under researched. This approach appeared to be appropriate due to the lack of understanding surrounding the topic in the UK. Many researchers point out that due to the emphasis on discovery and the need to enter the research process with an open mind, this approach is most suitable for phenomena where a deeper understanding is required (Glaser & Strauss, 1967; 1998; Holloway & Wheeler 2002; Denscombe, 2003). Though weight increase and dysfunctional eating behaviours (Stice & Shaw, 2003; Parkes, Saewyc, Cox & MacKay, 2008; Stice, Ng & Shaw, 2010; Warren, Lindsay, White, Claudat & Velasquez, 2013), have been observed among substance misusers in recovery from drug and alcohol addiction, little is known about the multiple experiences, meanings, and functions of weight change, food and eating during the recovery process. Therefore using this approach will enable the researcher to explain the phenomena from the perspective of the womens' experiences of weight changes and facilitate an in-depth understanding of the womens' meanings applied to food and eating in recovery. As little is known about the subject matter, grounded theory is particularly useful as it attempts to draw out the important issues for a certain group of individuals, and generate meaning about those issues through the analysis process and theory building stage (Glaser, 1978; McCann & Clark, 2003). Grounded theory builds a theory from exploring

various individuals' who share the same processes, interactions or actions and that are unlikely to be located in the same place or interacting so regularly that they develop shared patterns of behaviour and beliefs (Creswell, 2007). These can be explored through theorising, which holds the key to unlocking the reasons for behaviours. It was deemed that the pragmatic roots of grounded theory would not only develop theory, but also aid practitioners to develop a new theoretical understanding of the topic and consequently enlighten the design of interventions (such as nutritional education) for women in recovery settings. This methodology would therefore provide a means of answering the research questions posed and fulfil the aims of the study.

2.2 Procedure

2.2.1 Participants

The study adopted two sampling procedures: purposive sampling and theoretical sampling. Initially the study used a purposive sampling method of three participants. Purposive sampling uses the knowledge of the researcher to choose participants who possess specific characteristics (Berg, 2001). The researcher intentionally selects the participants with a particular purpose in mind. There were three key aspects on which the participant inclusion criteria were based. The participant had to be a woman over the age of 18, and in recovery from drug and alcohol addiction. Recovery time had to constitute at least one month of abstinence from drugs and alcohol. The length of one month was chosen as this is the earliest stage of recovery and considered as a time when the client moves into treatment and focuses on becoming abstinent (Flores & Georgi, 2005). Within grounded theory not all participants can be chosen at the beginning of the data collection process (Glaser, 1978). As the study progresses, theoretical sampling is used seeking further data collection for the purpose of *developing* the emerging theory (Charmaz, 2006). During this phase, specific concepts that emerged earlier can be tested, discarded and expanded, by accurately deciding on further participants and questions that may need additional elaboration. The participants at this stage are not selected on the basis of their representativeness,

but rather their knowledge of the phenomenon that requires further understanding or clarification (Smith & Biley, 1997). This would entail follow up interviews with the initial participants or interviewing other appropriate participants that have expert knowledge to further clarify unclear aspects of the research (Jeon, 2004). The researcher in the current study coded and analysed the data from the initial three participants, before deciding which data to collect next, in order to further develop the theory. As the study progressed, an additional five participants were selected using theoretical sampling. The five participants at this stage were women not interviewed before and during this phase further questions were developed. The women at this stage had to still meet the set criteria mentioned earlier, however more focused questions were used during the interviews, building on from what the previous three participants discussed in order to further develop the emerging theory. Sampling continued until a level of theoretical saturation had been reached. Theoretical saturation occurs when there is no new data to generate further theoretical insights (McCann and Clark, 2003). All the categories at this stage had been 'saturated', explained and interpreted (Saturation and theoretical sufficiency are explained in detail under data analysis).

The Process of Recruitment

Prior to gaining approval from two substance misuse treatment services, the purpose of the current research study was explained to the manager of each service and a brief overview of the proposed research was sent to the managers (ethical considerations discussed at the end of this chapter). This overview was also advertised within these services to raise awareness of the study. The interviews took place at a location that the participant preferred, and that provided privacy. The interviews were additionally arranged at a time convenient for the participant. All the participants were briefed about the study verbally and provided with a written overview of the study's aim and intention (Appendix A includes the briefing letter). They were all given time to read through the briefing letter, prior to the interview, before written consent was obtained from each participant. The consent letter included agreeing to participate voluntarily, agreeing to have the in-person interview audio-recorded and agreeing for the researcher to use anonymous quotations in any written work or publication that comes of this research (Appendix B includes an example of the consent letter). Participants were all aware that they had the right to withdraw from the research at any stage

during the interview and were not obliged to give a reason for their withdrawal. On completion of the interview, each participant was given a debriefing letter, which thanked the participant for their generosity and willingness to participate in this study. It also included specialist contact details for places to contact if they felt distressed or wished to speak to someone about their thoughts. Additionally, the letter included a couple of references within this area of research for them to peruse if interested (Appendix C includes the debriefing letter).

A protocol was in place for the researcher to follow if participants become distressed during participation. This protocol has been created to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the research, as some may be suffering from psychological trauma as a result of their previous experiences. The protocol created by Chris Cocking (2008) follows a three-step process detailing signs of distress that the researcher would look out for, as well as action to take at each stage (Appendix D includes the protocol).

At the end of each interview, the researcher asked the participants about how they thought the interview went, particularly emphasising what they had said and what the researcher had asked. This form of inquiry allowed the researcher to understand the participants' experience of the interview and enabled the researcher to reflect on what the researcher asked, and how the researcher asked the questions during the interview. All the participants that took part in the research indicated that they felt at ease during the interview and none of them claimed they felt distressed. Many highlighted that they enjoyed the experience and found that taking part was valuable. They pointed out that they were pleased that somebody was interested in understanding their experiences.

2.2.2 Data Collection Procedures

Grounded theory is a method that utilises methods of data collection that generates rich data that are "detailed, focused and full" (Charmaz, 2006, p. 14). By gathering rich data, such as in-depth interviews, the researcher can generate "strong grounded theories" from the data itself (Charmaz, 2006, p. 14). An in-depth interview can be

compared to a directed conversation, which enables a detailed exploration of a topic in which the research participant has relevant experience (Lofland & Lofland, 1995). The current study employed individual in-depth face-to-face interviews as the main source of data, structured around open-ended and semi-structured approaches, as they yield rich and detailed elements of the participants' experiences, views, intentions, actions, feelings, structures and contexts of their personal lives (Charmaz, 2006; Goulding, 2002). These approaches follow a kind of formal interview, whereby a guided conversation takes place between the researcher and the participant, but also at the same time enables the participant to take control of the interview content (Duffy, Ferguson & Watson, 2004). In grounded theory, flexibility allows the researcher to use a number of data collection methods to attain rich theoretical data. Charmaz (2006, p. 14) states:

> *"Like a camera with many lenses, first you view a broad sweep of the landscape. Subsequently, you change your lens several times to bring scenes closer and closer to you".*

The data was initially collected through open-ended interviews and only a few broad, open-ended questions were explored at this stage. The open-ended questions gave a broad understanding of women's weight changes, food and eating experiences in recovery from substance addiction. As stories and statements started to emerge, the lens changed to provide a different view in the second phase of interviews (Appendix E includes the full interview schedule). The interview guide at this stage followed a semi-structured approach in which more focused questions were developed in order to obtain data to explicate the already existing categories. The following general questions were asked in both phases of the interview:

1. How long you have been in recovery?

2. Have you noticed your weight changing during recovery (how)?

3. What does food mean to you?

4. Tell me about your eating behaviours.

2.2.3 Data Management

All interviews were recorded by a dicta-phone, where the dicta-phone was placed in view of the participant and turned on before the interview commenced. All interviews were transcribed by the researcher and placed on a word document, leaving space on the right hand side of the sheet for coding purposes. Chronological numbers were allocated to each line, in order to easily track the original data during later stages of the analysis. The researcher transcribed the entire interviews, in order to avoid the risk of losing valuable data, but also transcription of the data brought the researcher closer to the lived content of the interview. To ensure the accuracy of the transcripts, each interview was re-examined and compared with the audio file. The transcripts of the interviews were all stored securely on an unshared laptop. Anonymising transcripts was a priority and care was taken to identify information that could possibly uncover a participant. Where there was potential identifiable information, a cross mark was inserted as a replacement to orientate the reader. Pseudonyms were adopted to protect the real identity of the participants and used in alphabetical order, in order to maintain the order that the participants were interviewed.

2.2.4 Data Analysis

Grounded theory analysis does not follow a linear path, rather, data analysis in this approach occurs right from the start of the research process. Typical characteristics within the data analysis include coding, categorising, memoing and integrated review of the existing literature. Data collection, analysis and conceptual theorising is a continuous procedure within this methodology, until a theory is generated, grounded from the data itself. Grounded theory follows a detailed and focused step-by-step process. This section details the research journey accounting for the methods used in analysing the data.

Open Coding
The first stage of the analysis included open coding or initial coding, which involves examining each sentence of the transcripts line-by-line and/or incident-by-incident

(Appendix F includes an example of open coding). Line-by-line coding helped the researcher reduce any preconceived notions of the data, by building the analysis from the ground up based on the participants' statements. The researcher in the current study stayed as close as possible to the data, line-by-line, and integrated the participants' own words into the coding process. Charmaz names these codes *in vivo* codes referring to the participants' special terms and serve as "symbolic markers of the participant's speech and meanings" (Charmaz, 2006, p. 55). Using *in vivo* codes enabled perception of their experience, from their perspective. If the meanings of the participants' statements are ignored, the analysis may reflect an outsider's perspective, rather than an insider's perspective (Charmaz, 2006). Additionally, she points out there is a risk of importing a pure professional language to describe the experience. Therefore within the initial coding, some of the labels were the actual words used by the research participants, whilst others were more descriptive. At times several interpretations of the data were made, by questioning 'What does this mean?' or 'What is going on here?' (Strauss & Corbin, 1990; Charmaz, 2006). This sometimes resulted in two codes allocated in one sentence. Thoughts and questions about certain codes were reflected on in memos, described later in this section.

Focused Coding

The second major stage of analysis was focused coding. Focused coding is more directed, selective and conceptual than the open coding. Focused coding was used to sift through large amounts of data by capturing and synthesizing the main themes through exploring earlier initial codes (Glaser, 1978, Charmaz, 2006). At this stage the codes from the initial coding were categorised into focused codes, in which similar codes were grouped together into meaningful units for further exploration. Through focused coding the researcher moves across interviews to capture the most reccurring themes in the participants statements (Charmaz, 2006). When undertaking focused coding the researcher in the current study compared the women's experiences, actions and interpretations to gather common codes emerging from the data. For example one focused code emerged as *weight gain*. All the data across the interviews were explored to understand how each woman spoke about *weight gain*. The experience of *weight gain* was compared amongst the women, and aided the researcher to define *weight gain* as a focused code. The researcher was led to explore the reasons behind weight gain, the impact of weight gain and the strategies they used

to cope with weight gain in recovery. The focused code *weight gain* was then considered whether it should be developed as a category. A category represents a common theme or pattern in several codes. It seeks to explain what the participant has said and is interpreted by taking into consideration the other interviews. During the early analysis, it is important to note that when some of the focused codes where considered as categories, this was only provisional. The researcher remained open to evaluate whether these tentative categories would be kept as conceptual categories to help shape the emerging theory.

Constant Comparative Analysis

Comparative analysis is an essential feature of grounded theory (Strauss & Corbin, 1998). The constant comparative method was used during the entire analysis, which enabled comparisons between events, participants and categories. During the analytic process, the method was not only used to compare data, but to also identify similarities and differences in order to assist with the development of categories. The comparison method helped connect categories together, which is crucial in the theory development process (Charmaz, 2006). Though theory is grounded in the data, the constant comparative method simultaneously validates the theory through this approach (Strauss and Corbin, 1998). Through employing the comparative analysis, data earned its way into the study when the method uncovered recurrent patterns in the data (Chiovitti & Piran 2003). The researcher in the current study continually returned to the participants' statements by using previous data and analysis in order to influence future data collection and analysis.

Memo Writing

Memo writing is a fundamental tool in grounded theory, and is used between the stages of data collection, analysis and theory development. Memo writing prompts the researcher to stop, explore and discover their ideas about the data, particularly during category formation (Glaser 1978; Strauss & Corbin, 1998; Charmaz, 2006). The researcher used memo writing during the early stages of the analysis and continued until the main findings were defined. Charmaz (2006, p. 72) describes memo writing:

> *"Memo-writing provides a space to become actively engaged in your materials, to develop your ideas, and to fine-tune your subsequent data-gathering".*

Memo writing allowed a place for exploration that proved valuable, as all the researcher's thoughts were recorded in one place. Memos were typed as short analytic paragraphs on a word document and used as an 'analytic diary' to record thoughts or ideas that occurred at the time. It was important to capture and record these insights as they came to mind to use at the time or for later retrieval. The use of memos helped the researcher analyse codes, categories and data and assisted the researcher in developing the focused codes into main categories, by identifying similarities and connections within the data. Additionally, memo writing was used to raise questions about the data that were unclear or needed further clarification. These questions helped the researcher to determine leads to follow through theoretical sampling.

Saturation or Theoretical Sufficiency

Saturation in grounded theory refers to the point at which the researcher has identified that no additional data can be obtained. As the researcher approaches saturation, less and less new data is revealed and there are no new theoretical insights emerging. Data collection stops at this point (Charmaz, 2006; Glaser, 1978). It is important to note that saturation is not the repeated occurrence of the same stories that participants share, rather the richness of the data is imperative. For example one of the intentions of the current study was to determine whether women in recovery experienced weight changes. Though most of the women in the interviews stated they did, *weight change* was not saturated without analysing the experience of weight change and what it portrayed. If the researcher engages in limited analytic treatment, early saturation may produce less rich data. There are a limited number of guidelines for settling with an adequate sample size or deciding on the right amount of data necessary to achieve saturation (Morse, 1995). Charmaz (2006) indicates that category saturation is not dependent on the sample size, whereby some studies may have a small sample size, but still achieve a rich project. Though the study needs to be representative, in grounded theory the researcher must be mindful of collecting vast volumes of data, as this could potentially lead to the researcher becoming overwhelmed by the data and lose track of the prominent aspects of the research (Stern, 2007). Whether saturation is fully achievable has been debated. The term 'theoretical sufficiency' has been increasingly adopted as an alternative and the term 'saturation' has been challenged in grounded theory where it has been stated that categories are not saturated by the data, but *suggested* by the data (Dey, 2007; Charmaz, 2006). Data collection and analysis

for the current study was a continuous process until no new theoretical insights emerged. The researcher used these as signals to end the data collection. The sufficiency of the sample size and collected data was determined by the quality of the data. Taking into consideration the questions raised about saturation, the study aimed to achieve theoretical sufficiency.

Conceptualisation & Theory Development

Conceptualisation is the stage after the coding phase and before theory development. Conceptualisation involves raising the most significant categories to concepts. These main categories shape and become concepts of the theory (Charmaz, 2006). Deciding on which categories to raise into concepts entailed the researcher determining which of the categories contained important characteristics that would make the data meaningful and help move the analysis forward (Charmaz, 2006). According to Clarke these categories should stand out because they carry "substantial analytic weight" (Clarke, 2005, In Charmaz, 2006, p.139). The categories in the current study emerged through the data and the high frequency mention from the participants helped the researcher identify them. During the early data collection and analyses, the researcher identified initial categories to aid with the theorising process. Although the researcher kept these categories in mind when carrying out the second phase of interviews, the researcher was cautious not to stay too close to these categories, but rather stay open to further new data. However, as the study progressed it became clear that the initial categories were all linked to the other categories.

Developing categories into concepts involves exposing them to further analytic shaping and evidencing their relationships to other concepts. Concepts in traditional grounded theory are represented as core variables, which hold "explanatory and predictive power" (Charmaz, 2006, p. 139) whereas, in constructivist grounded theory, the core variable does not serve as a main feature. Instead, Charmaz (2006) views the concepts as interpretive frames in which they provide deep understanding of relationships. In comparison to the core variable, they additionally represent more data and are often more obvious within the data. The concepts within this study guided the researcher to generate a theory, which differs from just describing a phenomenon, as grounded theory must go beyond description by providing a conceptual abstract explanation of the phenomenon under study (Corbin & Strauss

2008; Holton, 2007). The researcher in the current study developed theoretical concepts by continually moving through the data and constantly making comparisons of the data. That process itself became more and more focused and the formation of categories predominantly became more obvious. This represented within it the development of a theory that integrates the theoretical concepts that exist within the data. Chapter 3 includes a detailed account of the categories that shaped the emerging theory.

2.3 Ethical Considerations

This study was granted ethical approval from London Metropolitan University and was carried out according to the British Psychological Society (BPS) and the Health and Care Professions Council (HCPC) ethical guidelines. As the researcher already works with individuals who misuse substances, it was seen unethical to conduct interviews with the same client group that attend the service for treatment. A number of factors were considered when making this decision. Firstly, clients within the same service may have felt obliged to take part. Though participation is voluntary, they may believe it is part of their treatment. Secondly, clients may have misinterpreted the researcher's role and the aims of the research. As the researcher knows some of the participants well, the researcher may be seen as the facilitator with their treatment, rather than a researcher. Thirdly, clients may have been uncomfortable disclosing particular personal experiences with the researcher given the existing therapeutic relationship and continued contact after the research. Given the above disadvantages for recruiting participants within the same service, a number of different substance misuse services were contacted for the purpose of recruiting participants as ethically as possible. Ethical clearance was granted from two separate drug and alcohol services (Appendix G includes approval letters from both services).

CHAPTER 3
FINDINGS & DISCUSSION

The purpose of this chapter is to present the findings from the data analysis for eight women in recovery from substance addiction. It will identify and discuss the various categories that influence the emerging theory presented in this study, and the findings will also be discussed in relation to the existing literature. A portrait of each of the participants is included to provide a brief description of their lives and to orient the reader about their personal recovery process.

3.1 Participant Portraits

While all the women who participated in this study were in recovery from substance addiction, their characteristics differed greatly. The women in the study were between 25 and 65 years old. Seven of the women were British White, whilst one was British Asian. The women also had diverse employment status, where four of the women were volunteers, one retired, two were unemployed and one of the women was working. Only three of the women were married; the other women were widowed or divorced.

Interview 1- Angela

Angela is British-Asian married woman in her mid-forties. She lived with her husband and teenage son. Angela was abstinent from alcohol for five years and then relapsed in 2010. At the time of the interview she was nine months into recovery. She is currently unemployed. In 2006, Angela was diagnosed with atypical anorexia nervosa, but does not believe she is anorexic and has chosen not to see any local eating disorder professionals since her move.

Interview 2- Betty

Betty is a White-British married woman in her mid-forties. She lived with her husband, daughter and son. She was 10 months into recovery from alcohol addiction at the time of the interview. Betty was unemployed, but had recently started volunteering at a community treatment centre for substance addiction in an aid to support other people in active addiction and recovery from drug and alcohol misuse.

Interview 3- Charlotte

Charlotte is a White-British woman in her mid-twenties. She was in a long-term relationship and lived with her parents and other siblings. This was her first attempt at maintaining sobriety and was 14 months into recovery from drug and alcohol addiction at the time of the interview. Charlotte, like Betty was also a volunteer at a drug and alcohol service. She started volunteering quite early in her recovery and now facilitates support groups for other addicts and recovering substance misusers.

Interview 4- Daniella

Daniella is a White-British widowed woman in her early-fifties. She lived on her own and had an adult son, daughter and grandchildren whom she saw regularly. She had attempted to abstain from alcohol previously, but relapsed and was now three and a half years into recovery from alcohol addiction. Daniella had recently suffered from a heart attack. She was unemployed, but was a mentor for two clients at a local community substance misuse service. She also used the service once a week to touch base with her recovery.

Interview 5- Eileen

Eileen is a White-British married woman in her mid-sixties. She lived on her own, due to her past alcohol misuse, but spent time with her husband daily. She has two adult sons whom she saw occasionally. Eileen, like Danielle had attempted to abstain form alcohol on numerous occasions, but repeatedly relapsed. At the time of the

interview she was 17 months into recovery from alcohol addiction. Eileen was a retired secretary.

Interview 6- Fae

Fae is a White-British divorced woman in her late-forties. She lived in her own home with her adult son. She also had a daughter and a grandchild whom she regularly looked after. Fae had also tried giving up her substance addiction in the past, but constantly relapsed. At the time of the interview she was three years into recovery from drug and alcohol addiction. Fae had recently had a hysterectomy. She was currently part of a volunteer industrial refurbishing scheme for recovering substance misusers. Fae attends a spiritual church once a week and has strong faith in it.

Interview 7- Gina

Gina is a White-British divorced woman in her late-fifties. She shared her home with her partner and adult daughter. Gina has been in recovery on and off. At the time of the interview she was 11 months into recovery from alcohol addiction, but has had the occasional drink during this period. She recently had her gall bladder taken out. Gina works part-time as a personal assistant.

Interview 8- Hazel

Hazel is a White-British divorced woman in her mid-fifties. She has two adult daughters, a son and a grandchild. She shares her home with her son. She is in a long-term relationship. Hazel has been in recovery from alcohol addiction for 16 years and is currently in recovery from food addiction, as she refers to it. Hazel is currently unemployed, but uses her time to attend food groups regularly.

<u>Note</u>

The primary substance that all eight women misused during active addiction was alcohol. A number of them also used drugs alongside. The women mostly relate the discussions to their alcohol addiction.

3.2 Stage 1: Descriptive Analysis
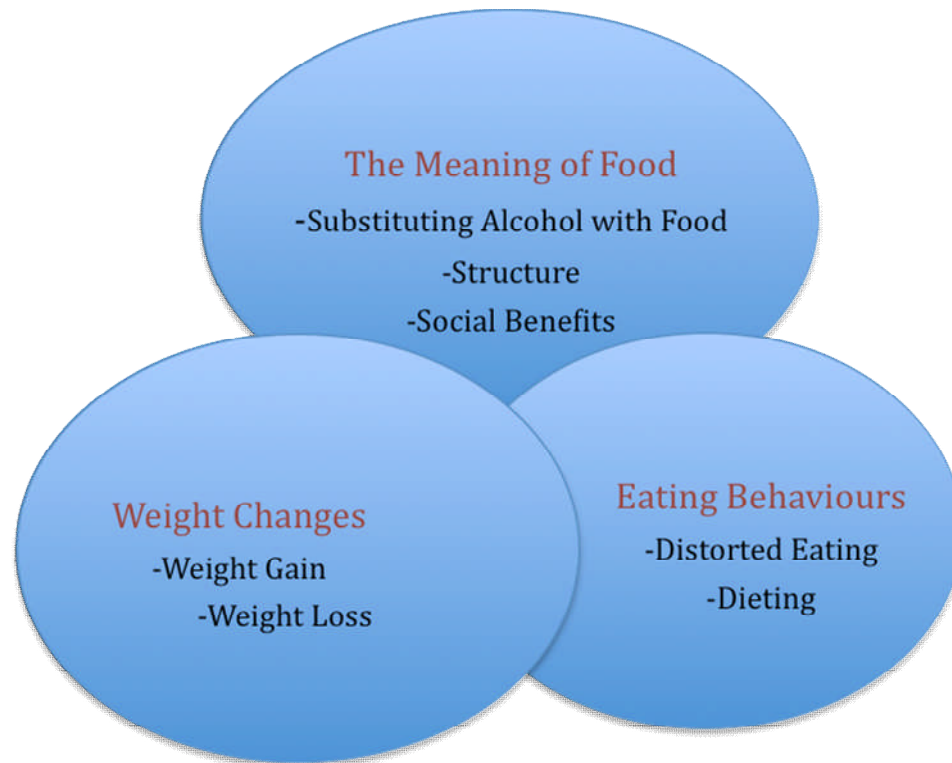
Figure 1.1: *Organisational Framework*

The meaning of food, weight changes and eating behaviours were explored in detail for a total of eight women in various stages of recovery from drug and alcohol addiction.

'The meaning of food' described the many functions and meanings of food in their lives, from the early days of recovery to their current recovery time. Three areas from the meaning of food question were identified: *substituting alcohol with food*, *structure* and *social benefits*.

'Weight changes' described how their weight changed since entering recovery and how they found their current weight. Two areas from the weight changes question were identified: *weight gain* and *weight loss*.

'Eating behaviours' described how eating patterns developed from the early stages of recovery compared to their current stage in recovery. Two areas from the eating behaviours question were identified: *distorted eating* and *dieting*.

3.2.1 The Meaning of Food

The meaning of food illustrates the many functions and meanings of food in the women's lives. It also describes how the meaning of food changed from the early days of recovery to their current recovery time. Three areas from 'the meaning of food' question were identified: *substituting alcohol with food*, *structure* and *social benefits* (Figure 1.2). *Substituting the alcohol with food* provided comfort and helped dampen cravings and urges experienced through abstaining from the alcohol. *Structure* referred to how food was used to provide routine and structure in the day and *Social benefits* describes how food provided pleasure though the enjoyment of eating socially with others. In the next section these three areas will be demonstrated with data from the participant interviews and discussed in light of the existing literature.

The Meaning of Food

Substituting alcohol with food
Structure
Social benefits
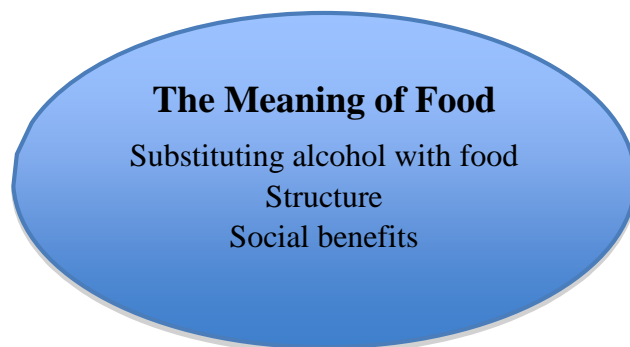
Figure 1.2: *The Meaning of Food*

Substituting Alcohol with Food

During active addiction food has very little value, where the primary focus during this period is getting enough of the substance. A great deal of research has been carried out on brain chemistry showing how substances change memory, emotions and mood (Leshner, 2001). The lack of nutrition during addiction has been linked to the addictive chemical's influence on the brain, causing false triggers between the neurotransmitters, which produce more desire for the substance in order to provide similar feeling responses (Taylor, 2010). When abstaining from alcohol or drugs it is clear that sugar-rich foods change brain chemistry, giving that similar substance effect

of euphoria. Sweet foods and drinks stimulate a soothing beta-endorphin release, therefore 'sugar' is often suggested to individuals recovering from alcohol addiction during early recovery, to help with the alcohol cravings (DesMaisons, 2008). The first area *substituting alcohol with food*, was a common experience for all the women in this study. They spoke about how their relationship with food had turned into consumption of sugar rich foods, particularly during the early stages of recovery. Here, Betty shares how food became cross addiction:

> *"...I would even say it became cross addiction. Cakes that I would normally not eat...Yeah food was very important to me when I gave up drinking. That's all I thought about basically...I did it because I was doing so well with not drinking. [Ohm] so I'd never baked cakes in my life, I started baking cakes [laughs]. So that was a bizarre thing...you know but it just...I can't explain it really. I'd eat them as well you know so...."* (Line 6, 64, 72: 10 months)[1].

Gina below, describes how food helps take away the cravings from alcohol:

> *"Well, I know when I am trying not to drink, if I eat it helps. But sometimes it actually literally takes the craving away. It doesn't just damp it down, it literally takes it away, but if I can you know get through to dinner and have a really nice dinner or have something really sweet to eat, I can actually sometimes...sometimes, not all the times, but sometimes be perfectly alright afterwards"* (Line 57: 11 months).

She also talks about planning to save having her sweet treats till the late afternoons, when she really needs them. This is when her alcohol craving would be at its highest point:

> *"Now when I go back to being really careful, so that I can when I need it to have a bar of chocolate because I have got a drink craving or to treat my day at the end of the day or something without piling the weight on. So basically be good when I can be good. I.e. so that during the day when I am not craving the drink...I might start thinking about a drink sort of mid afternoon, but I can quite easily not have one till late afternoon, so I don't need to have sweet treats during the day really. So I will save them when I need them you know..."* (Line 180: 11 months).

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[1] The numeric refers to the line number from the transcript and the months/years refers to recovery time

Charlotte describes how much she craved chocolate during early recovery, something she did not desire previously, and how her body has settled down from the chocolate phase:

> *"Well at the beginning, it was really bad. You crave chocolates. Like crave sweets...[Ohm] yeah you crave because your body is missing all the sugar from the alcohol. So you are craving it from something else...Yeah, but I am not a great chocolate person. I never have been. I did go through a "Kinder Bueno" stage. I loved them [laughs]. Now my body has settled down. I'm not really a sweet person. But at the beginning yeah"* (Line 228, 232: 14 months).

Daniella, also describes how her body craved the sugar from the alcohol in early recovery. Though she talks about the sugar craving tapering off now three years into recovery, she also has to watch what she eats due to her health condition:

> *"...Your body is craving that sugar from the fuel to feed your body, you will eat sort of anything and it becomes like a human dustbin in a way. But then it does slow down, it does taper off...unfortunately I have to be aware of what I'm eating now because of my cholesterol level. So you know I have had to look at my fat intake, my sugar intake...yeah I have had to look at a lot of things"* (Line 136, 147: 3 years).

Though all the women spoke about how sugar generally helps dampen their cravings and urges experienced from their substance misuse, they also spoke about how using sugar changed their mood, by giving a 'hit' and a 'buzz' and also referring to it as cross addiction, whereby sugar is labelled as 'a drug'. Eileen talks about the comfort in food, particularly the sugar in chocolates, which was the case for her in early recovery. She still craves the sugar 17 months into recovery, however she is using fruits excessively to dampen the sugar craving:

> *"Well, I never thought it was a comfort. It's an assisting for me food. I like sweet nice food...It's the sugar in fruit I am after and it's the sugar in chocolate I was after. I can't believe that that's a physical hangover from drinking, because it's been so long now. But then sweetness is a treat actually that's the truth of it. It's spoiling myself isn't it? I got that same feeling on a Friday night, the house work is done, the world is where it should be, everybody is happy and I can sit down and open a bottle of wine, which went over to a bottle of vodka, a bottle of brandy...And I do exactly the same thing with sweets. Everything was done, and they would be on my lap, and I would get that small piece out there, and then they would go...the whole lot. And I do the same with fruit"* (Line 110: 17 months).

In the next paragraph she describes how she is struggling to get rid of the sweet tooth and how obsessive her consumption with fruit has become in order to get the most out of the sugar from the fruit:

> *"Trying to get rid of that sweet tooth. And so far I can't, and I am going to battle it. I'm gonna deal with that the same way I dealt with alcohol, that is not have it in the house...And maybe I have got this silly embarrassment...maybe I am a throw back to the monkeys. Yeah one banana [laughs] is not enough and a bunch is too many...But I think the alcoholic behaviour, releasing that I have got it quite concerns me. I have got to control it, haven't I? It's more than just controlling your drinking isn't it? I have got to...or get rid of that. All or nothing...It's all or nothing isn't it? And I want to get rid of that really...And I think there is something really sad about hiding a bowl of fruit so you can eat it on your own isn't it, you know it's a bit pathetic isn't it?"* (Line 147: 17 months).

Below, Fae talks about using the sugar as a comfort and to fill a void from the substances she used. Three years into recovery, she still uses sugar as substitute at times when she is craving the alcohol to fill that emptiness and change her mood:

> *"...Just to try to fill that void. Yeah and the sugar craving as well, which is why it was always chocolate...you are missing your sugar in the alcohol...And you are still not sort of liking yourself anyway. So you just tend to eat the rubbish, because you are rubbish. In my opinion, to myself you know...Chocolate and biscuits yeah, not normal dinners. Didn't fancy it, didn't wanna cook. Yeah, just convenience, junk really...Everything seems to be a pattern...I am realising the drinking...I was very close to relapsing on Friday because of XXX. I ate. Yeah I really stuffed myself with a load of biscuits. It is a comfort thing, the sweets...Yeah also if I am fancying that drink, the sugar helps. I don't know why, it just does. It gives you a buzz. You know it's not as good as what you want, but it's doing something"* (Line 129, 17,147, 151: 3 years).

Fae's statement about 'eating rubbish, because you are rubbish' expresses almost a negative meaning to food, which is reflected in the way she feels about herself. She uses how she feels about herself by expressing it through the food she eats. She also describes the sweets as giving her a 'buzz', which ultimately changes her emotional states 'feeling rubbish'. Green (2007) states that when an individual is in the grip of a mood, feeling, attitude, experience or emotion there are at least three responses a person may have: keep it inside, act on it, or choose to verbalise it. For Fae it certainly appeared as if she was acting on her emotions, by attempting to change her emotions

through food. Similar to Fae, Hazel below also expresses how sugar is still a 'drug' for her 16 years into recovery from alcohol addiction and also refers to her desire for chocolate in early recovery:

> *"...I wanted to eat more chocolate all the time, but I was mortified that I was going to put masses of weight on. And...so like when I was in treatment centre, basically I was having loads and loads of chocolate. But I weren't going to eat anything at the dinner table...It's right until now. I get a hit...sugar is a drug to me. And I do get hits off of it. And I can...if I say I can't sleep or whatever, I can go -Oh well I will have a tub of ice-cream or whatever..."* (Line 176, 196: 16 years).

Also, Gina describes the pleasure and the 'hit' she used to get from alcohol and how chocolate gives her a similar feeling:

> *"Because it takes away part of the craving and your blood sugar comes back up and it's pleasure which for me alcohol was pleasure. So it's part of the pleasure thing and partly giving you the hit that you want, which you know sometimes chocolate does"* (Line 119: 11 months).

Below, Betty also talks about developing a sweet tooth in early recovery and how drinking tea and coffee became an association with her recovery:

> *"[Ohm...ohm] well you know chocolate bars, I would eat all of them. Yeah so I would eat things to excesses. ...the substitute...coffee and biscuits...I started eating biscuits and I suppose maybe I associated that like the tea and the biscuits with my recovery, you know and then I started buying chocolate and it went from there"* (Line 124, 129: 10 months).

Other women interviewed also shared the large quantities of tea or coffee they were consuming in their recovery. This may also be seen as a substitute for the alcohol, as both tea and coffee contain caffeine and have psychoactive ingredients that act as a drug on a person's body and mood (Ogden, 2012). However, caffeine drinking is also seen as a learned behaviour, as it is often associated with social interactions and hold positive outcome expectations on the basis of a person's previous experience (Ogden, 2012). In Betty's case it is clear how drinking caffeine was associated with her recovery through for instance associative learning, which can be learned through association with a range of cues such as social groups (e.g. AA or other substance misuse groups). Such an external factor can become a cue for further caffeine

drinking behaviour. For Gina below she describes how caffeine gave her a boost and how she was drinking coffee around the same time as she would drink her alcohol:

"When I am not drinking...I have more coffee, it does give me a little bit of a kick...I find having a cup of coffee after five o'clock with a couple of biscuits or something, will you know give me a bit of a boost. Whereas before I wouldn't be interested in coffee, because sort of five o'clock it was drinking time you know" (Line 159: 11 months).

Gina's association with drinking her coffee at the same time when her alcohol drinking would have taken place could be viewed in relation to reinforcement. As she describes it giving her a 'boost' and a 'kick', this could be interpreted as improving her mood, increasing her energy and reducing any stress. These are all fairly immediate positive consequences, which can become reinforcing for the behaviour with the person drinking more caffeine as a means to experience these instant benefits (Ogden, 2012). The women's descriptions show how they are pursuing those good feelings from when they used to use substances. For example, Fae three years into recovery spoke about how close she was to relapsing a few days before the interview took place, however she stated that she instead ate a load of biscuits, as this comforted her and ultimately affected her mood on that day. In Baptiste & Hemelin's (2009) study they also observed that the women reached out for comfort foods when they experienced isolation and loneliness.

Most of the women spoke about how they would eat the 'sugar' in secret when no one is watching, but also recognise and know it is part of their addiction behaviour. For example Eileen above spoke about hiding her fruit, so she can eat it all herself, but also points out how embarrassing and pathetic her behaviour is and how she plans to tackle her addictive behaviour again. Other studies have also explored the feelings of individuals who are addicted to sugar, where it was also reported that eating chocolate was done in secret, lead by a craving for the chocolate and then the feeling of guilt after (Hetherington & Macdiarmid, 1993; Macdiarmid & Hetherington, 1995). Again this sequence of behaviour is similar to alcohol addiction where the behaviour would be carried out in secret, a craving may trigger the urge to drink and feelings of guilt and shame are experienced as a consequence. In line with this, the sweet foods for the women represented pleasure and a need to be fulfilled. Their consumption is then

followed by guilt and feelings of sadness, shame and embarrassment. Based on the women's statements it is clear that sugar rich foods became a substitute during their first year of recovery and for some of the women with longer periods of recovery it is clearly still used as a substitute for their past alcohol addiction and represented a forum for conflicts between comfort, pleasure and guilt.

Structure

Most of the women spoke about how food provided a kind of structure and routine to their day. The women in the study shared how they rarely ate during active addiction and if they did than it was always in the form of takeaways and was considered less important. Daniella, three years into recovery describes how she avoided eating in addiction, as it made her sick. She talks about how she started to eat properly one month into recovery:

> *"I think it was because I was eating properly and sensibly. I was eating three meals a day. Having my breakfast, my lunch, my main meal. Whereas before as I say I could go for four/five days without eating. Also when you are drinking and you don't know what time of day it is, you wake up and it unbalances your metabolism...when you are sort of drinking the days and nights run into each other, so you're not sure when to eat and I wasn't eating properly anyway..."* (Line 103: 3 years).

Most of the women said that they started eating regularly a month into recovery, however this was a gradual process. Charlotte below describes how painful it was to eat in early recovery and how she had to build up her meals to eventually having three meals a day:

> *"I found it difficult to eat. Very, very, very difficult to eat...I suppose because I had damaged my body so much. It was so difficult to swallow and having the feeling of food settling in my stomach...Coz it just build up. Like I'm talking...say ok, so I stopped drinking in mid September. By mid October I was struggling. For that month it was soup and bread. Once...you'd only get your appetite like after a month. And then, so I would then start to eat lunch and dinner, and then it would be breakfast, lunch and dinner..."* (Line 88, 97: 14 months).

Here she talks about having three proper nutritious meals a day, which was something she did not have in addiction. It is interesting to note how much she is trying to be in control of how much she now eats, when she eats and the need to exercise after she has eaten:

> *"In recovery food means to me a proper meal you know. When I was drinking like I said I wasn't eating at all. But even when I was binge drinking before that, it was takeaways or a sandwich here and there. Now food is three proper meals a day, which I've never had in my life ever. I can never wake up in the morning being hungry. Now I'll have a banana for breakfast and I'll have a sandwich for lunch, then I'll have a balanced meal in the evening…and then I exercise it off. So I keep it at the same time each day. And yeah I don't eat after a certain time…"* (Line 68, 221: 14 months).

Gina, also talks about specific times in the day, where she would have her main meal:

> *"…I don't do the way you are supposed to if you know. Breakfast like a king, dine like a…and all that stuff…no I have a couple of bits of toast for breakfast, sandwich for lunch and…about half past four or five o'clock I might have a you know…a sandwich or a couple of biscuits or something. Then I will have my dinner about half six…"* (Line 94, 200, 215: 11 months).

Eileen 17 months into recovery explains how structure in her day was very important soon after she went into recovery. Planning her meals kept her busy and filled up her day:

> *"…Right from day one. And right from that minute I started to do everything properly. I needed a structure in my day, because I am quite lazy naturally, and I could spend all day with my head in the book or do puzzles…Once that light went on, I wanted to sort of get on the programme straight away and I did, I actually did. By half past nine I would be eating my breakfast and then by one o'clock thinking about what I was going to have for my lunch and then in the evening. I had to think about what I was going to eat and that was good. That gave me something to do everyday. Something to think about"*
> (Line 194, 200, 215: 17 months).

For most of the women in the study food also provided some form of structure to their day, by planning, preparing and setting time aside for daily meals. Substance misusers often experience boredom during recovery (Ferguson, 2009) and therefore a food routine gave the women in the current study something to focus on everyday. Hazel, however, struggles with her eating, but manages to eat two meals a day, referring

them to as 'feeding sessions'. She feels like she has to eat in order to change her eating patterns and create that structure. As she describes this is a big step for her, compared in early recovery where she would not eat at all:

> *"…Right now I find it more difficult to actually miss meals, because I know that it's not loving to me. It's been quite engrained in me actually…I call them feeding sessions in a day. [Ohm] and I am also aware that if I do that, I don't starve my self or go into full-blown binges. Because I will skip and if I can skip, I will skip and actually I have skipped one already today…I try to eat two sandwiches a day and then just six biscuits. I can either have morning coffee biscuits or rich tea biscuits to the cup of coffee. Now that, right now today is how I like to live everyday, ok. That is a lot more than what I was doing before I came in food recovery four years ago. I would be trying to eat nothing all day, and just have six dry crackers at the end of the day. So I…for me I come what feels like a long way to be able to get up and have breakfast…"*
> (Line 284, 148: 16 years).

Hazel's relationship with food is complex and eating appears to be an everyday struggle, however she has worked on creating a structure around her food to her benefit, as the structure actually helps and prevents her from not eating at all or overeating, which she recognises is not being caring to self. So in that aspect food is also used as self-nurture. For the other women above introducing food into their day was a gradual process, but for Hazel her struggle with food has been with her all her life, and therefore her structure around food appears to be more challenging. Although she feels that she has come a long way from hardly eating to eating a small amount each day, she clearly still struggles with this aspect, portrayed in her comment that she had already skipped a meal today. Skipping a meal seems to be almost giving her that feeling of control, comparing it to the times when she would hardly eat at all before she came into food recovery four years ago.

Social Benefits

Though food provided some form of structure to their daily routine, food for some of women also meant eating socially. Most of the women describe their experience of enjoying the social aspect of food, particularly cooking the food and eating it with family and friends. Eating with other people also meant for Charlotte that it felt like she was doing what everybody else was doing 'being normal', as her life had been consumed by the chaos of addiction. She expresses how much she values and

appreciates the family meal and how important it is for her family that she now can share a meal with them:

> *"Just to be normal. My life had been so erratic [ohm] nothing that I did was normal. And so it was really nice to be able to sit down and have a meal with my mom. Like I go out to dinner with my family, because I could never do that before. So you know and I started cooking a lot more...I never, ever could appreciate a meal. Never! Like when I was drinking I would eat and go straight outside and be sick straight away. It was like I suffered from bulimia. It was awful. And now you know to be able to sit down and have a meal with my family means the world to me and to them..."* (Line 209, 291: 14 months).

Daniella three years into recovery also talks about being able to go out and enjoy meals, as well as having meals with her daughter once a week:

> *"...Yeah I went out for a meal on Thursday, but I had steak and salad...I go to my daughter's. She comes to me one Sunday, I go to her the following Sunday and we always have a roast dinner"* (Line 355: 3 years).

Both Daniella and Charlotte talk about how important food has become within their family dynamic. Often food has a central place for communication and interaction within the family and the dinner table becomes a place for the family to get together and interact by sharing stories and experiences of events that has taken place in their day. Ogden (2010) additionally highlights that the way the food is cooked and the kinds of foods eaten can almost form a sense of group identity such as 'the birthday party' and 'the Sunday lunch'. For Daniella above that weekly family meal of roast dinner became a ritual between her and her daughter and the meaning of the meal became a way to maintain the family harmony. Gina below, like Charlotte and Daniella also discusses how her experience of eating in the company of her friends and family has changed in recovery:

> *"...I do enjoy that whole social thing like going out for a meal or sort of cooking for family or if it is a special occasion or something you know...Quite a few times lately we have had my parents and my daughter's boy friend over for dinner. And my mom has not been well, so I sort have seen more of her. So, yeah I love that whole social eating thing. Looking after people, making nice food and that...I think I take more notice of the food now, because I am not pissed and because that is the bit of pleasure that you're part of the company of being with your family or friends. That's what you are getting out of it. You*

know the taste of the food rather than the taste of the drink, so probably pay more attention to it now" (Line 127, 137: 11 months).

For Gina, preparing and cooking food for others also portrayed the meal as a symbol of showing love and affection to others; particularly she talks about her mother who is ill. Cooking and eating with her is a way of showing that she cares about her. Planning and preparing meals for a woman has been seen as a way in which the woman can demonstrate her concern and love for the family (DeVault, 1997). However, preparing food for others can also be seen as a forum for many other interpersonal conflicts, such as eating and denial. Whilst women take control of food by planning, preparing and providing it to others, they can also at the same time deny themselves the pleasure of eating what they have prepared, in order to remain thin and attractive (Ogden, 2010). For example Fae below, talks about how she would make food for others, but not eat them herself, unless she is actually told to eat:

"If I hadn't had this going on, like the unit that we are doing, I would probably not eat actually much. When I was making sandwiches, I would make them for everybody else, I never had anything, you know. But when it is put in front of you and someone else is saying –You gotta eat that, then I will" (Line 56: 3 years).

For Eileen, like the other women, her drinking came in the way of eating socially, as she had to restrict her drinking in front of others and was always in a rush to get home to be able to drink more. Now in recovery she enjoys the social aspect of eating, as the preoccupation of the next drink is no longer there:

"…If I was out, I wanted to get home, I would have to restrict my drinking if I was out. So yes, I was always in a hurry to finish up and go home, so I could get to the alcohol, but that's the only way I enjoy it more. It's nothing to do with my taste buds…I haven't got enhanced or anything like that. I just…because it is my general demeanour really. I just enjoy it more…I have got time for it now. Enjoy what I am doing right now, rather than worry about the next glass I am gonna have…" (Line 264: 17 months).

Summary- The Meaning of Food

The meaning of food described the many functions and meanings of food for the women, from the early stages of recovery to their current recovery time. Three areas were identified from the meaning of food question: *substituting alcohol with food*, *structure* and *social benefits*. The next section will describe the areas that were identified from the weight changes question.

3.2.2 Weight Changes

Weight changes referred to the weight changes the women experienced during the early stages of recovery and up until their current recovery time. Two areas from the 'weight changes' question were identified: *weight gain* and *weight loss* (Figure 1.3). *Weight gain* was the excessive weight gain six of the women experienced during the early stages of recovery and *weight loss* referred to the weight two of the women lost during the early stages of recovery. In the next section these two areas will be demonstrated with data from the participant interviews and discussed in relation to the existing literature.

Weight Changes

Weight Gain
Weight Loss

Figure 1.3: *Weight Changes*

Weight Gain

Weight gain was a common experience for the women, particularly during the first few months into recovery. Six of the women in this study stated that they gained weight during recovery, particularly because they got their appetite back after a month of sobriety. Most of the women in the previous sections spoke about the high intake of sugar as a substitute for their substances to mainly help with their cravings, which in turn caused weight gain. They commonly all gained the weight about a year into recovery, where the weight gain differed, ranging between 4.7kg – 25.4kg. The weight gain in these women is consistent with previous studies (Emerson et al., 2009; Hodgkins et al., 2007; 2004; Fontaine, 2001) where it was also found that the women in their studies attending treatment for substance misuse gained weight within first 8-12 weeks of treatment. Betty below, 10 months in recovery, talks about her weight

gain in early recovery due to eating everything, as her focus was on stopping the drink and how now she is attempting to lose the weight gained:

> *"Oh God yeah, I put on about a stone and a half (9.5kg). I'm now [ohm] 10 months sober and I've been on a diet. That's in the last…I was stupidly overweight…I want to lose that and maintain it yeah. It's important to me because…you know when you…like at first, when I first gave up drinking, my whole focus was on stopping drinking. I was just eating what ever…yeah so that dawned on me as well"* (Line 8, 37: 10 months).

Charlotte states how she rarely ate during active addiction and how she got her appetite back after three weeks in recovery. She talks about the weight gain and how she was unable to exercise it off:

> *"…Like when I was drinking I didn't eat at all…And then when I stopped drinking…I got my appetite back…And then I put on about three quarters of a stone (4.7kg) within the first six months…I tried to do yoga…pilates and zumba. But I couldn't because I'd damaged myself so much, my stomach especially. I couldn't do any stretches or I couldn't swim, so I think that's why I put on the weight, because I was eating, but I wasn't able to burn it off. And then after six months my health…thank God I'm so lucky, I really am, went back to normal and then I could start exercising and then sort of stable…"* (Line 9, 25: 14 months).

Similar to Charlotte, Daniella discusses how she used alcohol as a substitute for food and how she rarely ate during active addiction:

> *"…So actually when I was drinking, even though I was drinking, I was still controlling my weight and the alcohol was a way of controlling it…as a food substitute…So I could go four, five days without eating. And I was…instead of eating I was living on lucozade. Which I thought had all the glucose and the sugar in…you know to help me"* (42: 3 years).

Here she talks about her excessive weight gain in early recovery due to regaining her appetite and how the weight gain continued for a year into recovery:

> *"I got my appetite back and I think…Because you got your sugar in your alcohol, so your body is craving for that sugar. So you are looking for substitutes. [Ohm] I'm not a sweet tooth person [ohm] but yeah I would [ohm] I would eat anything! [laughs]…Well I had put on about between three and a half and four stones (22.2-25.4kg)… Yeah I piled it on. [Ohm] sort of once I stopped drinking I would say over about a year I put it on…Then it levelled*

down...I think it was because I was eating properly and sensibly..." (Line 58, 14, 101: 3 years)

Hodgkins et al. (2007) in his study on nutrition and exercise found that all the participants attending substance misuse treatment regardless of the intervention received gained weight, however the control group, who did not receive any exercise or nutrition education, gained most weight. None of the women in this study engaged in any form of rigorous exercise plan, apart from walking. Little physical activity may have also played a part in the weight gain, similar to Hodgkins et al. (2007) study. Although some of them spoke about their weight levelling after a year, some were clearly still struggling to lose that weight even after 3 years of recovery. Gina below, who recently suffered from a heart attack had been classified as borderline obese on the day of the interview. Past research has also indicated that the excess weight increase in recovery may contribute to health problems, as obesity may play a key role in increasing chronic conditions (Howard, Arnsten & Gourrevitch, 2004; Sutter & Vetter, 1999). Though Gina's weight levelled out after the first year of recovery, three years later she is till trying to lose the weight gained from early recovery. She talks about wanting to lose the weight because of her current heart condition and the fact that she is not happy with the extra weight gained:

> *"...I am about a stone and a half (9.5kg) overweight for my size now...Want to lose weight because of my heart condition and I don't like carrying the weight. And of course when they tell you that –Oh yes you are bordering obese...I think –Hang on I'm not that bad! But then they see obese as anyone who's got a BMI sort of over...can't remember what it is now. And like I say I was there this morning and I am 11 stone four (72.3kg) and I am classified as being obese...so yeah I have got to lose it. But then having said that I have lost some weight since October...I've lost a stone and three quarters (11kg)!"* (Line 339, 26: 3 years).

Eileen states how she lost weight in early recovery, but how it then piled on after six months into recovery:

> *"Yeah, six months into recovery, I lost a stone in weight naturally. Just by eating properly when I should eat and walk more, going out more. They were all saying –Wow you look! Then Easter time, I have never had a sweet tooth ever and Easter time someone said –Would you fancy some chocolate? Well I only put that chocolate down in December...Talk about you know you are an alcoholic!"* (Line 29: 17 months).

Here, she describes how she would actually go out of her way in the dark, although she does not like going out in the dark to stock up on chocolates over a period of eight months. This was a powerful influence to the weight gain she later describes:

> *"...I had one bar of chocolate, then I went out and bought two Easter eggs, and ate the Easter eggs and what was inside them. And then I would go over to the shops opposite where I live in the dark, but it's not something I would like to do...and stocked up on a week's chocolate and get home and eat the weeks chocolate like I would drink a week's booze...I went up to 14 stones (89kg) and I have never been this big. I mean I have never ever been this big in my life and I was always a slim person...And that's from you know, I put on two stone from March until now (12.7kg)...Nearly three stone (19kg) actually"* (Line 85, 98, 248: 17 months).

Fae three years into recovery talks about her experience with excessive chocolate intake, as a way of dealing with her alcohol cravings during Christmas time, and how that consequently made her weight increase. When she describes 'wanting to be filled with something' sounds like she is eating the chocolates to feed a feeling she is experiencing, a form of emotional eating:

> *"...Christmas time for example when everybody was drinking around me and I just sat there eating lots of chocolates...whole boxes of Quality Street. But that's just replacing something I am craving, if that makes sense? Because everyone else is doing that, I wanted to fill me up with something. Which wasn't good, because I got very fat at Christmas...Yeah, and then I go on a guilt trip about putting on too much weight I suppose"* (Line 65, 71: 3 years).

She further discuses noticing her weight gain in her clothes and the changes she is putting in place to lose the weight:

> *"I put on weight yeah. I fluctuate between...I don't know what I weigh now. I don't actually weigh myself anymore. But yeah I can tell by my jeans. When I am drinking, I am pretty thin, because I don't eat at all. So when I come off the drink, it's just eating chocolate, chocolate, chocolate...I keep going until my jeans can't fit me anymore and I think –Oh God help me! [laughs] I've got to change...And then sort of -Gotta get this right now...So yeah then I go onto fruit and being healthy and now I am just having two meals a day, and a snack between"* (Line 20, 28: 3 years).

Gina talks about how she did not gain any weight during the early stages of recovery, due to being ill, but how that eventually after a few months changed:

"...I was eating these sweets to sort of you know cheer myself up and because it really helps with the cravings if I can have something sweet...I have put on a stone (6.3kg) since Christmas...But because since sort of Christmas what has been happening, I was still eating the sweets...and I was still trying not to drink...So obviously the weight it has started to come back on again, you know. But now that I got my dog, hopefully I will be walking and not drinking, hopefully the odd bar of chocolate or pudding isn't gonna do too much damage. You know start to lose a little bit again" (Line 36: 11 months).

Weight Loss

Weight loss during early recovery was a common experience for two of the six women that took part in this study. In contrast to the women that gained weight, they lost weight during early recovery. They discuss gaining weight during active addiction, because they cared less about what they ate, and lost the weight in recovery, because they were excessively restricting their food intake. One of the women pointed out that during addiction, alcohol actually makes her gain weight and during recovery she loses the weight, as she restricts her food intake and engages in excessive amounts of exercise. During addiction there seems to be less worry about what and how much she eats, however when she is in recovery restricting food is a constant battle for her. She shares how she eventually relapsed 3 years ago, as she had lost so much weight. For her, drinking again also meant that she could eat again, as she cared less about what she ate. Additionally, she was consuming calories from both the food and the alcohol, which may be linked to the weight gain during addiction. Here Angela describes her experience:

"There's some sort of link or some...I mean the reason I relapsed in 2010 is because I'd reached a weak state and low weight because of it [ohm] and the drink was to relieve the obsession...and relieve hunger...relieve everything [ohm] from it, because it was too much [ohm] and I started to think that I could drink and substitute the drink for food, but it didn't quite work like that...I didn't...this time around I didn't really put on significant amount but in my mind it was too much" (Line 29, 35: 11 months).

Here, she talks about her weight gain when drinking, aware that she is different form other recovering alcoholics who gain weight in early recovery:

"...Drink is the one that actually makes me put on weight...yes...so I'd put on some unnatural amount of weight for my natural size then if you like...Quite a lot...very rapidly quite a lot...It makes me put on...because I know with a lot of people it's the other way around" (Line 19, 22, 52: 9 months).

She further shares her experience with the weight loss during recovery:

"You lose it, but then I exercise all the time and I restrict my food...because they think I've got an eating disorder which ok, there's obsessions and issues about it...and it is constantly with me when I'm in recovery, when I'm not drinking this is the sort of thing that takes obsession and hold...[ohm] it's quite strong...[ohm] so that might be why...Yeah, because it makes it a big priority and it takes up all my mind space, it takes up my thoughts, and a very large percentage of it, it's occupied my brain...occupied by it...yeah of different ways to restrict and how not to eat too much...and how to...it's just...yeah...I can't help it honestly" (Line 108: 9 months).

Although Angela talks about her obsession with restricting food and has previously been diagnosed with anorexia nervosa, she doesn't agree that she has an eating disorder and has therefore refused to see any further professionals. It is interesting to note the level of conflict some of the women describe regarding food and weight as they often seem to say it's 'not them' by for example saying they are not a big person or they have never liked sweet foods before, as if they are redirecting the focus off themselves. Below Hazel talks about how the weight loss was a focus off her. Similar to Angela, she talks about weighing 17.3 stone (110kg) before she stopped drinking and how she went on to weigh eight and a half stone (54kg) in recovery:

"...And then I just went to the other end of the scale...And it wasn't something that I consciously choose to do. I can remember once my mom saying to me...I said to her -Oh what is the matter with you? At least I have stopped drinking haven't I? And she went –Yeah, but I didn't ask you to stop eating. And I remember thinking at the time –No neither did I, how has this happened?...It was just another focus to focus off me. And I can see that today"
(Line 26: 16 years).

She further describes her weight experience when entering a treatment centre for alcohol dependency:

"...When I was in treatment centre, in actual fact my eating disorder kicked in a big way...And because I had come off drink...I seemed to want to eat sweet things and the message was that I am going to be humongous again. And I wasn't gonna allow that to happen, so I actually picked up the addiction of not

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eating...and to eat food the message was BIG. And because I wasn't eating when I was drinking, a very small amount of food once I put the drink down, felt big, because it was all distorted. So in my mind and I think as well like when I was 17.3 (110kg) stone and I lost weight, so many people told me how good I looked....I felt like I must have been disgusting and looked absolutely terrible, because of all the positive comments I was getting from people, but of course they weren't aware..." (Line 43, 51: 16 years).

Both Angela and Hazel had a similar experience and it is quite clear that they both had food issues and struggled with their body-image. It seems as if the drinking was a way of coping and forgetting about their weight and what they ate, as they did not restrict their food intake whilst they were in addiction. One of the reasons women misuse substances has been related to weight issues (Brecht et al, 2004; Greenfield et al., 2007), where body dissatisfaction has been linked with substance misuse and distorted eating such as dieting and extreme calorie restriction (Stice & Shaw, 2003; Parkes et al., 2008; Stice et al., 2010; Warren et al, 2013). This will be discussed in detail below, as most of the women suffered from distorted eating when asked about their eating behaviours.

Summary- Weight Changes

Weight changes described the experience of hardly eating during active addiction and how this changed during recovery. Most of the women recalled gaining their appetite back and using sugary snacks to help alleviate the cravings from the drink, which caused excessive weight gain during recovery. The women spoke about how they are now struggling to lose that weight. In contrast, two women experienced weight loss during recovery, due to their restriction of food intake when entering recovery. Two areas from the weight changes question were identified: *weight gain* and *weight loss*. The next and final section will describe the areas identified from the eating behaviours question.

3.2.3 Eating Behaviours

Eating behaviours referred to eating large portions or overeating (bingeing) in one go and controlling food intake excessively by dieting. Two areas from the 'eating behaviours' question were identified: *distorted eating* and *dieting* (Figure 1.4). *Distorted eating* entailed the struggle to eat healthily, particularly during the early stages of recovery and the ability to control their eating in recovery. *Dieting* referred to controlling their food intake by going on a diet or joining a slimming club. In the next section these two categories will be demonstrated with data from the participant interviews and discussed in relation to the existing literature.

Eating Behaviours
Distorted Eating
Dieting
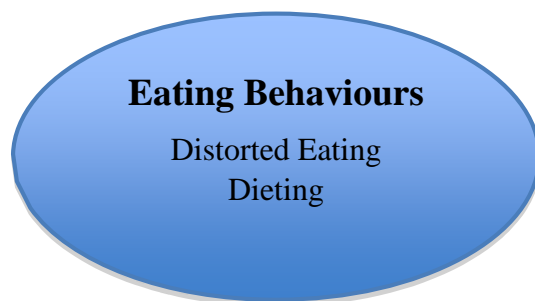
Figure 1.4: *Eating Behaviours*

Distorted Eating

Distorted eating was experienced by five of the women throughout their recovery. Though the women were aware of the need to eat healthily, they struggled with this aspect, as they often consumed large portions of food over a short period of time or radically restricted what they ate. Sugar-rich food such as chocolate, ice-cream, cakes and biscuits appeared as the most problematic ones, as they would eat these to excess and consequently feel guilt and shame. Their eating behaviours were the same as their drinking patterns, which involved buying large quantities of 'it', hiding 'it' and eating 'it' privately all in one go. Eileen shares how she has swapped her drinking habits from alcohol, to chocolate and now to excessive fruit consumption and talks us through her compulsive patterns. Here she describes how she cooks and takes care of what she eats, but struggles to control her binge eating habit:

"...I cook everything from scratch...I take care of what I eat. But the sweet element, the forbidden element of it if you like, which is what I do in secret. You know I stuff myself...The behaviours that I adopted to drink, I am adopting now when I treat myself. Because I obviously see it is a treat, don't I? And I don't do it publicly, I do it privately, when no one is watching. But I will...I stopped smoking, I stopped drinking...I will...I will break this...But in terms of patterns, the only thing that I will swap the drink for a bar of chocolate and a bar of chocolate for a banana. You know it gets slightly healthier, but the pattern is still there isn't it? And I hog out, I really do pig out..." (Line 127, 326, 348: 17 months).

She further talks about hiding food and binging on chocolate in the early days of recovery to currently binging on fruit:

"...At Christmas time my neighbour gave me a box of chocolate biscuits and I ate them in one night!...I took sweet stuff exactly same behaviour, same pattern as drinking, and I know in the last five weeks since I have been on the diet, I have been straight on fruit. Hide it all, scoff it all, don't share it with anyone...and then eat it all in one go. Why would you be ashamed of...why would you hide fruit? It's absolutely alcoholic behaviour, and I can laugh at it, because it's a whole new substance...I haven't learned anything about impulse control by being sober. Because not with chocolate and certainly haven't learnt it with fruit. So today is my [laughs] first day of eating...not scoffing fruit you know" (Line 89, 101: 17 months).

Below, she describes her compulsive binging behaviours where she would eat 15 bananas, 10 pears and 2 packs of grapes in one go:

"The way I ate that food, was the way I hide my booze. We would have friends for dinner and they would complement me on my dessert and there was enough in the fridge to give them another helping three times over and I didn't give anyone it. I saved it when they had gone and ate it all on my own...I nearly spent nearly £17 on fruit that lasted me one day, exactly the same way as I was drinking, so I have got to approach that. That is my alcoholic behaviour isn't it? I just thought that once the drink would go, the habits would go...About 15 bananas, 10 pears, 2 packs of grapes, I ate that whole lot...And when my husband came round yesterday, I hide the fruit bowl in the pantry, just so that he wouldn't think –Why is that empty?...But my eating habits are those my drinking habits....So I am going to deal with that, the way I dealt with drinking. And that is don't have anything in the house. Just don't buy it, or if you're gonna buy it, eat two bananas a day"
(Line 34: 17 months).

As the women themselves describe it, food became cross addiction. From a social learning perspective, it is possible to examine the similarities between behaviours

through a cross-addictive behaviour perspective. The PRIME theory developed by West (2006), includes a model of addictive behaviours that could be applied to all drug-based and behaviouraly-based addictions. For example a person with alcohol dependency, who is feeling emotionally vulnerable and finds relief when drinking will be more likely to drink. Even if the person does not respond well to the negative effects of alcohol, their dependency will carry on, because according to the PRIME theory the drinking behaviour will be maintained through the persons impulses ('I need a drink'), emotional states ('I am anxious'), motives ('I want a drink') and evaluations ('drinking will make me feel better'), consequently making it unlikely that they may make plans to alter or stop their behaviour (Ogden, 2004, p. 98). These factors can also be applied to eating for instance: ('I need some chocolate'), emotional states ('I am feeling down'), motives ('I want some chocolate') and evaluations ('some chocolate will lift my mood). The same patterns of thinking and behaviour can be applied across addictions, as the person's emotional states and motives may still be there, but the person may initiate another form of excessive behaviour whether this is a substance-based or behavioural-based addiction. Eileen above, is a classic example of this and how she went from the alcohol, to the chocolate and now to the sugar in fruit! Betty below, also talks about how she was hiding chocolate bars. Similar to the other women she too felt ashamed of her chocolate consumption and refers to it as 'stupid' behaviour, as if the 'sugar addiction' became the new substance, rooted in her past alcoholic behaviour patterns:

> *"...I think, it's because [ohm] I've got a [ohm] food, but it was becoming an issue...like literally hiding bars of chocolate...you know...really, really was stupid..."* (Line 21: 9 months).

Most of the women talked about episodes of binge eating over short periods of time or excessively controlling their food intake. Fae talks about eating excessively for a couple of months and then having periods where she hardly eats anything:

> *"...If I have been on a binge...when I first come out of that, it's just like I want chocolate, chocolate, chocolate and that can go on for about two months. And after that I tend to sort of cut loads of food out and hardly eat at all for a while...And I think that I am made of iron, or something you know...I am strong, I don't need it. Then I start realising that I am getting weak. But I don't know if it is a sort of controlling thing that I am doing...But I am aware that I need to eat healthily...Well, today I had a jacket potato, prawns and*

salad. So stuff like that is not going to pile on the pounds, that's good for you"
(Line 10, 73: 3 years).

Hazel too talks about her experience of either eating excessively or not eating at all. She talks about the 'trigger' food that she is unable to control, which can lead to a binge:

> *"...I gave up alcohol for three years, but then I am seeing someone for anorexia. It kind of like leaves me with a dirty feeling or something. It can trigger something that I need to binge or I need to starve...And I am not talking normal foods...like for me cakes, biscuits, chocolates and ice-cream are a big trigger for me. But like the other night, I knew if I went out and had the meal that was actually on the night... There is technically nothing wrong with like sausages...it was all good food. But my head would get messed up with it. So I had to just eat my own food and just stay away from it. Otherwise I would have found myself going on a full blown binge and not been able to control my eating...When I start on it, it takes me way down because I can't get off. And I can't stop, and then I have got my head over the toilet throwing up and I go an eat more and back and forth like that. Or I go in the other way, where I can't control it..."* (Line 127, 322: 16 years).

Such binges are followed by feelings of loss of control, which are usually carried out in secret and relate to very fast eating that often contain foods that the person would normally avoid including in their diet, such as cakes, ice-cream, chocolate, puddings, biscuits or even bread, pasta, cheese and meats. The person may also engage in compensatory behaviour as a way to manage their weight caused by the binges, such as excessive exercise, food restricting, laxative use or self-induced vomiting, which usually takes place after the bingeing episode. This is similar to what Hazel above talks about. These behaviours provide a sense of control caused by the overeating and for example vomiting provides a sense of relief from the tightness caused by the overeating. From this perspective it can therefore become a habit and promotes further bingeing episodes and further vomiting (Ogden, 2010), which may explain the women's repetitive cycle of binges. This cycle of binging and restriction is associated by a set of beliefs and attitudes regarding weight and food. Individual's who have a distorted relationship with food often overvalue the ideas about the importance of attaining and maintaining a particular shape or body weight and are often mortified of weight gain (Warren, 2013). Though the women interviewed stated that they overeat, they also expressed that they also restricted their food intake by controlling what they ate, which meant that they would diet.

Dieting

For some of the women, the weight gained during the early stages of recovery became problematic and at this stage the majority of the women were trying to control their food intake through a form of diet or being a member of a slimming club, whilst others used exercise alongside a diet to lose the weight. Charlotte 14 months into recovery talks about how she now uses exercise and restricts her food intake after a certain time, because she is worried of losing control over it and consequently gaining weight:

> *"…I'm trying to lose weight now…And not too much [eating]…And also my times of eating I won't eat after 6.30 now and I will go for a run at about nine o'clock everyday…Yeah, I'm quite disciplined with it. You know I don't wanna put on weight, so I'm quite disciplined with what I'm eating and the times"*
> (Line 33,76, 80: 14 months).

Betty, however discusses a specific diet she has chosen to use:

> *"…Like this particular diet, I'm on the "Ducan Diet". Basically, there's an awful lot you can eat and a lot of non fat dairy…It's a long-term diet…I've been really careful about choosing the diet and [ohm] it's been proven that if you can do five days for every one pound you have lost…if you do that your body will not want to put that weight back on, because that's what's most people do. You lose a lot of weight and your body wants it back…but you won't go back…and I've read testimonials and God knows what on it…do you see what I mean? So it's like a mini goal of mine I suppose"*
> (Line 23, 26, 195: 10 months).

She further talks about reaching her ideal weight, before letting go of the diet:

> *"Yeah, I haven't got down to my ideal weight yet, so it's quite strict at the moment, but I'm hoping to get down before Christmas…And to me that's manageable, coz I can see a light at the end of the tunnel and, but I do want to be able to eat properly again. I do want to have chocolates and stuff like that again. I can't just…I wouldn't be able to just…if I knew that this is how I was gonna eat for the rest of my life, I wouldn't be doing it"*
> (Line 42, 188: 10 months).

Daniella three years in recovery, talks about always being cautious about her weight before she went into recovery and how she went to Weight Watchers to lose the weight gained during her first year of recovery:

"I went to weight watchers! So it's just this vicious circle...I didn't like it, because I have always had a thing about my weight anyway. That was one of my controlling issues...[Ohm] I didn't have an eating disorder, but I always sort of watched what I eat. I was always going to slimming clubs...It was because a comment was once made about the size of my thighs and the size of my back side as well and so that always played on my mind. So you know I had to be very careful. So actually when I was drinking, even though I was drinking, I was still controlling my weight and the alcohol was a way of controlling it..." (Line 347, 35, 38,347: 3 years).

Eileen talks about how she now has joined a slimming club because of her high consumption of sugar and how she is currently on a diet to lose the weight she gained during recovery:

"I have now started a slimming group, because of the habit...And also now because of the diet...I have my frozen fruit...and I have fat free natural yogurt. So I am trying to treat myself, because I like those things and take the sweetness out of it, but still have the treat. So yeah it seems to me a bit of a comfort really. The sin part of it, not the normal everyday food, that's...I have to have that because I want to stay healthy and I want to lose weight"
(Line 32, 138: 17 months).

The fear of gaining more weight became an obsession and the desire to reach an ideal weight meant being thin in order to fit in with everybody else and the rest of the world. Both Fae and Hazel describe that experience:

"Once you start coming back to life if you like...you do all of that bit of eating the chocolate...then you start becoming more aware of your outside world a bit more. Then you notice other people –Oh my hair don't look as good as that. You know, you do start comparing yourself a bit and that's when it all sort of kicks in –I better eat better and...Wanting to fit in with the way everybody else is...I want to be thin...I would like to be like when I was 19, but it's not likely. But it's a dream. No I just want to be healthy"
(Line 197, 41: 3 years).

Again, Hazel 16 years in recovery talks about going on a diet to lose weight in order to fit in this world:

"...I now know that I gave up alcohol to go on a diet and I just picked up another form of addiction and then I would just focus on what started off in my mind as a diet. Lets lose some weight, because I might then fit in this planet...There's this message of less is best. Which is really quite bizarre. When more was best with alcohol. But less is best with food for me and my mental state" (Line 26, 284: 16 years).

From what the women described, body-dissatisfaction seemed to be in the background throughout their addiction, however came more to light during recovery, as a person during this period is also more in touch with their feelings and thoughts (Apostolides, 1996). The findings on body-dissatisfaction in this study are similar to previous studies where it was revealed that women with a history of substance misuse also suffered weight-related concerns, body-image dissatisfaction and preoccupation with thinness (Olsen et al., 2005; Warren et al., 2013). Given the pressure to look a certain way within the Western culture, the achievement of ever-decreasing weight has become a sign of virtue, mastery and control (Harrison, 2003; Ogden 2010). For instance when Fae spoke about becoming more aware of the outside world and comparing her self with others when coming into recovery, it is quite clear how her ideal perceived image of a woman has influenced her desire to look thin in order to fit in, as more recently the value of physical appearance has been associated with personal worth for a woman (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999; Lopez-Guimera et al., 2010).

These insights relate to other theories where it has been proposed that 'health' has become a central factor within the formation of one's identity in contemporary societies (Williams, 1998; Odgen, 2012). Crawford (1994) for example pointed out that health in modern life has become a portrayal of the good responsible self and is tied up with what people view is good, respectable or accountable. These theories suggest that good health now is not only a symbol of good physical and mental well-being, but also a representation of beauty. More than ever has the shape and size of the body become an indicator of a personal and a cultural image of self-determination, strength and will-power (Grogan, 2006; Ogden 2010). The outcome of this effort is to try and create a sense of personal and social order by practicing healthy lifestyles, which positions itself in the meanings that are attached to risky and unhealthy behaviours such as substance misuse, unsafe sex or eating junk foods. These become practices that represent on the other hand irresponsibility, badness and lack of control (Crossley, 2000; Ogden 2010). This may explain the feelings the women associated with the junk foods they were consuming, where they often expressed how they struggled to control this side of it, leaving them feeling 'rubbish', 'dirty' 'embarrassed', 'stupid' and 'ashamed'.

Summary- Eating Behaviours

Eating behaviours described the women's eating patterns, where most of the women interviewed shared how they struggled to eat healthily. Overeating was an issue for most of the women, which in turn affected their body-image and consequently resulted in some form of diet to lose the extra weight gained during recovery. Two areas from the eating behaviours question were identified: *distorted eating* and *dieting*.

3.3 Stage 2: Higher Order Analysis: Theoretical Development

Recovery from substance addiction is a time for change touching on all aspects of the individual's life. Weight changes, the meaning of food and eating behaviours were predominant changes that the women in this study experienced through their journey of addiction and along their journey of sobriety. The key findings and main outcome of this study lead to a substantive theory:

'Food during recovery involved providing structure to the day, enjoyment of social eating and substituting alcohol with food, particularly sugar rich foods during early recovery to 1. Replace the substances by filling a void, 2. Dampen the cravings and urges experienced from the substances and 3. Experience a change in mood. The excessive intake of sugar rich food caused weight gain and in turn resulted in dieting and distorted eating behaviours later in recovery'.

Substance addiction is often associated with a chaotic lifestyle and little daily structure, including irregular eating patterns, as the person's appetite is often suppressed and their life revolves around the substance. As recovery is a time for change, establishing a routine and structure around meals is encouraged (Ferguson, 2009). Most of the women spoke about how they rarely ate during active addiction and how that gradually changed during recovery. Food not only gave their life a new structure and routine to the day, it also brought along social benefits and a new way of interacting with others. Half of the women in this study expressed how much they valued the social aspect of food in recovery, as eating during addiction seemed to be less important, therefore the social aspect of food had little meaning. For many of the women the social benefits of food also involved the pleasure of being part of the company of being with their friends and family, cooking for the family and looking after them. Most of the women were mothers and felt that part of their role in recovery was to be able to 'mother' again by preparing meals, which symbolised their love and care to their children, grandchildren and even to their own parents. It allowed for a sense of connectedness that they could not experience in active addiction. Although the women were actively cooking and eating more, the sweetness of the food and eating to excess in secret became a substitute for their past alcohol

addiction. The sweet element of food for the women represented pleasure by *filling a void*. The women describe using sugar rich foods as a 'fix' and to 'fill a void' to compensate for their drug of choice. Taking a critical health psychology stance may further help us understand the meanings and functions associated with health-related behaviours and how they are linked to the social and cultural world we live in. In today's society more than often visions of 'the good' have manufactured a distinctive meaning of personal identity and selfhood in which individuals appear to be on a continuous pursuit for 'the good'. As this is not always easily achievable, the individual may feel empty and nonexistent, and may therefore also experience a recurring need to be filled up as a way of relieving the feelings associated with emptiness and loss which are associated with the failure to reach perfection (Crossley, 2000). Although the women in this study had given up their addiction of drugs and alcohol, they clearly substituted it with comfort foods, to fill the emptiness and void as they themselves expressed.

It is important to understand the theories that unite identity and health-related behaviours, because according to Crossley (2000, p. 40) one of the central ways in which human beings may cope and deal with their emotions of emptiness is by "consuming and producing" in different ways in an effort to feel comforted and fulfilled. Feelings surrounding 'I need a fix' as many of the women in this study described, are more than often signals of profound suppressed emotions of depression, anxiety and loneliness (Cohen et al., 2010). Because the resulting behaviour of, for example misusing substances and food fails to relieve the underlying nature of such emotions, the behaviour is then often replicated compulsively (Odets, 1995). Over-indulging and developing an 'addiction' to other practices such as smoking, shopping, exercising and food often provide comfort, and may fulfill that emptiness, which was apparent through all of the women's relationship with food- that need and search of fulfillment. The search of using food as a comfort for these women with a history of substance addiction, may have also meant that the triggers, urges and compulsion were all still there, only they were using food to feel comforted, rather than the alcohol.

The replacement of sugar rich foods, did not only fill a void, it also helped *dampen the cravings and urges experienced from the substances*. It has been pointed out that although sugar does help with cravings at the time, it primes the beta-endorphin system to want more sugar and can cause the individual to have stronger cravings whether this is in the form of sugar, or an alcohol relapse (DesMaisons, 2008). When the individual stops consuming alcohol, the brain reacts by opening significantly more beta-endorphin receptors to balance or give back the reduction in beta-endorphin triggered by abstaining from alcohol. As there are more receptors open, the consumption of sugar creates an influx in beta-endorphins, which in turn produces a stronger reaction. DesMaisons (2008) points out that the low level of beta-endorphin triggers the individual to crave sugar whether this is chocolate or alcohol, as a way of releasing beta-endorphins, as sugar rich foods and alcohol initially sends out good feelings. However, regular sugar consumption results in the beta-endorphin system down-regulating over time, closing down several receptors in order to stem the intake of sugar-stimulated beta-endorphins, causing the person to want to consume more sugar to get those good feelings of euphoria (DesMaisons, 2008). The women spoke about how sugar gave them a 'buzz' and *changed their mood*, and referred to it as cross addiction, whereby sugar was labelled 'a drug'. Sugar can boost self-esteem, as it increases serotonin levels, which means that it also lifts a person's mood (Fortuna, 2010).

Although the sugar rich foods during early recovery replaced the substances by 'filling a void', 'dampened the cravings and urges experienced from the substances' and worked as a 'mood enhancer', it also holds a central position as a statement of the self. Food provides information about the person's identity and "acts as a communication of internal needs, internal conflicts, and a sense of self" (Ogden, 2010, p. 66). What the women *feel* about their food behaviour is central to the meaning of food. For the women in this study, food represented a complex array of meanings of comfort, pleasure and guilt. It was a place to work out feelings, a 'safety valve' where they would eat sugar, rather than drink alcohol. Comfort eating was a common experience for all the women and can be viewed as learnt behaviour instilled in human beings from birth (Ogden, 2010; 2012). From birth if a baby cries milk is provided as a comfort and from a young age children are often comforted with treats if they hurt themselves, or rewarded with it if they were good. In turn this becomes

learnt behaviour where the message is that 'food makes us feel better'. Although sugar rich foods are often associated with pleasure, they are also associated with guilt (Ogden, 2010). This conflict between pleasure and guilt for most of the women in this study resulted in weight gain, due to the excessive intake of high calorie foods, which in turn resulted in dieting and distorted eating later in recovery. Though the women were aware of the need to eat healthily, they struggled to practice healthy eating behaviours.

In recent times, the focus towards self-improvement has widely increased, with constant worries over one's health and the need to integrate exercise, diet and other forms of holistic mind-body practices (Grogan, 2007). It has been suggested that through the engagement of such practices, the body and mind become *"sites of control"* which provide a sense of security in an increasingly insecure world (Crossley, 2000, p. 42). Control has become a central underlying concept linked with a range bodily practices such as exercise and dieting. Although the women in this study binged on food, they also often restricted their food, which could be explained through the need of regaining that control to compensate for the times they overeat. Controlling their desire to use substances and controlling their food intake may be linked to letting themselves 'slip' and binge on food because it is safer than having a drink, although it is the same behaviour, as they are ultimately cross addicting. This overlap between substance misuse and distorted eating has been explained by similar personality traits such as perfectionism and high impulsivity across both addictions (Bulik, et al., 2004; Wolfe & Maisto, 2000), as well as dysfunctional coping strategies to balance emotions (Corte & Stein, 2000; Badger et al., 2013). This may have caused difficulty for the women to cope with any negative emotions, leading them to self-medicate whether this was in the form of substances or food.

This substitution of food in search of a replacement for the substances the women misused during addiction subsequently lead to a number of consequences. The implication and identification of this theory is discussed in the next section.

CHAPTER 4
CONCLUSION & RECOMMENDATIONS

In this chapter the achievement of the study's aim is demonstrated, with the emerging theory being evaluated using the criteria proposed by Charmaz (2006). The implications of this study's findings and general limitations and directions for further investigations will be presented.

4.1 Evaluation of the Emergent Grounded Theory

The following evaluation considers the position of the researcher through the course of this study with regards to what has been achieved through a reflection into the research journey, and through looking forward to imagining how the endpoint appears to the readers. Charmaz (2006) points out that the endpoint of the study makes sense to the researcher, as they have been part of the process, however for the audience the stages between the process and the final product can become unclear. She further explains that the researcher must consider their audience, as other scholars are likely to evaluate the grounded theory process as a fundamental part of the final product. Whether the audience may be practitioners, educators, or lay people, they will more than likely be the ones that will consider the usefulness of the methods adopted to reach to the final product. The criteria suggested by Strauss and Corbin (1998) for evaluating a grounded theory research included judging the 'research process' and 'ensuring empirical grounding' of the research. To allow the reader to evaluate the quality of the 'research process' all research processes utilised in this research have been documented in detail in chapter two, providing a thorough account of the step-by-step process such theoretical sampling, constant comparative procedures, memo writing, data collection and analysis, identification of categories and the development of a theory. Charmaz (2006) proposed four criteria for evaluating grounded theory studies: credibility, originality, resonance and usefulness. These criteria account for the empirical research study and the development of the emerging theory. In an effort to ensure that the criteria for grounded theory have been meet, each criteria is

considered to outline how the researcher ensured that the trustworthiness of this study was maintained.

4.1.1 Credibility

According to Meehan (1999), credibility is reviewed according to the accuracy with which the data are interpreted and analysed, and the closeness of the final findings to both the participants and others' experience of the phenomenon. In order to maintain credibility in constructivist grounded theory, reflexivity is a crucial element throughout the research to identify, describe and incorporate the researcher's interpretations into the research process (Charmaz, 2006). Reflexivity started with understanding the importance of the researchers own values and attitudes towards the research process, which involved taking a critical view inward and a reflection of the researchers own experiences and lived reality. Questions that where part of this process included: 'How does who I am influence the research process?' and 'What shapes the questions chosen for inquiry?' (Nagy Hesse-Biber, 2007). The researcher's own personal and professional interests are acknowledged, as these were brought to the research through own experiences and views.

Reflexivity

Reflecting on my own perspective, some of the underlying assumptions brought to this study are discussed. The study is informed by my own experiences as a substance misuse worker, a health psychologist, an educator and trainer, and also as an individual who previously suffered from eating disorders. I have, for a number of years worked within the substance misuse addiction field, delivering psycho-educational interventions in an effort to reduce distress and facilitate lifestyle change for individuals in active addiction and in recovery from drug and alcohol dependency. This experience meant that I had a high level of experience of working with individuals in substance misuse facilities and was familiar with some of the difficulties they faced during this period. This degree of experience presented the risk of taking the role of a therapist during the interview process, however I was aware of my position within the research and therefore for these reasons amongst others did not

interview women from the same service (see chapter 2 *ethical considerations* for further detail). Interviewing women that I did not therapeutically engage with helped me to maintain my stance as 'researcher'. In recent years I have also been an educator and trainer, teaching health psychology in specialty settings. Experience as a health psychologist and, educator and trainer meant that I have an understanding of theories and models of addiction behaviours in general, and the effects of these behaviours on human health. My experiences as a person who has in the past suffered from distorted eating and weight issues allowed me to relate to some of the experiences and stories of the women in this study, but also provided me with a different perspective through new insights and understandings. I acknowledge that although individuals may have similar experiences, they also all have different life stories that may shape their experiences. Remaining conscious and transparent of these perspectives was considered important, as they served as tools and helped me understand and explore the women's experience of weight changes, food and eating during recovery, from the perspective of the women themselves.

The methods used in this study to facilitate reflexivity included a number of constructs. A reflective log was kept during the entire research journey, in which thoughts and feelings were recorded during the stages of sampling, data collection, analysis and write up. In addition, memos following the transcriptions helped me make connections on assumptions, and record reflective questioning, particularly after the initial coding phase. Reflexivity was also incorporated into both research, placement and clinical supervision meetings and regular face-to-face, phone and email contact with my own research supervisor, which allowed the review of notes, memos, transcripts, analysis and any issues or concerns that arose to be discussed. Both the first and second supervisors provided a high level of critical challenge throughout the study. The last reflexivity construct included meeting with 'experts' with certain expertise in grounded theory to discuss emerging categories and provided different points of view. All the reflexivity constructs helped challenge my thinking and allowed me to become more aware of personal assumptions.

Additionally, to ensure that the data was credible, informant feedback also took place within each stage of the research. The research supervisor read all interview transcripts and reviewed all the focused codes and categories to aid with

trustworthiness. The supervisor also undertook blind coding with one of the transcripts to help with avoidance of forcing or early closing of analysis. Credibility was also achieved by allowing the women interviewed to guide the inquiry process, confirming the meaning behind their statements, and using the women's own words in the category formation and theory building stage. The evidence presented of decision-making during this research process should also aid credibility and enhance the rigour and trustworthiness of this study (Charmaz, 2006).

4.1.2 Originality

Charmaz (2006) states that there are various ways a study can provide an original contribution to the existing knowledge. She points out that if the researcher is able to offer a new and in-depth understanding of a given phenomena, then they are contributing to an original piece of work. From the outset of this research in 2011, it was identified that whilst the literature provided insight into weight increase and dysfunctional eating behaviours amongst substance misusers in general, the multiple experiences, meanings, and functions of weight change, food and eating for women during the recovery process had not been addressed in the UK or internationally. I have also conducted a systematic review prior to this research reporting on the effectiveness of interventions to promote healthy eating within a substance misuse population and only generated a total of seven studies reporting on the outcomes. Though most of the studies reviewed reported positive outcomes regarding increasing healthy eating and nutritional knowledge during and after the interventions, there was little evidence found to determine long-term sustained behaviour change within this population. Therefore, by gaining a deep understanding of weight changes, the meaning of food and eating from the perspective of women in recovery from substance addiction, it may further be possible to address the difficulties these women face during this crucial time of change in their lives. This study provides fresh insight into these experiences and also provides a new theory with underpinning theoretical understanding, which adds to some of the limited literature on the importance of incorporating a healthy eating plan and addressing body compositions within substance addiction treatment facilities.

Additionally, the way I presented the women's experiences was through 'giving them voice'. I attempted to present their perspectives from as close to the experience as possible, which was demonstrated through transcript extracts.

4.1.3 Resonance

The resonance of this study is demonstrated through the higher-order analysis: theoretical development of the *meaning of food*, *weight changes* and *eating behaviours*, portraying the fullness of the experience of women in recovery from substance addiction. The emerging theory developed provides the reader with a deeper understanding of the multiple meanings and functions of food, eating and weight changes women in various stages of recovery are faced with. This insight is achieved through the theory explicating the categories, which impacted upon this development.

4.1.4 Usefulness

Yardley (2000) states that research should be both important and useful. It may portray a new way of conceptualising a topic and as such improve or change peoples understanding and enlighten their behaviour or practice within the field. For example some of the women interviewed found that taking part of this study was empowering. They pointed out how valuable it felt that somebody was interested in understanding their experiences and that their views were being listened to:

> *"...I think what you are doing is really important, coz I think from a side where service users are coming...I think what you are doing, that's why I jumped at the chance of doing it, it's really valuable because it's important that you know exactly the score, do you know what I mean? Exactly how it is. Like you can't tell somebody that's in active addition that they need to be eating three meals a day, coz it's just gonna scare...them and it's never gonna happen. You know, but there are certain things that people can put in place like taking...you know even if you are drinking, it's still really important to get all your vitamin B, take some vitamin C...you know put some good things in your body even if you are still abusing it. And then just to slowly, slowly build*

*yourself up. And not to cross addict, coz a lot of recovery alcoholics cross
addict. So when you stop drinking, you start eating crap loads of chocolate.
It's important to get a really healthy balanced lifestyle"*
(Charlotte, 14 months, Line 300).

*"…Just you know I think that's great this observation. It's great! It's not just
about what you're doing, it's not just about the immediate problem is it? It's
prevention as well as cure isn't it?"* (Eileen, 17 months, Line 351).

Though the women that took part found this research useful and valuable, Stiles
(1993) indicates that the research should also be useful and believable to other parties,
as well as the participants. It is important to highlight that this research study will be
particularly useful by adding knowledge to the health psychology discipline, as most
studies on food and weight have been carried out on children, the elderly, pregnant
women and ethnic minority groups.

As the nature of the social world is always evolving and changing, grounded theories
of human behaviour are both preliminary and relative in perspective and time. I
therefore present my interpretation as one point of view amongst others consistent
with the constructivist approach, which "does not seek truth – single, universal and
lasting", rather it seeks to determine "what research participants define as real and
where their definitions of reality take them" (Charmaz, 2003, p. 272).

4.2 Implications for Practice

The theory that emerged from the findings of this study provide some support for an
interventional approach to address dietary concerns and weight-related components,
as these have been undervalued in treatment facilities (Gordon, Johnson, Greenfield,
Killeen & Roman, 2008; Killeen, Greenfield, Bride, Cohen, Gordon & Roman, 2011),
particularly in the United Kingdom, whereas in the United States although limited,
there is evidence that nutritional and exercise education has been implemented
(Liberty & Schoonmaker, 1990; Kropp, Winhusen, Lewis, Hague & Somoza, 2010;
Lindsay, Warren, Velasquez & Lu, 2012; Cowan & Devine, 2012; Badger et al.,
2012). Substance addiction rehabilitation services generally target addiction

behaviours exclusively, with limited attention towards health-related behaviours. However, given the existing weight concerns, distorted eating patters, and body dissatisfaction of women in the literature and in this study, it is crucial that health promotion education is incorporated into treatment services that extends beyond mental health therapy. Incorporating these elements into treatment programmes may increase self-esteem and confidence to help facilitate healthier eating patterns, and allow women in recovery settings to identify how food impacts on mood. Eating the right type of food at the right time help keep brain chemicals in balance, and by supporting women in recovery to make healthier food choices based on understanding how brain chemistry work, will allow them to discover and learn about other ways to increase the bodies natural production of beta-endorphin without resorting to alcohol or high content calorie foods. Implementing an integrative health promotion intervention will also be the foundation of preventing a number of health conditions such as high blood pressure, heart disease, diabetes, cancer, asthma, dental caries and obesity (NICE, 2007; Shepherd et al., 2006). Obesity and substance misuse disorders are complicated and costly preventable public health problems (NIDA, 2008), and it is therefore crucial that treatment providers play a role in reducing the rates of obesity in an effort to reduce the economic impact and burden of a second adverse health condition amongst this unique population.

Theory based interventions such as cognitive-behavioural and social-cognitive framworks for behaviour change have been considered useful in changing health-related behaviours. For example the use of interventions driven by a cognitive-behavioural principals, which combines the cognitive and behavioural approaches have increased based on their effectiveness, as they aim to help change how the individual thinks, feels and behaves (Michie & Abraham, 2004). There are also other effective theoretical frameworks that have been applied such as Social Learning Theory (Bandura, 1977) and The Transtheoretical Model (Prochaska & DiClemente, 1983) (discussed in chapter 1.) amongst others, which have differing historical antecedents and can inform both individually based and large-scale interventions. Interventions that have been suggested to be the most effective in promoting behaviour change, are the ones that are formed by a theoretical explanation of the links between the behavioural causes as they imply how the intervention should be carried out in practice. For example the systematic three-step approach often utilised

includes, a needs assessment to identify the causes of the behaviour, designing and carrying out the intervention, and evaluating the effectiveness of the intervention to help aid with future programmes (Bennett & Murphy, 1997). Other important considerations for effective implementation of any interventions, is that those delivering the interventions are competent (Michie & Abraham, 2004), which means training staff or employing experienced professionals to implement such behaviour change programmes.

4.3 Limitations and Future Research Directions

There were several limitations that occurred from this study. It was difficult to obtain participants willing to take part in this study, as the criteria involved one month of sobriety and most of the treatment services that were approached had women that were in active addiction. It was also difficult to schedule appointments with the women that had longer periods of sobriety, as they had other commitments in their life such as jobs and family responsibilities. All of the women that took part in the study, apart from one, where white British and therefore the findings of this study do not apply to other ethnic groups, which may be perceived as a limitation. This may be due to that participants were recruited from one geographical area or that women from other ethnic backgrounds may have been hesitant to take part in the study. As most of the participants were unknown to the researcher, this may have had an impact on sharing personal information. Though the majority of the participants did open up and shared a significant amount of personal information that was potentially emotionally painful for them, others may have been less comfortable in doing so. Other limitations experienced by the researcher was the lack of experience in conducting a grounded theory study, however the chosen methodology of constructivist grounded theory was a strength of this study through its flexibility and in-depth exploration of the women's meanings and experiences associated with weight changes, food and eating in recovery from substance addiction. Additionally, the uniqueness of this methodology, which involved developing a theory in an area that has not been previously reported in the literature through one on single study, has been far more valuable.

Though this study had its limitations, one of the aims was to attempt to develop a theory, which would act as a platform enabling further investigation into this area. Interesting areas for future research include recruiting participants from various ethnic backgrounds in order to understand whether cultural differences may have played a role in food, eating and weight changes during recovery. As there have not been any studies exploring these experiences amongst men in the United Kingdom, a comparison between women's and men's experiences may produce further interesting findings. This study had a balance of individuals in early and mid recovery, however only one individual in late recovery, therefore future studies may include further investigation of how food, eating and weight changes are experienced in late recovery in order to gain an understanding of what changes have been implemented and sustained during this longer period. Furthermore, future research could implement trial nutrition interventions tailored to specific age groups and recovery stages as well as the length of time in the treatment, by for example administrating a trial intervention in early, mid and late recovery and compare the outcomes. Additionally, it may be useful for treatment centres to carry out weight and nutritional assessments upon admission and monitor weight whilst targeting specific nutritional needs throughout recovery. Although the participants were asked what recovery meant to them, further investigation may include what factors were involved that influenced each person's need in seeking recovery. Whether they were personal choices, health or family related choices involved in the treatment process, as these insights may produce additional interesting responses of the women's recovery process and perhaps inform whether this influenced their food choices and eating patterns. Though there are a number of recommendations for future research in this area in general, the findings from this study could be viewed as an important contribution to enable a comparison of findings across other genders, age groups, cultures and recovery stages, to further build a theory based on the existing one that emerged from this study.

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APPENDICES

Appendix A- *Briefing Letter*

<div align="right">

London Metropolitan University
166-220 Holloway Road,
London, N7 8DB
0207 423 0000

</div>

Dear Client

This letter is an invitation to participate in a research study. As a full-time doctorate student in the Faculty of Life Sciences at London Metropolitan University, I am currently conducting research under the supervision of Dr ████████ on weight concerns, and the meaning of food and eating behaviours amongst female substance misusers in recovery.

Study Overview

Weight gain and disturbed eating patterns have been noticed among individuals in recovery from drug and alcohol addiction. However, food choice behaviour and the meaning of food in substance misusers lives have not been studied much and not much is known about these experiences. By carrying out this study I hope to understand the different experiences, meanings of weight change, food and eating from females in recovery from substance addiction. I also hope to develop a new understanding to help inform future designs for recovery programmes.

You play an important role in this research, and your input will provide key information to this study. I would like to invite you to participate in a one-to-one interview.

Your Involvement

The one-to-one interview will include questions about your weight changes in recovery, what food means to you and your eating behaviours in recovery. You may wish to consult other staff in your service regarding any thoughts about the questions after the interview.

All interviews will be conducted in person. The interview would last for approximately 30 minutes and would be arranged at a time convenient to you. I would ask your permission to audio record the interview.

Participation in the interview is entirely voluntary and there are no known or anticipated risks to participation in this study. You may decline to answer any of the questions you do not wish to answer. Further, you may decide to withdraw from this study at any time, without any negative consequences, simply by letting me know your decision. All information you provide will be considered confidential and the data collected will be kept in a secure location and confidentially disposed of in seven years time.

Your name and the name of the service you attend will not appear in the written work and/or publication resulting from this study. Excerpts from your interview may be included in the written work and/or publications to come from this research, where quotations will be anonymous to protect your identity.

A different name for you and the service you attend will be used to protect the anonymity of your identity. After the data has been analysed and the research completed, if you would be interested an electronic copy of the entire research can be made available to you.

Participation in this research is not part of your treatment within your service, nor will your decision to participate or not impact on your treatment.

Contact Information

If you have any questions regarding this study, or would like additional information about participation, please contact me at ████████████ or by email ████████████████████. You can also contact my supervisor Dr ████████████ by telephone at ██████████ or by email ████████████████████.
This study has been reviewed and received ethical approval through the Office of Research Ethics at London Metropolitan University. If you have any comments or concerns resulting from your participation in this study, please contact director of studies, Dr ████████████ by telephone at ██████████████ or by email ████████████████████.

Thank you in advance for your interest and assistance with this research.

Yours truly,

Suzanne Ashter
Trainee Health Psychologist

CONSENT FORM

I have read the information presented in the information letter about a study being conducted by Suzanne Ashter of the Faculty of Life Sciences at London Metropolitan University, under the supervision of Dr ███████████. I have had an opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I understand that participation in this research is not part of my treatment and that my decision to participate will not affect my treatment.

I am aware that I have the option of allowing my interview to be audio recorded.

I am also aware that excerpts from my interview may be included in the written work and/or publications to come from the research, with the understanding that quotations will be anonymous.

I was informed that I may withdraw my consent at any time without giving reason by advising the researcher; Suzanne Ashter by telephone at ███████████ or by email ███████████.

This project has been reviewed by, and received ethical approval through, the Office of Research Ethics at London Metropolitan University. I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the director of studies, Dr ███████████ by telephone at ███████████ or by email ███████████.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

❑ Yes ❑ No

I agree to have the in-person interview audio-recorded.

❑ Yes ❑ No

I agree to the use of anonymous quotations in any written work or publication that comes of this research.

❑ Yes ❑ No

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Name of Researcher   Date   Signature

Debriefing on participation of study
"Weight concerns, meaning of food and eating behaviours amongst female substance misusers in recovery"

Weight gain and disturbed eating patterns have been noticed among individuals in recovery from drug and alcohol addiction. High rates of binge eating, overeating and the use of foods, particularly those high in sugars and fats, as replacements for drugs and alcohol have been observed. In spite of this, not much is known how substance misusers themselves experience food and eating whilst in recovery and how food plays a part in their lives during the recovery process. This study intends to understand the different experiences, meanings of weight change, food and eating from females in recovery from substance addiction. You play an important role in this research, and your input will provide key information to this study. The study hopes to develop a new understanding to help inform future designs for recovery programmes.

You may have found it difficult to answer some of the questions in the interview, and your generosity and willingness to participate in this study are greatly appreciated. You may have found the subject matter of these interviews disturbing. If answering any of these questions led you to feel distressed and you would like to speak to someone about your thoughts, please contact your key worker or one of the following sources:

Mind in Mid Herts	01727 865 070
b-eat (Beating Eating Disorders)	0845 634 1414
Wired in to Recovery	http://wiredintorecovery.org

If you have any complaints, concerns, or questions about this research, please feel free to contact me by telephone at ▮▮▮▮▮▮▮▮▮ or by email ▮▮▮▮▮▮▮▮▮▮▮. You can also contact my supervisor Dr ▮▮▮▮▮▮▮ by telephone at ▮▮▮▮▮▮▮ or by email ▮▮▮▮▮▮▮▮▮▮.

If you have any comments or concerns resulting from your participation in this study, please contact director of studies, Dr ▮▮▮▮▮▮ by telephone at ▮▮▮▮▮▮ or by email ▮▮▮▮▮▮▮▮▮▮.

If you are interested in this area of research, you may wish to read the following references:

Siple, M. (2008*). Eating for recovery: The essential nutrition plan to reverse the physical damage of alcoholism.* Philadelphia: Da Capo Press.

Nollen-Hoeksema, S. (2006). *Eating, Drinking, Overthinking- Women's Destructive Relationship with Food and Alcohol.* London: Piatkus Books Ltd.

Thank you for participating in this study.
Your time and effort are much appreciated.

Protocol to follow if participants become distressed during participation:

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in our research into PTSD, as some by definition will already be suffering from psychological trauma as a result of their previous experiences. There follows below a three step protocol detailing signs of distress that the researchers will look out for, as well as action to take at each stage. The PI (Chris Cocking) is a grade 5 qualified Mental Health Nurse registered with the NMC, and so has experience in monitoring and managing situations where distress occurs. It is not expected that extreme distress will occur, nor that the relevant action will become necessary. This is because most of the participants with PTSD will be approached through contacts in professional services and so there will usually be an existing structure set up to deal with extreme distress which professionals can implement. However it is included in the protocol, in case of emergencies where such professionals cannot be reached in time.

Mild distress:

Signs to look out for:
1) Tearfulness
2) Voice becomes choked with emotion/ difficulty speaking
3) Participant becomes distracted/ restless

Action to take:
1) Ask participant if they are happy to continue
2) Offer them time to pause and compose themselves
3) Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:
1) Uncontrolled crying/ wailing, inability to talk coherently
2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
3) Intrusive thoughts of the traumatic event- e.g. flashbacks

Action to take:
1) The researcher will intervene to terminate the interview/experiment.
2) The debrief will begin immediately
3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
4) The researcher will recognize participants' distress, and reassure that their experiences are normal reactions to abnormal events and that most people recover from PTSD

5) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
6) Details of counselling/therapeutic services available will be offered to participants

Extreme distress:

Signs to look out for:
1) Severe agitation and possible verbal or physical aggression
2) In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

Action to take:
1) Maintain safety of participant and researcher
2) If the researcher has concerns for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.
3) If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

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-OK, before we begin the interview itself, I'd like to confirm that you have read and signed the informed consent form, that you understand that your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at anytime.

-Do you have questions before we proceed?

Keep asking questions about how these have changed from early recovery to their currant stage

1. May I ask how long you have been in recovery and what recovery means to you?

2. Have you noticed your weight changing during recovery? How?

3. What does food mean to you?
   Has the meaning of food changed for you in recovery? How?

4. Tell me about your eating behaviours.

5. Was food used as a substitute? Why?

6. Has the social aspect of food changed for you in recovery?

7. Do you engage in physical activity? Why?

8. How is your coffee and tea consumption?

-Is there anything else that you might not have thought about before, that occurred to you during this interview?

-Is there anything else you think I should know to understand weight changes, meaning of food and eating behaviours in recovery better?

-Is there anything you would like to ask me?

Participant: Eileen
Recovery time: 17 months
Date: 13/02/13
Length: 34.40 minutes

1 I: I: So can I ask you how long you have been in recovery for?

2 P: 17 months almost

3 I: And what does recovery mean to you?

4 P: It's my life's back isn't it. It's my life's back…all the things I care about. It's return to self-respect	Elements cared about back into her life
5 as well, that means a lot. Because I think my drinking was very much hidden. I couldn't show it	Return to self-respect
6 with the people I love the most, the people that could help me the most and when I did…when I	When drinking problem revealed, it was a
7 finally did tell the truth…the support have been phenomenal. And you know everything's better	relief
8 now…everything's better. And when in group when people say –right would you say on a scale of	
9 0-10 at this moment. At that moment I can honestly say almost 10. It doesn't mean that things are	
10 gonna come in and out of the day that would spoil it, but very few things do now really. So	
11 recovery for me is that I didn't lose the people that I loved, I was lucky. They didn't quite stop	Didn't lose the people she loves
12 loving me but I think they were on the cuffs of jettisoning me if you like. But not anymore, I've	
13 got them all back again. I am so extremely lucky, very, very lucky I realise that. I didn't lose my	Lucky to be in recovery
14 sons. My children were adults by the time I really started to go down hill. And my drinking	
15 pattern was very much of a secret one so a lot of people were not aware of it, which had its draw	
16 backs actually. If more people were aware I might have opened up a lot quicker to it you know.	
17 But my life yeah. Everything. Its such a small word. Four letter word with a huge meaning.	
18 Everything, friends, family, honesty, *enjoyment*. You know I took my husband out on a Saturday	Family, friends, honesty, enjoyment

19 night, he is 70 with a group of friends. It didn't…It didn't…its just so much fun without alcohol.
20 Its real enjoyment of it. Because before it was were is the next one coming from. So yeah
21 everything that word entails, I've got it all back.

22 I: So have you noticed your weight changing during recovery?

23 P: To start with when I was first in recovery the first six months from September, the middle of
24 September to…I cant remember when Easter was last year, but I know it was in March, it was in
25 early Easter. And in that time I probably lost over a stone in weight. Because my calorie, my
26 calorie count wasn't so high and I was out and about more. Because I used to stay in to drink, I
27 wasn't out that much.

28 I: When was this, six months into recovery?

29 P: Yeah, six months into recovery, I lost a stone in weight naturally. Just by eating properly when
30 I should eat and walking more, going out more. They were all saying –wow you look okay, you
31 look okay. Then Easter time, I have never had a sweat tooth ever and Easter time some said –
32 would you fancy some chocolate? Well I only put that chocolate down in December and I have
33 now started a slimming group, because the habit. Talk about you know you are an alcoholic.
34 The way I ate that food, was the way I hide my booze. We would have friends for dinner and they
35 would complement me on my dessert and there was enough in the fridge to give them another
36 helping three times over and I didn't give anyone it. I saved it when they had gone and ate it all
37 on my own. Just honestly the sweet stuff, I ate that exactly the same way I drank. And now I am
38 on this diet, I am told that you can have as much fruit as you like, unhindered. So just the day
39 before yesterday, XXX and I went out and I nearly spent nearly 17 pounds on fruit that lasted me
40 one day, exactly the same way as I was drinking, so I have got to approach that. That is my
41 alcoholic behaviour isn't it. I just thought that once the drink would go, the habits would go. And
42 when my family came round the day before yesterday I eat it all in one go. About 15 bananas, 10
43 pears, 2 packs of grapes, I ate that whole lot, I ate. And when my husband came round yesterday,
44 I hide the fruit bowl in the pantry, just so that he wouldn't think –why is that empty? Because he

Got her life back

Lost 6.3 kg the first 6 months

Low calorie intake
Out much more

Eating properly, walking more caused weight loss
Others comment she looks good
Developed a sweet tooth for 7 months
Started a slimming club

Ate and hide sugary snacks same as drink

Now on a diet

Eating excessive amounts of fruit
Alcoholic behaviour, same behaviour with food

Hiding fruit

45 doesn't live with me. So out of sight, out of mind and he didn't notice. And that in a way that
46 really does endorse. My drinking wasn't…it would be lovely if you could just kid yourself that I
47 would be like a little blip in life, but my eating habits are those my drinking habits. So I have got
48 to now, as from yesterday really, address my…I'm loosing weight…I have lost 10 pounds in five
49 weeks, so the diet is working. And it's true what they about it being [inaudible segment] that is
50 wrong, so I am going to deal with that, the way I dealt with drinking. And that is don't have
51 anything in the house. Just don't buy it, or if your gonna buy it, eat two bananas a day.

52 I: But you said you put on weight in the six months?

53 P: No, no I lost weight.

54 I: Yeah, sorry you lost weight, but once you came off your drinking, in the first six months, so straight
away?

55 P: Immediately! Within three or four days, my face went back to its initial shape.

56 I: Where do you think that came from?

57 P: I think all the extra calories in the drink. When I wasn't talking those calories, I was watching
58 what I ate and I know my moms diet, which is the programme that I am on now, so I knew the
59 things which are good and not good to eat. So I was eating properly, I was selecting my food
60 properly, I was cooking it myself, I wasn't buying processed food, like you do on the run. Because
61 all you care about is drinking, you don't care about cooking a lovely healthy meal, and then
62 bearing in mind my drinking was in secret, so the family meals and all that I was eating good
63 food. The only time I lost control of my eating was when I was hungry, and I was hung over and
64 no one was watching me. Then I would eat all the junk in the world. I stocked up on junk, just to
65 take care of those moments, but in the [inaudible segment] my eating was okay, and also I put
66 on weight. But yeah in the first month I lost nearly a stone, or just over a stone. Everything fit me
67 just after six months.

	Eating habits same as drinking habits
	Diet working
	Lost 4.5kg in 5 weeks
	Trying to deal with her eating behaviour same as her drinking
	Lost weight first 6 months
	Lost the puffiness from drinking
	Not watching what to eat when drinking
	Eating properly, cooking it
	Not on the run
	Loss of control over food when hungry and hung over
	No one watching
	Ate junk
	Put on weight from the calories and junk food
	Lost weight first month of recovery

68 I: So in that early recovery time…

69 P: Yeah, everything just came off. But I was full of it as well, there was this buoyancy, their was
70 this enjoyment of life about me that settled down now, but because I wanted to go out, I couldn't
71 wait to get out. XXX and I, we worked it out in the end that we were probably walking about 15
72 hours a week. I didn't work it out in how fast it was or how many miles it was, just how long I
73 was actually mobile. I stopped bussing everywhere. From where I live I can walk up to Tesco's
74 and things like that now. Then I discovered chocolate.

Enjoying life and out more in early recovery
Walked 15 hours a week

75 I: Is this six months after?

76 P: Yeah, I discovered chocolate and I that was last March I discovered chocolate. A year next
77 month. So Easter time was [inaudible segment] and I took to chocolate like a duke to water. And
78 again, my drinking habits came back, because I didn't drink at all. The day I stopped drinking, I
79   didn't have any alcohol. But I am terrified of the dark. I really mean scared of the dark. But you
know…

Discovered chocolate 6 months into recovery
Obsessed about chocolate

80 I: Of the dark?

81 P: Yeah, I don't like going out on my own, I don't [inaudible segment] I actually went to XXX the
other day on my own.

Diverts the topic to being scared of the dark

82 I: So when you had that chocolate you said…

83 P: Yeah it was like drink.

Chocolate like drink

84 I: Did you start putting on weight?

85 P: Asolutely immediately, within days. But I had one bar of chocolate, then I went out and bought
86 two Easter eggs, and ate the Easter eggs and what was inside them. And then I would go over to
87 the shops opposite where I live in the dark, but my street lights they are up and that but its not
88 something I would like to do…went over there in the dark and stocked up on a weeks chocolate
89 and get home and eat the weeks chocolate like I would drink a weeks booze. I would stock up on
90 alcohol and drink it all in one go, and I ate the chocolate in one go and I did that up until
91 Christmas time. At Christmas time my neighbour gave me a box of chocolate biscuits and I ate
92 them in one night!

93 I: So that went one for about eight months?

94 P: It did, from March till December. Longer than when I was in recovery that eating, that sweet
95 tooth used to drive me mad. And then I would just eat a bar of chocolate on the way down, eat a
96 bar of chocolate on the way back.

97 I: And then you decided to go on a diet?

98 P: Well, I went up to 14 stones and I have never been this big. I mean I have never ever been this
99 big in my life and I was always a slim person and I put on weight because of the drinking. And
100 because of the aging process anyway, but then when I had to stop working, I had the broken
101 foot and the crouches and all of that. So that made it difficult. So yeah I took sweet stuff exactly
102 same behaviour, same pattern as drinking, and I now in the last five weeks since I have been in
103 the diet I have been straight on fruit. Hide it all, snoff it all, don't share it with anyone…and then
104 eat it all in one go. Why would you be ashamed of…why would you hide fruit? It's absolutely
105 alcoholic behaviour, and I can laugh at it, because it's a whole new substance. But you know if it
106 was dope or booze I would be straight [inaudible segment] I haven't learned anything about
107 impulse control by being sober. Because not with chocolate and certainly haven't learnt it with
108 fruit. So today is my [laughs] first day of eating…not scoffing fruit you know.

Put on weight alongside the chocolate habit

Went out despite her fear of the dark to buy chocolate
Eat it on her own at home in one go like with the drink

Chocolate craving for 8 months
Sweet tooth took over
Associated chocolate with everything

Went up to 89kg, biggest she's ever been
Always been a slim person

Took to sweet like drinking behaviour
On a diet for 5 weeks straight on the fruit
Hide the fruit, eat it in one go

Fruit a new substance
Alcoholic behaviour, impulse control
First day of not scoffing fruit

109 I: So what does food mean to you?

110 P: Well, I never thought it was a comfort. It's an assisting for me food. I like sweet nice food. But
111 I don't crave it. It's the sugar in fruit I am after and it is the sugar in chocolate I was after. I can't
112 believe that that's a physical hangover from drinking, because it's been so long now. But then
113 sweetness is a treat actually that's the truth of it. It's spoiling myself isn't it? I got that same
114 feeling on a Friday night, the house work is done, the world is where it should be, everybody is
115 happy and I can sit down and open a bottle of wine, which went over to a bottle of vodka, a
116 bottle of brandy. But that was my initial thing. The first day I was spoiling myself, the second
117 day you are indulging. And I do exactly the same thing with sweets. Everything was done, and
118 they would be on my lap, and I would get that small piece out there, and then they would go and
119 get the whole lot. And I do the same with fruit.

120 I: You described it as comfort, the sugar.

121 P: It must be, I can't think of what else. And it is at that moment, when I sit down and all my
122 chores are done and I it down and spoil myself. But I only…you know a nice way of spoiling
123 yourself would be have that, but in small pieces, be satisfied and put it away. And then the
124 alcoholic comes in and whoff I take the whole lot.

125 I: So do you find that the meaning of food has changed for you in recovery?

126 P: Not the meaning of good food hasn't. Because I cook everything from scratch because of my
127 diet. And I have been doing that for the last few years, I cook everything from scratch…I take
128 care of what I eat. But the sweet element, the forbidden element of it if you like, which is what I
129 do in secret. You know I stuff myself.

130 I: The sugary part of it?

Food is comfort
Craves the sugar in fruit and chocolate
A physical hangover from drinking
Sweetness a treat, spoiling herself

Same obsessive pattern with drink, sweets
and fruit
Starts with a small piece
Ends up eating it all

When all chores are done
A way of spoiling herself
Loses control and eats it all

Cooks everything from scratch
Takes care to what she eats
The sweet element, the forbidden element
done in secret

131 P: Yeah, that's…[ohm] that is important to me yeah.	The sugar is important
132 I: And that come more now to you now in recovery?	
133 P: Yeah, I have never had a sweet tooth. My downfall would be patty, strong cheeses. I have	No sweet desire previously
134 never ever…it means nothing to me. If I have a dessert when we go out for a meal I would have	
135 a cheese board. Never have desserts ever. But last March, boy desserts with capsulday and…I	
136 mean I go to the local travel lodge, because XXX cant drive and its down the road from where	
137 we live and…because of his eyes, he cant drive, so we go in there a lot and you know they know	
138 that I want sweets. They just know…now I don't have any. And they sort of smile. And I also	
139 now because of the diet, I have [inaudible segment] water and elder flower. I have taken the	
140 elder flower out, because its quite heavy in calories and I am trying to do that and my sweet	
141 things. I have my frozen fruit, which is quite tart and I have fat free natural yogurt. So I am	Still trying to treat herself, but take the
142 trying to treat myself, because I like those things and take the sweetness out of it, but still have	sweetness out
143 the treat. So yeah it seems to me a bit of a comfort really. The sin part of it, not the normal	Stays away from the sin part
144 everyday food, that's…I have to have that because I want to stay healthy and I want to lose	Wants to stay healthy and lose weight
145 weight.	
146 I: You are trying to get that balance?	
147 P: Trying to get ride of that sweet tooth. And I…so fare I cant, and I am not going to battle it. I'm	Battling the sweet tooth
148 gonna deal with that the same way I dealt alcohol, that is not have it in the house. I can do	Dealing with it same way as alcohol
149 without it. I think one banana is too many [laughs]! And maybe I have got this silly	
150 embarrassment…maybe I am a throw back to the monkies. Yeah one banana [laughs] is not	
151 enough and a 100 is too many. I am gonna have to do that. But I think the alcoholic behaviour,	
152 releasing that I have got it quite concerns me. I have got to control it, haven't I? Its more than	A need for controlling the sweet tooth
153 just controlling your drinking isn't it? I have got to…or get ride of that. All or nothing…It's all or	All or nothing
154 nothing isn't it? And I want to get ride of that really. I quit like boring. And I think there is	Get ride of it

155 something really sad about hiding a bowl of fruit so you can eat it on your own isn't it, you know it's a bit pathetic isn't it?	Sad about hiding a fruit of bowl
156 I: Where do you think that came from?	
157 Well I think it's the sugar you see and I don't want to share. Why did you feel like you had to hide it…	Don't want to share the sugar
158 P: Because if they notice they would take it off me and the shops would be shut and I can't get 159 anymore. It's like alcohol. They are not gonna drink my alcohol.	Hides it because concerned others will want some
160 I: Again, you said that was your comfort…	
161 P: Oh of course, absolutely, all in secrecy. It is very easy to see that this a pattern. What causes 162 the pattern, I am not too worried about. I just got to break the habit really. But yeah it is exactly 163 the same as drinking. Not sharing it, making sure. You know I might I might throw at a banana 164 and {inaudible segment] you know I am joking about it, because it's a harmless thing, but it's a 165 worry. It could be a cigarette couldn't it? I smoked exactly the same wouldn't smoke all day 166 when I was at work. I wouldn't smoke at all, get home, shut that door and I would smoke 20 167 cigarettes. So it's all or nothing really.	Secrecy Break the habit Was obsessed with cigarettes
168 I: So, can you tell me a little bit about your eating behaviours. Have you got a routine to you eating…?	
169 P: Not as best as it should be, not as best as it should be. I find if I weighed my tummy, I think I 170 eat too much. But basically I bought, I invested in this…you see it at three o'clock in the morning 171 on TV when you cant sleep. I bought this non-fat cooking kettle…frying pan and I have a couple 172 of eggs in the morning, one slice of toast maybe. Very, very big old fish. I cook everything from 173 scratch now. I hardly…my latest approach is learning how to do ratatolie and freeze it, because I	Not best routine as it should be Taking more care to cooking healthy foods

174 suck off of that. Yeah I eat properly. I do eat properly. Maybe not as often as I ought to, but when
175 I again you see, I can eat a lot. I would rather my tummy be small. I would rather graze than eat
176 a lot. But my appetite is quite big when I eat.

Doesn't eat often
But eats a lot
Big appetite

177 I: Did you have this appetite when you were drinking?

178 P: Oh yes, I never did before. I could eat normally then. My nan used to call it a whisky hunger.

Appetite when started to drink

179 I: Then? When do you mean then?

180 P: Before I started drinking. All the time I was drinking, I used to eat huge amounts. And I
181 would eat normally with the family and eat when they had gone. Because I didn't want
182 everyone to see how much I was eating. That was just caused by alcohol. So my nana called it a
183 whisky hunger, you know people that got a hang over. And you eat all fatty horrible food, that
184 you would not normally eat you know. But yeah I used to eat a lot then.

Ate huge amounts when drinking
Eat normally with family
Eat more when they had gone
To hide how much she was eating from family
Fatty horrible food

185 I: Do you think that you have structured meals in your routine.

186 P: Yeah, I do now, very much so. The last five weeks I have started cooking properly you see,
187 since I have stopped drinking. I put it in my freezer, but I might forget something to eat it for a
188 while. I haven't eaten so fare today, but I don't feel remotely hungry. But when I go home, I am
189 going to have a stir fry. So when I go home I will probably have that and then for my supper if
190 you like, I have this low fat dessert tart fruit and then I might have something before I go to bed.
191 So I move my days eating starts later everyday. But I have always been a bit like that. I don't
192 think I used to eat on my way to work.

Structured meals in the past 5 weeks

193 I: Did you have this routine in your early days of recovery as well?

194 P: Yeah, as soon as…do you know once the light went on. Right from day one. That last time

195 when I came in I stopped that Monday and I came in to see XXX on that Thursday…I stopped on
196 the 19 of September. And right from that minute I started to do everything properly. I needed a
197 structure in my day, because I am cute lazy naturally, and I could spent all day with my head in
198 the book or do puzzles. That's how I spent my time.

199 I: That food structure was important to you?

200 P: Yeah I had to, because it gave me something to do every few hours really. I didn't…I was quite
201 lucky in the sense that I didn't have…I had very, very few cravings from alcohol. Very few.
202 Sometimes if I was there…I remember one time, I actually had a physical reaction in the shop.
203 All the booze was over there and I had this tingly feeling in my tummy. But that is very, very
204 rare that happened. But of course, the quality of my sleep was better, very quickly.

205 I: You mentioned when you were drinking, you still had an appetite, but your food was not very
structured. It was eating…

206 Well, when I eating with the family, and I used to go out quite a lot with my girl friends and that,
207 and we will eat out maybe once, twice a week, so I never ate rubbish really, publically. But my
208 fridge would be full of pork pies and junk, that I knew that I would want to eat when I was
209 drinking. I didn't care about what I ate when I was drinking. I cared about what I ate when I was
210 outside, what people could see. When drinking I ate rubbish food. But publically I have always
211 eaten good…you know I have always thought don't cut back on our heating and our food, so I
212 have always eaten good food.

213 I: But when you went into recovery, did that become more important?

214 P: I needed to get up and do something. And I wanted to lose weight as well. Because I wanted
215 to be who I used to be you know very quickly. Once that light went on, I wanted to sort of get on
216 the programme straight away and I did, I actually did. That last time I floated about before that,

Structure as soon as she came off the drink
Structure important in her day

Few cravings from the alcohol

The chocolate may have been the craving for the alcohol?

Eats proper food publically

Fridge full of junk food
Didn't care what she ate when drinking

Going into recovery, going back to how she used to be

117

217 but I needed, because I live on my own. By half past nine I would be eating my breakfast and
218 then by one o'clock thinking about what I was going to have for my lunch, whether it was
219 [inaudible segment] and then in the evening. I had to think about what I was going to eat and
220 that was good. That gave me something to do everyday. Something to think about. But then of
221 course in between times because my mom and my husband especially, because he did
222 everything he could for me. Then it was nice weather September, August time and we were out
223 and about and all that, and I was out a lot and I would eat out a lot as well, so you know if was
224 alright in a way. But straight away I got into…it was just finding something for me to do in my
225 day, rather than being concerned about what I ate or I needed to eat. And I wanted to lose
226 weight very quickly, so I got…hopefully I did alright, until I discovered the chocolate.

Three structured meals provided planning and filled up her time

Out more in the summer months
Eating out publically
Gave her something to do
Not thinking about what to eat
Desire to lose weight quickly in early recovery
Discovered chocolate

227 I: So why do think…did you feel that food was used as a substitute?

228 P: No, I think that the chocolate. Yes, absolutely and the fruit. But it is the sugar. People have
229 said to me that you go for sugar when you stop drinking, because all the sugar in the alcohol…I
230 don't know whether that is true or not…six months had gone past…I didn't go through it then.
231 Once I tasted it, boom I was away, to the extent that my doctors mentioned my weight and all
232 that. And that has never happened to me ever.

Chocolate and fruit substituted the alcohol
Others have said it is normal
No sugar craving in the first 6 months
Took over 6 months later
Didn't realise how much she put on until doctor mentioned it

233 I: Once you tasted the chocolate, you spoke about it much, didn't you have any chocolate before that?

234 P: No, I might have the odd one. You know I never…a bar of chocolate would be nice in the shop
235 you know, break of a bit and pay for it at the till, and give the rest, share it with XXX. Never like
236 that, never nothing! You know I would substitute chocolate for food. I could just sit there all day
237 long and ice-cream…that was just disgusting. You know you got the ice-cream jug, or
238 container...some people would come round and –ok here's the ice-cream that's fine. And the rest
239 would go away and –oh that's lovely. Oh good thank you very much. And they would want some
240 one. And they would go and if there was nothing to eat in the ice-cream I would put jam on it, or

Never been sugar mad in her life

Substituted the sugar with food

241 syrup on it, or put a load of fruit on it. And I would sit up in bed at three in the morning and eat	Eating anything with sugar in it
242 that. That's not normal is it? You know that is odd behaviour, but that is what I was doing. And	Questioning her behaviour
243 that was just up until Christmas, so I have done well. I started that slimming group. I was very	Felt safe at Christmas, other people around
244 good over Christmas, but again I was in company over Christmas and XXX stayed with me and I	Not overeating
245 stayed with him over Christmas. You know just the odd night here. So I couldn't do that in front	Realised sugar eating needs to stop
246 of him. And then I thought this has got to stop. A bit like when I was drinking. I was okay over	Joined slimming club
247 Christmas and I went to the slimming club on the 3ed of January and I weighed in at 14 stone!	Weighed 89kg
248 And now I am just under 13, but its fare. I'm five foot four. And that's from you know I put on	82.5kg 5 weeks into her diet
249 two stone from march until now I put on two stone in weight. Nearly three stone actually.	Put on 19kg in 11 months

250 I: What about the social aspect of food. How do you find that?

251 P: Good as gold when I am out. Yeah really, I have…I think that is part of the alcoholism as well	Eating habits okay when out socialising
252 really, part of the alcoholic nature. Mine was always in secret. When we went out on Saturday	Eats in secret
253 night…I am so determined for this diet to work, I didn't have any desserts. I had a melon to start	
254 with and I have the ideal excuse –oh well XXX is 70, come on I will do that, but I didn't. You	
255 know I am so determined that I am gonna lose this weight. And on Tuesday…Monday my fruit it	
256 just went…in fact I finished the last four bananas, four not one! I finished the last four bananas	
257 for breakfast yesterday and I had…you know those great big bunches you get of free tray	Overeating bananas
258 bananas, you get huge big things, and I got two of them and I got a small green one, so I let that	
259 ripen. I didn't want that to go off. Well it was never gonna go off, because I ate it. You know, but	
260 I do the right wise to eat now, slightly not so right there and then [inaudible segment] ones	
261 there, so they ripen up. So by the time these have finished, the normal ones…but they go in a	
262 day. Ripe not ripe…	

263 I: But do you enjoy food now more?

264 P: Yeah, I do. No difference about the food. I always liked food. Nice food, well prepared. I have	Always liked nice well prepared food
265 always liked that and that is always what I have had. I enjoy food, very, very much. So in that	
266 way yes I do, because if I was out, I wanted to get home, I would have to restrict my drinking if I	

267 was out. So yes I was always be in a hurry to finish up and go home, so I could get to the alcohol,
268 but that's the only way I enjoy it more. It's nothing to do with my taste buds…I haven't got
269 enhanced or anything like that. I just…because it is my general demine really. I just enjoy it
270 more…I have got time it now. Enjoy what I am doing right now, rather than worry about the
271 next glass I am gonna have. I don't know if that makes sense?

272 I: Yeah, yeah, that's where you are at with it.

273 I: What about physical activity? How is that? Where you normally active when you were drinking?

274 P: No, not really, but I am not actually a sporty person. You know I am not. But I like walking. I
275 can't do it so much anymore. But I love dancing, but I can't do it, because of my weight and my
276 breathing. But, last week I managed to successfully display my bosoms to a whole group of
277 people at aqua aerobics. I went last Friday. And there was this little chap…I mean it doesn't
278 matter whether he was gay or not. He was very, very…he was vertically gay. I was…everyone
279 was looking at him, and I can't do much with this arm. So I was having very much difficulty
280 during the exercise and he nodded and I though that was him nodding at me, telling me that I
281 was doing okay. Then he nodded again and I thought –oh I am doing alright! Then I thought it
282 was a bit giggly and my top was down there, and I turned around to my mom and I said –oh
283 mom, look what I have done! But my mom she went yesterday, I couldn't go because of my
284 chest. It's Tuesdays and Fridays, we went Friday. And I said I wouldn't go on Tuesday, because I
285 think I might have damaged my arm a bit. But, I didn't, in fact it didn't affect my arm, so I was
286 gonna go yesterday, but I couldn't…and my mom went yesterday, because we go twice a week.
287 And that was lovely, yeah we did that. And that was part of not using busses and part of…and I
288 like doing it actually. That again, we said –what does it mean? What it means, is that my life is
289 back and there is various ways of spending your day. And I don't want my days to be spent in
290 front of the telly and anything like that. So that is just part of, and is part of you know getting fit
291 again, helping me to lose weight, but it was a lot of fun too.

Enjoys food more now
When drinking in a hurry to get home to drink more
Enjoys what she is doing and not think about next glass

Engaging in aqua aerobics

Getting active and fit part of getting her life back
Lose weight and fun

292 I: So, you are incorporating it much more now?

293 P: Yes, yes. I am quite happy to do more now as well than I did before. I joined the libraries and
294 things like that. Although I am quite…I probably talk too much…I am not as social as I used   Feeling positive about doing things
295 to…well I am started to become as social as I used to be. All that went out of the window really.   Becoming more social
296 How I feel about doing things, have changed now. You know, so that's good as well the exercise   Doing things differently
297 part of it.

**298 I: What about teas and coffees. Did you find that you were having more of that in the early days
of recovery?**

300 P: Well, I have less water now actually. I never went out of those ozone chicken tonight jars. I
301 always had one of those full of water, small ones, because I was always thirsty. And I thought   Needs to drink more water
302 that was a healthy thing. Of course it was, I was thirsty, so I was just drinking. So all that
303 stopped over night. I don't think I am not drinking quite as much as I ought to at the moment. I
304 like to try and get two litters a day minimum, which I could do very easily.

305 I: Did you find yourself drinking more tea and coffee when you came off the alcohol.

306 P: No. Well, yes. Ok, more tea than coffee. Yeah more tea than I would do. But I was always   Drinking more tea
307 drinking without alcohol. I would have a couple of pints of water a day anyway, but that is
308 because of the alcohol I guess. But yeah I probably have a great big cup like that, so I would
309 have five or six a day. But, yes I never…

310 I: What's that?

311 P: Tea. But I never drank tea, unless someone was there. If I was thirsty, I would go…well I just   Tea has become important
312 drank alcohol all the time. When I was out it was water. But I would get panicky when I walked
313 out of the door if I didn't have water, because I knew I would get dehydrated.

314 I: Do you still drink about six cups of tea now?

315 P: Yeah easy! Sometimes more yeah. I drink a lot. Although lately since this diet thing, I don't
316 know why. I am realising I am not having as much as before. But maybe that is because I am
317 concentrating on other things really. You know, but I always have a cup of tea there, always. I go
318 through millions of tea bags. Always have to have a cup of tea on the go.

Didn't drink as much tea when drinking
alcohol
Desire for tea before drinking

319 I: Where do you think that come from?

320 P: Oh, I have always been the same. I have always liked my cup of tea. Before the drink got hold,
321 it was the tea that I took from room to room. So I have always done that. I have always loved a
322 cup of tea. I have loads of that. Loads of it.

323 I: Anything else that you might have not thought about before that just occurred to you during this
interview, with regards to what we have spoken about?

324 P: I think yeah, talking to you about this sweet thing and this fruit thing, it makes me realise
325 they are bad habits. It just made me realise that you know once an alcoholic, always an
326 alcoholic. And I have got behavioural problems that relates to my drinking. The behaviours that
327 I adopted to drink, I am adopting now when I treat myself. Because I obviously see it is a treat,
328 don't I? And I don't do it publically, I do it privately, when no one is watching. But I will…I
329 stopped smoking, I stopped drinking…I will...I will break this. But I realise that sweet…in a way
340 if I can break this habit, it will be a good thing, because it just makes me aware that the only
341 thing I have put down is the drink. My thinking is certainly much clearer, and kinder, and more
342 secure. But in terms of patterns, the only thing that I will swap the drink for a bar of chocolate
343 and a bar of chocolate for a banana. You know it gets slightly healthier, but the pattern is still
344 there isn't it? So I will try and break that pattern really. Because it is benin, it doesn't worry me
345 so much.

Behaviours adopted to drink, she adopts to
treat herself with
Break the habit

A pattern
Swap the drink with chocolate and a
chocolate for a banana

An obsessive pattern

346 I: But that is interesting how you said it…from the alcohol to the chocolate, to the bananas, being more healthier.

347 P: Yeah, it doesn't worry me, the chocolate worried me because I was going out that way and I
348 look at this water, honestly I am not exaggerating. So I was determined. I put down the glass,
349 picked up the chocolate, picked up the fruit…that's exactly what I have done. I used them in
340 exactly the same way to change for me no one else. But I will break that habit. I know I will,
341 because I am telling myself that I am going to. And I never thought that I would stop drinking.
342 Never ever. That's the thing. What it has actually given you. It gives you back. It has given me
343 back the confidence that I can do things. Even though if it is just braking that…not even…that's a
344 big habit. I never thought that I would be able to do it. So that's the mountain that I climbed…or
345 still climbing! I always look at it like that. Anything else I will be able to do.

Worried less at the fruit, more about the chocolate
Used the drink, chocolate and fruit in the same way
Determined to break the cycle
Didn't believe she could stop drinking
Regained confidence to do things

346 I: Is there anything else you think I should know to understand your weight changes, the meaning of food and your eating patterns or behaviours in recovery?

347 P: Not, the only thing is you know I have been absolutely straight forward as fare as my memory
348 goes. The only thing is just that these patterns when I treat myself. And I hog out, I really do pig
349 out. Other than that I take care you know.

Aware of the patterns when treating herself

350 I: Brilliant, is there anything you would like to ask me?

351 P: No, just you know I think that's great this observation. Its great! Its not just what you're doing,
352 it's not just about the immediate problem is it? It's prevention as well as cure isn't it?

More than just putting the drink down

353 I: ….Thank you so much for taking part!

354 P: Thank you for everything.

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17th December 2011

Re Research

With reference to our recent communications and on behalf of ▮▮▮ I wish to confirm that we are more than happy for you to conduct your research programme; "Weight concerns, meaning of food and eating behaviours amongst female substance users in recovery". This is required to be carried out in accordance to London Metropolitan University's frame work of policies and procedures.

As previously mentioned my team have spoken to some of our female service users who are happy to be interviewed. However it may be beneficial if we were able to provide them with some written information on the research programme, interview process, their anonymity, where and how the information will be used along with a consent form.

We look forward to working with you in the New Year.

Yours sincerely

Senior Practitioner

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██████████

Re: Research

With reference to our recent communications and on behalf of ████████ I wish to confirm that we are happy for you to conduct your research; "Weight concerns, meaning of food and eating behaviours amongst female substance misusers in recovery".

This is required to be carried out in accordance to London Metropolitan University's frame work of policies and procedures.

Yours sincerely

████████

Operational Manager

The Effectiveness of Interventions

To Promote Healthy Eating Within a

Substance Misuse Population

A Systematic Literature Review

Word Count: 6412

CONTENTS

ABSTRACT

Healthy eating is fundamental in preventing a number of chronic conditions and crucial for individuals suffering drug and alcohol problems due to the lack of nutritional deficiencies. An increasing number of reviews have been conducted on healthy eating amongst other populations (children, the elderly, pregnant women, ethnic minority groups), but no reviews addressing the substance misusing population have been found. This systematic review was conducted to describe the effectiveness of interventions aimed at promoting healthy eating within a substance misuse sample. Multiple electronic databases were searched. Journals were hand searched and references of eligible studies were checked for further relevant publications. Seven studies targeting healthy eating and nutrition for substance misusers met the inclusion criteria, including a RCT and before-and-after studies. The interventions were part of substance misuse treatments and ranged from one-to-one counselling sessions to intensive group-based interventions, including didactic lessons, group discussions, interactive learning activities and weekly assignments. Six of the seven studies reported positive outcomes regarding increasing healthy eating and nutritional knowledge during and after the interventions. Three of the studies included follow-ups, ranging from four-weeks to six-months. There is however little evidence to determine long-term sustained behaviour change within this population. The importance of incorporating a healthy eating plan within drug and alcohol treatment facilities is discussed.

BACKGROUND

Healthy eating adds to an overall feeling of well-being, and is the foundation of preventing a number of health conditions such as high blood pressure, heart disease, stroke, diabetes, cancer, asthma and dental caries (Shepherd et al., 2006). Substance misusers are a population that has been mostly excluded from healthy eating interventions. The project, 'Eating better, Thinking better' (Sandwell and Williams, 2007), proved how valuable it is to teach healthy eating behaviours as part of treatment for substance misuse. The project demonstrated that there is a desire amongst individuals in treatment services for nutrition guidance. Increasing knowledge and understanding of the link between nutrition and, physical and mental wellbeing is key, in order for this population to gradually change their eating patterns (Sandwell and Williams, 2007).

Abnormal eating patterns and weight gain have been observed amongst substance misusers (Hatcher, 2004; Hodgkins, Jacobs and Gold, 2003). Eating disorders, such as anorexia and bulimia have been linked with substance misuse and high rates of body dissatisfaction associated with dieting, binge eating, purging, overeating and excessive laxative use have been reported (Cepik, Arikan, Boratav et al., 1995; Hudson, Weiss, Pope et al., 1992; Stice, 2002). The use of substances as a motivator for weight loss, particularly in females, is on the rise. It is regarded important that treatment facilities for substance misuse address body image, eating and weight concerns. Drugs, particularly stimulants (methamphetamine, cocaine, nicotine, ecstasy and a number of prescription drugs) are viewed as ideal drugs for weight loss due to their side effects, which consists of increased energy and loss of appetite (National Institute on Drug Abuse [NIDA], 2009). Individuals attending treatment for stimulant use gain weight whilst in treatment because of the gradual cut down of drugs (Brecht, 2004). For many individuals weight gain in treatment is essential for maintaining health, as many who enter treatment are underweight. A study by Emerson, Amaro, Glovsky et al., (2009) found that females attending treatment for substance misuse, gained an average of 6.5 lb within the first 12 weeks of treatment. Hodgkins, Frost-Pineda and Gold (2007) found similar results; in their study on nutrition and exercise, all participants attending substance misuse treatment, regardless of the intervention received, gained weight during the 8-week intervention.

Although both groups gained weight, the control group, who did not receive any exercise or nutrition education, gained most weight (Hodgkins et al., 2007). The excess weight increase in treatment and recovery may contribute to health problems, as obesity may play a key role in increasing chronic conditions (Howard et al., 2004; Sutter and Vetter, 1999).

The risks of substance misuse, its effects and the procedure for treatment and recovery are distinguished according to gender, age, ethnicity, sexual orientation, population groups and other factors (Center for Substance Abuse Treatment, 2009). Pregnant substance misusers are regarded as a high-risk population, as maternal use of alcohol and other drugs can have an effect on pregnancy outcomes, in addition to childhood health and growth. Women, who are actively engaged in substance misuse during pregnancy, put their child at increased risk for prematurity, low birth weight, impaired physical growth and development, behavioural problems, as well as learning disabilities (Covington, Nordstrom-Klee, Ager et al., 2002; Delaney-Black et al., 2000). For women continuing to misuse substances after childbirth, the ability to parent may be restricted and they may also be incapable of offering stable, nurturing environments for their children (Kelley, 1998; Schuler, Nair and Black, 2002). Health related problems and poor nutrition are common traits for women who misuse substances (Curet and His 2002; Hankin, McCaul and Heussner, 2000). Sufficient nutrition in pregnancy is vital to allow the foetus to develop and grow both physically and mentally to its full potential (Kramer, 1993). Much research has focused on achieving positive health outcomes in the child or foetus, rather than the mother (Edwin et al., 1998). A healthy nutritious diet is also essential to the mother herself, particularly during a period when she is vulnerable and may still be in addiction (Rush, 1986). During pregnancy, nutrition interventions can have positive and far-reaching implications (Bowman and Spangler, 1995). Pregnancy is viewed as a suitable period for encouraging dietary change, as women may be more receptive to health advice in general (Anderson, 1996). It should also be noted that women mainly occupy a central position in making food choices for the immediate family. Apart from feeding themselves, they also make dietary decisions for any older children, as well as their partners or any other adults in the home. Dietary choices of a mother with younger children may therefore have an effect on other people in the household

and may also be adapted by future generations (Edwin et al., 1998). For example the project 'Eating better, Thinking better' demonstrated that for many women attending the healthy eating project, their main motivation came through the desire to provide healthy breakfast, meals and snacks for their children. Among the women, low self-esteem was found surrounding healthy eating. Repeatedly during the early sessions of the intervention, a number of women stated, "It's not worth cooking for myself" (Sandwell and Williams, 2007, p.14). For a few, offering nutritious food for their children was seen as more essential than preparing healthy foods for themselves. Although this could be used as an initial motivator, recognising that preparing healthy meals for themselves was also important (Sandwell and Williams, 2007).

Eating patterns and food choices are important aspects of health and understanding the process behind the choices individuals make is central to health promotion. A persons life-course transitions and trajectories (persistent thoughts, feelings, strategies and actions over the lifespan) are fundamental influences on the development of his or her personal way for making food choices (Devine, Connors Bisogni et al., 1998). Addiction to drugs and alcohol has major effects on a persons diet. The majority of substance misusers diets contain excessive amounts of sugar. This craving of sugar comes from the large amounts of sugary calories in alcoholic drinks. Drug misusers tend to experience a similar effect. Sugar is normally used as a substitute for the drug craving. As a result high amounts of tooth loss and tooth decay is caused by the sugary and fatty 'non-chewable' foods, in addition to the effects of the substances themselves (Smethers, 2011). Processed food containing high levels of fat and sugary snacks, alongside the effects of drugs and alcohol, hinder the body from properly breaking down and absorbing nutrients. The poor diet and the inability to digest foods properly, leads to a number of health-related problems such as gastrointestinal disorders cardiovascular diseases and diabetes (Smethers, 2011; Howard, Arnsten and Gourrevitch, 2004; van de Weil, 2004). As these chronic conditions have proven to be more common amongst the substance misuse population, interventions targeting to increase health knowledge and behaviour are essential. Increasing knowledge about healthy eating as well as physical activity is necessary in order to help substance misusers regain their health during treatment and recovery (Ashley, Marsden and Brady, 2003; Wing and Hill, 2001).

Although interventions are targeted to change behaviour, the question remains as to the effectiveness of these interventions within the drug and alcohol field. It is the aim of this systematic review to describe the different intervention studies available and to assess whether they are effective in order to suggest recommendations for policy, as well as future research in this area. Improvement of programmes regarding nutrition education in recovery facilities may be enhanced and further incorporated into treatment programmes to decrease disease and promote improved well-being and health.

No reviews of intervention studies designed to increase healthy eating within a substance misuse population were found at the time of conducting this review. The aim of this review is to describe the effectiveness of interventions aimed at promoting healthy eating in the context of substance addiction. This review intends to establish; (a) whether substance misusers change their dietary knowledge, attitudes or behaviours in response to specific interventions, (b) the extent of such changes (if any) and (c) the type of interventions (if any) which appear to be effective.

METHOD

Scope & Approach of Review

The current systematic review focused on interventions to increase improvements in nutrition behaviour in substance misusers.

The methods of the review were based on the Evidence for Policy and Practice Information and Co-ordination Centre (EPPI-Centre) (2010). The EPPI-Centre conducts systematic reviews, in addition to developing methods and tools for conducting systematic reviews.

Selection Criteria

The original intention of the review was to identify the effectiveness of interventions to promote healthy eating in the context of addiction behaviours. Given the high number of studies generated, the intention of the review was refocused on substance misuse, with drug and alcohol as the primary substances. Other addictive behaviours such as tobacco and anabolic steroids were excluded from the review.

Study design was not restricted to randomized controlled trials, and intervention studies were considered regardless of the intensity and duration of the intervention. It was necessary that the intervention targeted substance misusers, whether in active addiction or recovery from substance misuse. In studies where the aim was not clear or the study had multiple aims, the outcome measures of the study were explored. Only studies published in English language were included in the review. Studies were not restricted to specific year of publication. The searches covered the full range of publication years available in each database up to 2012 (when the review was completed).

Search Strategy

The search strategy was build around the PICO framework including, Population-drug and alcohol misusers, Intervention- healthy eating, Comparison- none and Outcome- increased nutritional knowledge.

The following electronic databases were searched: Academic Search Complete, EBSCOhost, Education Research Complete, MEDLINE, Psycharticals, PsychINFO, SocINDEX, OVID, WILEY, ScienceDirect, PubMed, The Cochrane Library, ERIC, Google and Google Scholar. Searches within the grey literature were preformed. References of eligible studies were checked for further relevant publications. In addition, libraries and authors were contacted where it was not possible to gain accesses to a specific journal. The following relevant journals were hand searched to identify further eligible studies:

American journal of public health 1971-2012

British journal of nutrition 1947-2012

Health education research 1986-2012

Health promotion international 1997-2012

Journal of human nutrition and dietetics 1997-2012

Journal of nutrition education 1996-2001

Journal of nutrition education and behavior 2002-2012

Nutrition and health 1996-1997

Preventive medicine 1997-2012

Addiction research & theory 1997-2012

Journal of substance abuse treatment 1995-2012

Appetite 1980-2012

Public Health Nutrition 1998-2012

Wildcard searching where appropriate was utilised. Three search categories with different search terms were carried out, then combined using AND as followed:

Search category 1
Substance use OR addiction OR alcohol abuse OR alcohol misuse OR drug dependence

AND

Search category 2
Healthy eating OR nutrition OR diet OR food preferences

AND

Search category 3
Intervention OR programe OR education OR evaluation OR outcome

Data Collection & Analysis

Characteristics of the included studies are summarised in table 1, including details of the sample, the intervention, the design and whether there was a significant effect of the intervention to increase healthy eating.

Synthesis

The heterogeneity of the interventions, the study designs, the statistical techniques, target groups, the outcomes and methods meant that the complete meta-analysis was not possible to conduct. It is not recommended to estimate an overall effect size when there are multiple crucial differences between the studies (Anderson and Green, 2002). Data from the studies included in the current systematic review has been synthesised in a narrative and tabular form. The summary tables were further examined to establish whether there were any differences amongst the studies included in the review.

Quality Assessment

Assessing the quality of the studies provides an understanding of the strengths and weaknesses of the studies. The quality of each study was assessed depending on the study design. The eligible studies included in the current review were predominately observational studies (case series), with one study being a RCT. The quality of the studies was assessed against two similar comprehensive checklists proposed by the Centre for Reviews and Dissemination (2009). The checklist for observational studies uses six criteria, whilst the checklist for RCT uses seven criteria applicable to the studies for the current review (see Table 2). A quality score was provided for each study, with the score of 1 for adequate, 0 for inadequate and 0 for unknown. Though the current checklist was used, the main strength of the studies was determined by the effectives of the intervention.

Table 1. Quality of non-randomized studies

Study	Quality score	Sample population	Inclusion criteria	Baseline characteristics	Follow-up	Outcome assessment	Comparison of sub-series
Liberty et al. (1990)	4/6	Inadequate	Inadequate	Adequate	Adequate	Adequate	Adequate
Niccols et al. (2005)	5/6	Adequate	Adequate	Adequate	Inadequate	Adequate	Adequate
Schlichtig et al. (2007)	4/6	Adequate	Adequate	Adequate	Inadequate	Adequate	Unknown
Barbadoro et al. (2010)	6/6	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate
Lindsay et al. (2011)	5/6	Adequate	Adequate	Adequate	Inadequate	Adequate	Adequate
Cowan et al. 2012	5/6	Adequate	Adequate	Adequate	Inadequate	Adequate	Adequate

Quality of RCT study

Study	Quality score	Random-ization	Treatment allocation	Baseline characteristics	Eligibility criteria	Assessor blindng	Point estimates and variability measure	Intention to treat analysis
Kropp et al. (2010)	6/7	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Unknown

Search Results

The search strategy for the current review generated a total of 1496 potentially relevant papers. The number was reduced after duplicates were removed to a total of 1415. 482 studies were generated via EBSCOhost, Education Research Complete, MEDLINE, Psycharticals, PsychINFO and SocINDEX, 653 via ScienceDirect, 266 via PubMed and 14 via relevant journals for the review. Eligibility at this stage was determined by examining the abstracts of 1415 studies using inclusion criteria. Based on the information from the abstracts, 73 studies were further identified as eligible. At this stage 66 studies were excluded from the review. Specifically excluded were studies aiming to reduce drug and alcohol misuse, with no intention to change dietary knowledge, attitudes or behaviours towards healthy eating. Other studies excluded were qualitative studies and studies lacking information on nutrition or substance misuse. A total of seven studies were found eligible for the current review.

Records identified through database searches (n = 1482)	Additional records identified through other sources (n = 14)

Records after duplicates removed (n =1415)

Records screened (n = 73)	→	Records excluded (n = 1342)

Full-text articles assessed for eligibility (n = 73)	→	Full text articles excluded (n = 66)

Studies included in qualitative synthesis (n = 7)
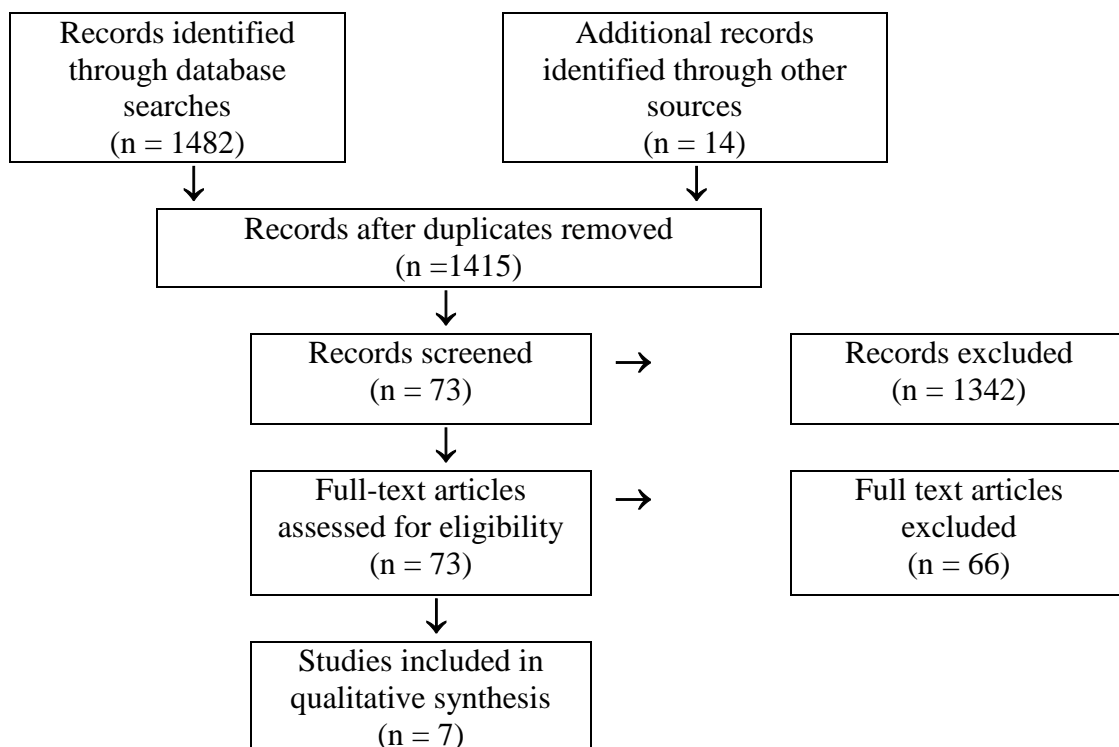
Table 2. Characteristics of included studies

Study	Sample	Intervention groups	Design	Result
Liberty et al. (1990)	Treatment programme attenders N = 12	Eight weeks educational program on healthy eating habits, proper nutrition and preparation with emphasis on the five food group using pictures and charts	Before-and-after study-six-week and three-month follow up	Development of nutritional knowledge indicating fewer items missed on the posttest when compared to the pretest Pre = 16.583, SD = 6.388 Post = 13.583, SD = 7.716, $p < .05$
Niccols et al. (2005)	Treatment programme attenders N = 13 women N = 13 children	21-months period. Clients involved for an average of 4 months (range 1–12 months) for nutrition counselling and skills development with other areas targeted for improvement; substance use, service use, social support, maternal depression, parenting and child development	Before-and-after study-three-months and six-months follow up during the intervention	Weekly servings of fruit and vegetables increased Baseline = 16.8, SD = 7.9 3 months = 16.9, SD = 7.1 6 months = 20.6, SD = 4.2 Weekly serving of dairy products increased Baseline = 9.6, SD = 5.7 3 months = 9.4, SD = 4.8 6 months = 11.6, SD = 4.2 Weekly serving of grains increased Baseline = 15.9, SD = 7.1 3 months = 13.9, SD = 3.8 6 months = 16.9, SD = 3.6
Schlichting et al. (2007)	Treatment Centre inpatients N = 8	12 sessions over a six week period on group nutrition education at lunch time	Case series- No follow-up	Not specified

Kropp et al. (2010)	Treatment programme outpatients N = 200	Active study phase four weeks in duration on healthy behaviours and parental care. Participants offered at least three individual counselling sessions in both treatment conditions, as well as group treatment, case management, intensive outpatient. During first month of treatment, participants were scheduled to meet with the research assistant on a weekly basis.	RCT- One-month and three-month follow up	Taking parental/ multi-vitamin: Baseline = 4.92, SD = 2.94, Active phase = 5.47, SD =2.57, p <.05 Drinking at least four glasses (8-ounce) of water per day: Baseline = 4.50, SD = 2.72 Active phase = 4,94 SD = 2.58, p <.01
Barbadoro et al. (2010)	Treatment programme inpatients N = 58	A lecture about the role of alcohol and food consumption on human health and liver diseases prevention. A brochure including information on nutrition and health.	Before-and-after study-six-month follow up	Improvements on groups of nutrients score from: 32.6 to 71.3%, p <0.05 Impact of nutrition on health score from: 38.7 to 84.6%, p <0.05
Lindsay et al. (2011)	Treatment programme attenders N = 124	12 group sessions on healthy food consumption and nutrition knowledge, alongside body dissatisfaction, eating pathology and thin-ideal internalization	Before-and-after study- No follow-up	Healthy behaviours: Pre = 68.44 SD = 12.05 Post = 75.83, SD = 14.38, p <.0001 Nutrition knowledge: Pre = 11.03 SD = 2.61 Post = 13.98, SD = 2.91, p <.0001
Cowan et al. (2012)	Treatment residential programme N = 55	Educational component based on six sessions consisting of weekly nutrition and cooking classes. Plus an environment component by adding healthy food choices to their menus	Before-and-after study- No follow-up	Daily servings of fruit: Higher = 0.631, SD = 1.0 Lower = 0.88, SD = 1.3 Daily servings of vegetables: Higher = 0.853, SD = 2.0 Lower = 1.23, SD = 2.5 Daily servings of fats, oils, sweets: Higher = -1.38, SD = 1.9 Lower = -0.34, SD = 2.6, p <0.005

RESULTS

Details of individual studies- intervention, outcome and evaluation

Liberty, L. H. and Schoonmaker, D. M. (1990) A model for teaching healthy nutrition to clients of rehabilitation services. *Journal of Rehabilitation*, **11439**, 35-39.

This reports the findings of a before-and-after study carried out in USA. Participants were part of a rehabilitation service and were diagnosed as having a variety of multiple disabilities and alcoholism. Participants were adult males and females aged between 23-59 years. The primary aim of the intervention was to educate participants on healthy eating habits, proper nutrition selection and preparation with emphasis on the five-food group. The intervention took the form of a weekly group meeting over an eight-week period, led by an education instructor and a special education teacher. Each week, one food group from the basic five was displayed on a poster board, with the last three weeks of the intervention emphasising on food preparation and meal planning.

Outcome data were collected at the end of the intervention, with a three-month follow-up. A t-test was performed to detect the differences between pre- and posttest scores, indicating a significant difference. The results indicated the intervention had a positive impact on nutritional knowledge. All the participants attempted to incorporate the five food groups into their diets and had spoken up at mealtimes if something was missing or not prepared in a healthy way. Prior to the intervention participants normally ate any type of food served.

Although there was increased nutritional knowledge, the study was based on only 12 participants, so the possibility of inadequate power needs to be considered. Insufficient information is reported to assess how many participants suffered alcoholism. The differences between the participants in diagnosis, may have introduced some confounding results. A comparison group may be a stronger way to identify similarities, differences and gains in awareness.

Niccols, A. and Sword, W. (2005) ''New Choices'' for substance-using mothers and their children: Preliminary evaluation. *Journal of Substance Use*, 2005, **10**: 239–251.

This reports the findings of a before-and-after study carried out in Hamilton, Ontario in Canada. Participants entered New Choices programme, part of a multi-sector service delivery in a large urban centre that offers a ''one-stop shop'' for mothers with substance use issues and their young children. Participants were all females aged between 21-36 and their children aged 0-6 years. The primary aim of the intervention was to improve health and well-being of women and their children by providing information, support and treatment for substance use, mental health, nutrition, and parenting. The intervention was an ongoing programme over a 21-month period, led by an interdisciplinary team of professionals. Participants were expected to attend groups and individual counselling two days per week. Participants attended the intervention on average of four months (range 1–12 months). The attendances were not continuous, as some left the programme for a while and returned.

Outcome data were collected three months and six months into the intervention. Pre-test mean scores were low, indicating low levels of consumption of nutritious foods. Following three months into the intervention, changes in mothers mean scores reflected small to medium decrease in the consumption of grain products and beans/meat alternatives and no change in the consumption of fruit/vegetables, dairy products, meat and fish. Following six months into the intervention, changes in mean scores reflected medium to large increases in the consumption of fruit/vegetables and dairy products, small increases in grain product consumption, small decreases in meat consumption, and no change in the consumption of fish and beans/meat alternatives. These dietary changes indicate some small changes to participant's nutrition, however the results were not statistically significant.

Although the intervention provided multiple services, improvements in nutrition was evident after six months. The results showed more improvements after six months, suggesting that length of programme involvement may be an important factor in outcome. 13 mothers and 13 children entered the intervention, 7 children and 11 children remained six months into the intervention. Inadequate power needs to be considered.

Schlichting, S., Boog, M. C. F. and Campos, C. J. G. (2007) Lunchtime as a therapeutic moment: A health education approach with alcohol-dependent women. *Rev Latino-am Enfermagem*, **15**: 384-90.

This reports the findings of a therapeutic lunchtime intervention. Participants were part of a treatment institution for alcohol misuse. Participants were adult females aged between 47-55 years. The primary aim of the intervention was to provide an opportunity for health education to occur outside the conventional pattern. The aim was to recover feeding and its meaning. The intervention took the form of 12-group meeting over a six-week period, led by a member of staff at the institution. The strategy employed for the intervention was group discussion during lunchtime, without a previously proposed theme. The theme emerged informally and spontaneously from the participants, allowing for the expression of not yet identified needs.

A tape recorder was used to categorise the verbalised content during and after the lunch. New foods were introduced to the participants during lunchtime, which allowed them to taste the foods, and share their experiences and knowledge about new flavors.

Although different themes emerged from the lunchtime discussions (some relevant to the introduction of new foods), it is difficult to evaluate the intervention, as no follow-up was provided after the intervention. Conducting a follow-up may have given an understanding of how the participants benefited from the intervention.

Kropp, F., Winhusen, T., Lewis D., Hague D. and Somoza, E. (2010) Increasing Prenatal Care and Healthy Behaviors in Pregnant Substance Users. *Journal of Psychoactive Drugs*, **42**: 73-81.

This reports the findings of a RCT carried out in four outpatient treatment cities in USA; North Carolina, New Mexico, Indiana and Kentucky. All participants were pregnant substance users from the age of 18 years. Participants were randomly assigned to receive Motivational Enhancement Therapy for pregnant substance users

(MET-PS) or treatment as usual (TAU). The objective of the trial was to evaluate the effectiveness of the MET-PS compared to TAU. The trial had multiple aims: to decrease stress, reduce substance use and increase engagement in healthy behviours. The active study period was spread across four weeks. For both treatment conditions at least three individual counselling sessions were available. The MET-PS intervention contained motivational techniques, particularly adjusted for pregnant substance users, delivered by the MET clinician. Participants assigned to the TAU group were offered the normal treatment provided by the community treatment program. The length of the individual sessions was equal in both groups.

Outcome data was collected at baseline, at the end of the active study phase, and follow-up at one and three months after the active study phase. Numerous statistical analyses were carried out to evaluate the effectiveness of the two treatment groups (MET-PS vs. TAU) for the different stages of the trial. For the engagement in healthy behaviours, participants had to include the following; taking vitamins, drinking milk or consuming calcium rich foods, eating at least two nutritious meals a day (including carbohydrates, proteins, fruits, vegetables and calcium), drinking at least four eight-ounce glasses of water, getting at least five hours of sleep and getting at least 20 minutes of exercise. Most participants were already engaged in healthy behaviours when assessed at baseline. At the end of the active study phase, participants continued to engage or increase these behaviours. Significant increases occurred with increases in vitamin intake and drinking at least four glasses of water per day.

Although there was no differences between MET and TAU, increases in healthy behaviours were found. Though all the healthy behaviours were carried out to some extent at baseline and vitamin intake and exercise was supported by one previous research (Faden, Hanna & Graubard, 1997), the study questions whether their findings are generalisable to this population or unique to its study participants, as they did not find any published results for rates of calcium intake, healthy meals, enough sleep and sufficient water intake for pregnant substance users. However, the study does not state whether they were exploring only RCT or any other types of studies.

Barbadoro, P., Ponzio, E., Pertosa, M. E., Aliotta, F., D'Errico, M. M., Prospero, E. and Minelli, A. (2010) The Effects of Educational Intervention on Nutritional Behaviour in Alcohol-Dependent Patients. *Alcohol and Alcoholism*, **46**: 77–79.

This reports the findings of a before-and-after study carried out in Italy. Participants were inpatients of a specialised rehabilitation clinic. Participants were alcohol dependent adult males and females, aged between 36-55 years. The primary aim of the intervention was to evaluate the nutritional status and the impact of an educational intervention on nutritional behaviour in alcohol-dependent participants. The intervention seeks to increase participants understanding on food and health. The intervention included a lecture about the role of alcohol and food consumption on human health and liver diseases prevention. Additionally each participant received a brochure including information on nutrition and health.

Outcome data were collected after the lecture in the form of a 10- item test, to assess participant's knowledge and awareness about the effects of alcohol and malnutrition on health. The same test was administered before the lecture. A six months follow-up took place, via a telephone questionnaire including questions about food and alcohol consumption habits. The results indicated significant differences on the short-term educational intervention, where major improvements was shown in relation to knowledge on nutrition groups, improved knowledge on the impact of nutrition and health and increases of knowledge on alcohol calorie content. Half of the participants toke part in the six months follow-up revealing that 71% of the participants eat three meals a day.

Although there were positive effects of the intervention, also proven in the follow-up, no significant differences were found between the baseline measures and the outcome of the intervention. This may suggest that participants already had some knowledge around health and food. Though the study reports no differences between the baseline measures and the outcomes, the study fails to explain why this may be. The briefness of the intervention may explain why participants did not increase their knowledge when compared to their baseline assessment.

Lindsay, A. R., Warren, C. S., Velasquez, S. C. & Lu, M. (2012). A gender-specific approach to improving substance abuse treatment for women: The Healthy Steps to Freedom program. *Journal of Substance Abuse Treatment*, **43**: 61-69.

This reports the findings of a before-and-after study carried out in southern Nevada, USA. Participants were recruited from seven different substance abuse treatment facilities. Participants were all females, aged between 18-64 years. The Healthy Steps to Freedom (HSF) was developed, as a health and body-image curriculum designed for women in substance abuse treatment who report weight-related issues. The aim of the intervention was to target body-image issues and educate participants on general health, nutrition and exercise. The intervention took the form of 12 weekly sessions, delivered by trained staff. Each session lasted for 90 minutes and delivered to groups of 6-15 participants at a time. Although sessions included didactic lessons, participants also engaged in interactive learning activities and weekly assignments aimed at putting the program material into practice.

Outcome data were collected at the end of the intervention. Paired t-tests were used to combine the differences between the pre-and posttest scores, indicating a significant difference on improvements of healthy behaviours gained from HSF program. Participation in the HSF program indicated increased knowledge on healthy food and physical activity, and an understanding of basic nutrition.

While this study aimed to target body-image issues for substance users, nutritional knowledge was a major part of the study. Although, improvements were made on increasing understanding on healthy eating, this figure is not based on the total number of participants that entered the program. Of the participants that started the program, 47% completed the program. Additionally, a comparison group may be another method to identify similarities, differences and gains in achieving a more healthful lifestyle. Furthermore, the study reports no indication of follow-up. Although there were significant increases on healthy food consumption and nutritional knowledge, it is difficult to assess whether participants translated their knowledge into practice.

Cowan, J. A. and Devine, C. M. (2012). Process evaluation of an environmental and educational nutrition intervention in residential drug-treatment facilities. Public *Health Nutrition*, **1**: 1-9.

This reports the findings of a before-and-after study carried out in Upstate New York, USA. Participants were recruited from six residential drug treatment facilities. Participants were all males, from the age of 18 years. The intervention named RHEALTH (Recovery healthy eating and active learning in treatment houses) aimed to promote healthy eating and reduce weight gain amongst men in treatment. The intervention took the form of six sessions consisting of weekly nutrition and cooking classes. Additionally, the intervention included procedural changes in the residential food service to add healthy food choices to their menus.

Outcome data were collected at the end of the intervention. Across the six residential sites the most regularly adopted food element by the residential food service was to offer choices of fruits and vegetables daily. Participants who were in the high participation and implementation sites (site 1, 3, 4 and 5) reported greater reductions in mean total energy, percentage of energy from sweets, daily servings of fats, oils and sweets and BMI than those in the lower implementation sites (sites 2 and 6). Additionally, participants reported positive satisfaction with the nutrition classes and cooking activities.

The six study sites implemented nine of the ten required food elements, which gave the residents healthier food choices from a menu that they do not have much control over. Changes to the menu alongside nutrition and cooking classes meant that residents gained an understanding of the dietary changes that were made within their residential facilities. Although there were significant changes during the course of the intervention, the study lacks information on whether the healthier menus will be implemented following the intervention. Additionally, no follow-up is provided to determine whether the residents sustained any changes to their diets following the intervention.

DISCUSSION

The aim of this review was to describe the effectiveness of interventions aimed at promoting healthy eating within a substance misuse population. It aimed to establish: 1. whether substance misusers change their dietary knowledge, attitudes or behaviours in response to specific interventions, 2. the extent of such changes (if any) and 3. the type of interventions (if any) which appear to be effective.

The interventions were all delivered in substance misuse treatment facilities and they all had an educational element, which took into account the learning level of the participants. For instance the intervention by Liberty and Schoomaker (1990) was delivered via visual props throughout the intervention as the reading and writing level of the participants were below average. A variety of methods of intervention delivery across the studies were utilised from one-to-one counselling sessions to intensive group-based interventions, including didactic lessons, group discussions, interactive learning activities and weekly assignments. Although all the studies aimed to increase nutritional knowledge and change dietary behaviour, this aim was not inclusive in all of the included studies. Some had multiple aims where healthy eating as an outcome formed part of the intervention. The study by Niccols and Sword (2005) aimed to improve well-being of substance misusing mothers and their children by offering support and treatment for multiple aspects such as substance misuse, mental health, parenting, child development and nutrition. Similarly the study conducted by Kropp et al. (2010) aimed to improve overall health of pregnant substance misusers by reducing substance misuse, decreasing stress and increasing engagement in healthy behaviours, including nutrition. Schlichting et al. (2007) lunchtime intervention aimed to restore health, healthy eating and its meaning for females in substance misuse treatment. Though the discussions were around health in general, nutrition was part of this, as the participants eat together during lunchtime and were able to taste new foods. The study by Cowan and Devine (2012) aimed to increase healthy eating and decrease excess weight gain for men in recovery. The other remaining studies by Liberty and Schoomaker (1990), Barbadoro et al. (2010) and Lindsay et al. (2011) aimed to increase healthy eating and nutrition knowledge exclusively, with the latter study including elements of body-image issues.

The interventions varied in how they were delivered and the underlying theoretical frameworks on which they were based differed as well. The design of the seven studies varied including an experimental study (RCT) and six observational studies, including a case series and five before-and-after studies. The effectiveness of before-and-after studies have been debated as to whether any differences seen can be attributed to the intervention, as one cannot be sure that the differences in the pre-test and the post-test are actually related to the intervention. However, before-and-after studies may provide some indication of effect on behaviour change when follow-ups are included, as this indicates whether any change has sustained over time (EPPI-Centre, 2010). Three of the studies in the current review included follow-ups with significant outcomes; Liberty and Schoonmaker (1990) before-and-after study with six-week and three-month follow-up, Barbadoro et al. (2010) before-and-after study with six months follow-up and Kropp et al. (2010) RCT with one-month and three-month follow-up. The before-and-after study by Lindsay et al. (2011) included no follow-up, but produced significant results, as did the study by Cowan and Devine (2012) and, Niccols and Sword (2005) with mixed outcomes. This may suggest that significant outcomes can still be accountant for with before-and-after studies even with no follow-up. However this is debatable, as a larger number of studies need to be included to determine this.

Put together, these studies provide data on the extent to which nutritional knowledge is improved and they promote positive attitudes and behaviour towards healthy eating. Although there were positive differences in attitudes and knowledge for most of the participants in the studies, long-term behavioural change is harder to account for. Liberty and Schoonmaker (1990) demonstrated positive changes in knowledge for the participants receiving the intervention, whereby the participants gained nutritional knowledge by including the five food groups into their diets, and also gained knowledge to self-direct their own meals and consider the consequences for their own choice of foods. Barbadoro et al. (2010) study produced similar findings where participants gained knowledge on the nutrition groups as well as improving their knowledge on nutrition and health. Although both studies had follow-ups, they were no more than six-months post intervention. Additionally Barbadoro et al. (2010) study had only half of the initial participants complete follow-up. Though nutritional

knowledge was achieved and facilitated into their diets for the duration of the intervention and during follow-up, it is difficult to predict that this change continued over a longer period of time. The study by Cowan and Devine (2012) was the first to combine changes in food menus within the residential food service alongside nutrition sessions for residents. Most of the required food elements were implemented, giving the residents a healthier menu to choose from. Participants that took part in the nutrition and cooking classes gained knowledge via learning about the food groups as well as 'hands on' experience by preparing and cooking the food. As no follow-up was provided it is difficult to establish whether any changes was implemented following the intervention.

The four remaining studies were all based on female substance users. The before-and-after study by Lindsay et al. (2010) targeted body-image issues, where increasing healthy behaviours was part of the study. The participants attitude and knowledge around healthy eating increased and participants gained an understanding of the basic nutrition groups. Although these were positive results that may have helped with body-image issues, it is difficult to estimate whether any healthy behaviours were put into practice, as no follow-up was provided. Schlichting et al. (2007) study, similar, had no follow-up and proves difficult to account for any changes to healthy food consumption. The study demonstrates how new foods were presented to the participants during lunchtime, giving the participants an opportunity to discuss and share their experiences around new foods. However, it is difficult to account for the gains the participants received as a result from the intervention. Niccols and Sword (2005) study revealed mixed outcomes, where there was indication of small changes in dietary behaviour for substance misusing mothers, three and six months into the intervention, with the latter showing the most increase in healthy food consumption. Participant's children were included in the study, but the study fails to report whether the children increased their consumption of healthy foods. As mothers occupy a central position in making food choices for younger children, particularly if they have made changes to their diets (Edwin et al., 1998), it may be possible that there were healthy changes to the children's diets as well. Kropp et al. (2010) found no differences between the two groups with pregnant substance misusers. Most participants were already engaged in healthy behaviours during baseline and continued to engage in these behaviours at the end of the intervention. However,

increases in vitamin and water intake were proved, indicating that pregnancy may still be a suitable time for encouraging dietary change, as they may be more open to health guidance (Anderson, 1996). Though the study found some positive increases, no previous studies to their knowledge was found published for quantities of water and vitamin intake. This indicates a gap in the literature for an important population who not only needs to change dietary behaviours for themselves, but also for their dependents.

Goode, Beardsworth and Keil et al. (1994) conducted a survey with 420 adults alongside 75 interviews to determine how dietary choices are made taking into account cultural, social and financial matters. The results reveal that many did not make dietary changes although there were high levels of awareness around healthy eating campaigns. This indicates the need for further clarification, as responses to information have proven to be less effective (Goode et al., 1994). There are different barriers to behavioural change, especially change of diet, including access, cost, family eating patterns, availability, support and self-efficacy. Behavioural change may also vary depending on what stage individuals are within their substance addiction and other problems that may exist or arise during the change process. Although there were many positive outcomes of the interventions, caution must be exercised before their outcomes can be recommended. Behavioural change is regularly reported during and shortly after interventions, while long-term change is less likely to be reported (Edwin et al., 1998), proving it difficult to assess the long-term behavioural changes of the included interventions in this review.

Although there was sufficient evidence that the interventions evaluated were effective at increasing healthy eating and nutritional knowledge within a substance misuse population, this review identified few intervention studies fulfilling the inclusion criteria. Important published studies were unlikely to have been missed because the search was not broad enough, as a range of electronic databases were searched, as well as manual searching of a large number of relevant journals. Though an attempt was made to identify further studies within the 'grey' literature, a greater emphasis on this literature might have identified further eligible studies. Studies published in languages other than English were excluded from the review. More studies may have been generated if these were included in the review. Selection bias reviews suggest

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that treatment effects may be misjudged if studies published in other languages are not included (Moher, Pham and Lawson et al., 2003; Song, Eastwood and Gilbody et al., 2000). Based on the quality assessment conducted for each of the studies, it is possible to suggest that they are robust enough to guide treatment into incorporating healthy eating information into substance misuse services. However, as there were few studies identified, it may be possible that treatment facilities for substance addiction underestimate the importance of a healthy diet within this population (Walsh, 2011). Professionals working within the substance misuse field may view substance addiction itself as a priority to address rather than raising awareness around a healthy diet, though there is increasing evidence of the benefits of following a healthy eating plan (Walsh, 2011). The serious nutritional deficiencies most drug and alcohol misusers develop, caused by the actual substances alongside poor dietary choices, highlight the importance of developing effective interventions addressing this element.

<u>CONCLUSION</u>

Despite a complete literature search, only seven studies of interventions aimed at increasing healthy eating within a substance misuse population were identified.

The interventions took place in substance misuse treatment facilities and varied in how they were delivered. They all had an educational element, but their underlying theoretical frameworks and design on which they were based differed. Although all the studies aimed to increase nutritional knowledge and change dietary behaviour, this aim was not inclusive, as some had multiple aims where healthy eating formed part of the intervention. The interventions were diverse, but generally appeared to change attitudes towards healthy eating and improve nutritional knowledge for individuals with substance addition. These changes were evident during and after the interventions. However, it is not possible to comment on the sustainability of these changes, as long-term follow-ups were not carried out.

Future research in this area could include further RCT's, in order to compare the differences between groups. Additionally studies need to have satisfactory power to assess the impact of the intervention on behaviour change. Including an assessment of the long-term nutrition outcomes beyond the treatment stay may produce further insight into the prolonged change process.

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Well-Being Sessions

For a Mental Health Service

A Consultancy Case Study

Word Count: 3014

CONTENTS

4.1 Assess Requests for Consultancy

Individuals with mental health conditions have the highest rates of morbidity and mortality, associated with lifestyle and social factors (Harris & Barraclough 1998, Brown, Inskip & Barraclough, 2000). These include, smoking (Ziedonis, Williams & Smelson, 2003), substance misuse (Frisher, Collins, Millson, Crome & Croft, 2004), inactivity (Brown, Birtwistle, Roe & Thompson 1999) and diet (McCreadie 2003). Additionally, the medications that help treat mental conditions also have negative impact on health, including increasing the risk of diabetes, cardiovascular diseases and obesity (Jayaram, Hosalli & Stroup, 2006; Newcomer & Haupt 2006; Enger, Waeatherby & Reynolds, 2004). Though there is an increasing need for health promotion amongst this population, the importance of a healthy lifestyle for people with mental health illnesses has been undervalued by health professionals. Practicing a healthy lifestyle helps treat mental distress, promotes psychological and social well-being (Walsh, 2011). Making small changes to only four lifestyle factors such as diet, physical activity, alcohol consumption and tobacco smoking, can influence mortality rates majorly (Khaw, Wareham, Bingham, Welch, Luben & Day, 2008). Lifestyle changes can be as effective as medication when treating depressive related illnesses (Frattaroli, Weidner, Dnistrian, Kemp, Daubenmier, Marlin & Ornishet, 2008; Pischke, Scherwitz, Weidner & Ornish, 2008; Sidhu, Vandana, & Balon, 2009). Changing lifestyles through interventions also helps empower clients to take control over their own health and well-being (Walsh, 2011). Though lifestyle changes can be positive in a number of ways, mental health professionals have utilised effective lifestyle interventions to the minimum. Briefer and less person-centered interventions have been practiced due to financial restraints and institutional pressures (Mojtabai & Olfson, 2008) despite the effective outcomes of lifestyle treatments.

Taking into consideration the lack of services offered to individuals suffering mental health problems, I contacted a mental health service user involvement project, offering health psychology services. The service users involvement project aims to voice people's views regarding their experiences of mental health services they have accessed. The emphasis to listen to individuals who are using or have used mental health services started in 1999, where the government produced 'The National Service Framework for Mental Health'. This framework involved the planning and

implementation of mental health services to be co-coordinated in partnership with local communities, including careers and service users (Department of Health, 1999). The service provides the appropriate support for service users through this process, including introductory courses for service users to train mental health care staff on their experiences. The service also delivers a range of courses to promote service users overall wellbeing, lead by relevant professionals outside of the agencies staff team.

I offered to deliver a range of sessions covering different topics such as stress, healthy eating, physical activity and smoking cessation in an effort to raise awareness of the importance of a healthy lifestyle. A meeting between myself, the operational manager and the training leader was set up to discuss how health psychology services would be of benefit to service users that access the agency. Service users had been attending a confidence-building course, which was due to come to an end. The training leader felt that the sessions I offered were a positive continuation of the confidence-building course. The service showed an interest in all the sessions and felt that the wellbeing program included choice and variety, allowing service users to choose from a range of options about something they want to learn more about, as well as providing opportunities for change. I was introduced to some of the service users to determine whether the wellbeing sessions would be of interest and the reason to why they would choose a particular session. Most of the service users present at the time of the assessment showed interest in attending some of the sessions.

4.2 Plan the Consultancy

Combining approaches have been considered more effective when attempting to create an intervention (Huffington, Cole, Brunning, 1997). As the organisation is not a therapeutic day service, but rather a training satellite, the staff only manages the service. It is their duty to invite expert professionals to provide training, support and life skills for the service users that access the service. They are therefore dependent on any consultants who work with them to bring their expertise to the service. Taking into consideration the above elements, I viewed the expert-model as the most appropriate model for the consultancy. The model describes the consultant as having a

better understanding for what may be required. The consultant's knowledge is viewed greater than the knowledge of the client regarding specific matters (the service in this case) (Nikolova, 2007). The relationship between the consultant and the client in this model has been put forward as a contractual relationship, where the main aim of the project is mutually agreed by both parties (Nikolova, 2007). The organisation felt that I would be the expert on delivering health psychology services, and would be seen as the person in charge of the delivery of these services. As the service did not wish to get involved in the delivery of the services, the expert model supports the relationship between the consultant and the client to be efficient, whereby there is minimal long and time consuming meetings during the consultancy project (Nikolova, 2007). The expert model has been described as appropriate when delivering training to services, which emphasised the usefulness of this model for this consultancy. Though I intended to utilise expert consultancy, I also employed the reflective practitioner model, which highlights the reflective conversation between both parties. The model aims to employ the knowing-in-action and reflection-in-action. These are seen as the main key parts of the model (Nikolova, 2007). Consultants use their knowledge, apply the knowledge where appropriate and most importantly reflect on it (Schön, 1983). Exchanging perspectives on problems that may arise or any progress made by both parties is considered important within the reflective practitioner model. I attempted to be as reflective as possible and exchanged any thoughts about this with the service. Though I aimed to use the above consultancy models with the organisation, the primary aim of the consultancy was to increase service users self-efficacy, prompt decisional balance and help service users overcome the challenges of changing behaviours. The well-being sessions specifically intended to raise awareness and support people experiencing or have experienced mental health problems, as this particular group lack the support, skills and opportunities to attain healthy lifestyle factors.

The consultancy model used for the intervention itself included process consultancy (Schein, 1999). The client as this stage involved the actual service users in which the intervention was aimed at. Process consulting involves helping the individuals to help themselves. Listening and active inquiry are regarded essential to help form healthy helping relationships (Schein, 1999). This model is chosen for the current part of the consultancy, as it is an intervention-based approached. It specifically aids individuals

to deal with issues they may be faced with, and learn how to better address future matters surrounding a healthy lifestyle.

4.3 Establish, Develop & Maintain Working Relationships with Clients

The details of the consultancy was discussed and agreed, and a contract (Appendix A includes the contract) on behalf of the service and myself was signed. The contract is an agreement between both parties, which informs the services to be delivered. The contract specifically entitles the nature of the services to be carried out, along with the aim of all the sessions. The method and time frame is described which details the location, the date and time each session will be conducted. The contract further details the consultant requirements, including an appropriate room from the organisation for the sessions to take place. Refreshments for the service users are also included under this section. The contract explains that there will be no cost for the consultancy, however a room for the purpose of the sessions free of charge will be provided by the organisation. Code of conduct is included in the contract for the intention of the service to be carried out in accordance with the British Psychological Society and Health Professions Council guidelines and standards. Intellectual property is noted in the contract, which indicates that the consultant shall be named on any publications arising from the work. Finally, confidentiality elements are described in the contract. This part emphasises that during the course of the services the consultant may have access to, gain knowledge of or be entrusted with information of a confidential nature. It also emphasises that by signing the contract, the consultant agrees, unless expressly authorised by a senior authorised person to so, will not disclose to any unauthorised person or organization any confidential information. The importance of storing and processing information in accordance with the Data Protection Act 1998 is highlighted. I also stated in the contract that a reflexive journal to evaluate and learn from the process of delivering the wellbeing sessions to the service users would be maintained. No service users will be identified within this procedure. The contract also indicated that I commit to keep the operational manager or the training leader informed of the progress of the sessions on a weekly basis.

Furthermore, I designed an information leaflet including an outline of the contents of the various sessions. This was distributed to service users, as well as advertised electronically on sites that service users accessed.

4.4 Conduct the Consultancy

The first session of the wellbeing program included stress. Two service users had committed to attend, however only one service user attended. The session was planned around a group context, as group sessions have been found to be effective for a number of mental health conditions. Via group sessions, individuals have the option of sharing their experiences with others present within a safe environment (Guidelines, 2006; Kanas, 2005). The service user did not hesitate to take part of the session despite that she would not be able to share her experiences with others. I found this quit a challenge as the structure of the session needed to be altered at hand to suit working with one individual rather than a group. I was also left with more time to use for the session. Given the circumstances, the session went extremely well and the service user shared a great amount of experiences relating to stress. The service user acknowledged she would not have shared as much as she did, if more people had attended. The session was evaluated through the service user completing an evaluation form. The feedback was positive and it appeared she found the session useful. Though no other service users attended the session it was an interactive session and the service user was very open regarding her experiences with stress and shared openly how stress affects her life. The second and third session of the wellbeing program included nutrition/healthy eating and calories/physical activity. Two service users had committed to attend the sessions, unfortunately both the service users had to cancel due to other commitments. The smoking cessation sessions had a very interested service user who committed to attend, but regrettably did not attend.

Though I was informed that the service users would not be able to attend a given session, I still attended the service in the event of other service users turning up. Due to the lack of attendances by the service users, not all parts of the intervention were

delivered. This was raised with the organisation and discussed accordingly (Further details below).

4.5 Monitor the Process of the Consultancy

I kept the service informed about the progress of the sessions and there were regular correspondence by telephone and email between us. Particularly discussed were the problems arising and how they could be dealt with. As there were no service users attending the second session, a reminder email by the service was sent out to a number of service users and calls were made to the service users that initially committed to attend. There was only one interested service user in the smoking cessation sessions and this was discussed with the service user about how he felt potentially being the only one in the session. He was happy to take part in the session, despite possibly being the only one. Unfortunately, he missed the first session of the smoking cessation, as he thought it was the following week. At this stage I inquired whether it would be appropriate to set up an additional date for this particular service user in order for him to have a chance to attend both sessions. This was confirmed by the service and an additional date was booked for this purpose. Regrettably the service user did not turn up at the first smoking cessation session and efforts on behalf of the organisation were made to get in contact with him on the day. The service user was contacted again just before the second smoking cessation session to confirm his attendance. Unfortunately he was not able to attend this session neither due to other commitments.

4.6 Evaluate the Impact of the Consultancy

At the end of the wellbeing sessions, a telephone conversation took place between the training leader and myself about the development and progress of the wellbeing program. Mainly discussed were the low attendances of the sessions. Healthy lifestyle changes for individuals with mental health conditions can involve substantial effort to implement change and service users may feel incapable or reluctant to deal with these changes. Individuals with mental health conditions often have little recognition of

unhealthy lifestyle factors, limited social interaction, and an understanding that restoration of health is achievable by medication only (Duncan, Miller, Wampold & Hubbleet, 2009). There have been identified a number of incentives and barriers to participation of programs that promote healthy living amongst people with mental health conditions. For example service users with mental health illnesses attending a community physical activity program stated that they had low confidence, body-image disturbances, poor motivation and low self-esteem as potential hinders to participation (Butterly, Adams, Brown & Golby, 2006). A paper on nutritional guidance for people with mental health problems similarly reported lack of enthusiasm, appetite disturbances, self-neglect and low self-esteem as possible barriers to engagement in healthy behaviour changes (Bottomley & McKeown, 2008). These factors may well be possible obstacles to participation, as well-being sessions have not been previously carried out within the agency. Service users may have therefore been reluctant to attend these.

Other barriers include financial issues, transportation problems and clashing schedules with other treatment plans (Skrinar, Huxley, Hutchinson, Menninger & Glew, 2005). Although payment for transportation was covered for service users, conflicting arrangements with other treatment services was the case for some of the service users. An additional barrier to participation may be due to service users not knowing me well enough, which can attribute to uncertainty and trust elements for a particularly vulnerable population. Although I was introduced to some of the clients at the service, I did not meet all the clients that access the service. The structure of the sessions were based on a group format, as the literature suggests that group sessions with motivational guidance have been valued by service users (McDevitt, Snyder, Miller & Wilbur, 2006). Group based sessions have also been associated by increasing interaction and motivation, and provides additional enjoyment via peer encouragement (McDevitt et al., 2006). In spite of this, a study by Edmonds and Bremner (2007) regarding one-to-one support for smoking cessation, group contexts was not encouraged as much as one-to-one support. The study revealed difficulties with group sessions, as not enough individualised support was utilised, hard for clients to stay focused due to more people present and difficulties in establishing adequate figures to structure a group within a mental health setting. The latter was a

consistent setback for me when attempting to form groups, as well as with other services I contacted prior to the current service.

The one-to-one support may have been more beneficial for the current wellbeing program, as the sessions could have been tailored specifically to suit each individual's needs and availability. Additionally one-to-one sessions provide increased knowledge level, since more time is allocated to the individual (Fogarty & Happell 2005; McKibbin et al., 2006). Furthermore, locus of control and self-efficacy may have also been important factors for service users attendances. While the service is not a structured day service, and there were no staff in charge of any activities, voluntarily participation may have been more challenging for the service users. This could be due to the fact that they have more control over their decision to participate, alongside low self-efficacy. Also, attending a particular session that is not part of their routine may have been a great influence for the service users.

Towards the end of the sessions, I suggested possible individualised sessions more geared around the service users needs and availability, however the agency did not wish to set any additional sessions following the wellbeing program. The project has been a great challenge, but a major learning opportunity in setting up a consultancy project with an external agency. Building and maintaining the relationship between the service and myself was a process that happened gradually with much respect and professionalism from both parties. Although I initially contacted the organisation, I found the manager and the training leader very helpful in assisting with the well-being sessions. The lack of attendances was a frustrating element, however the regular contact between the organisation and myself helped me reflect on this process. Though I have faced a few challenges, I have learnt to accept and adapt to a situation that does not go as planned. I felt that I was very clear about what my role was and what I aimed to deliver, which helped the service understand my position within the agency. I was also organised during the entire process, which is particularly important when working with an external agency as this shows commitment and a high level of professionalism. Despite the fact that not all the intervention sessions were delivered, the experience of setting up the consultancy, monitoring, evaluating and reflecting on the consultancy project has acquired new experiences and has proven to be a rewarding undertaking.

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CONTRACT FOR HEALTH PSYCHOLOGY SERVICES TO IMPROVE WELLBEING FOR ███████ SERVICE USERS

Contracting Client: █████
Consultant: Suzanne Ashter, Trainee Consultant Health Psychologist

NATURE OF SERVICES
To deliver wellbeing sessions to improve the quality of life for service users accessing ████████. The sessions include alleviating stress, promoting healthy eating, encouraging physical activity and smoking cessation.

Aims:

The sessions are aimed for service users to share their experiences based on the given topic and aid clients to change their behaviours appropriately.

The session on stress will explore ways to manage stress, including a relaxation and meditation exercise. The healthy eating session will explore what food contains and how to replace unhealthy foods with healthier alternatives. The session on physical activity will demonstrate how to improve health by getting physically active and the smoking cessation sessions will look at smoking behaviours, by exploring the reasons to why they would like change their habit and how to overcome the barriers to smoking.

The Trainee Health Psychologist undertakes to keep a reflexive journal to evaluate and learn from the process of delivering wellbeing sessions to clients of ████████.

METHOD AND TIME FRAME
The Trainee Consultant will be delivering the agreed sessions at ████████ in ████████████████ from the 07th August 2012 until the 12th October 2012. She will deliver the sessions once a week from 1.30pm – 2.30pm. She will keep the Operational Manager informed of her sessions on a weekly basis.

CONSULTANT REQUIREMENTS
A room with refreshments within ████████ premises.

COST
Trainee Consultant Health Psychologist;
5 Sessions free of charge

████████;
A room for the purpose of the sessions free of charge

CODE OF CONDUCT

The consultant will carry out the service in accordance with the British Psychological Society and Health Professions Council guidelines and standards.

INTELLECTUAL PROPERTY

The consultant shall be named on any publications arising from her work.

CONFIDENTIALITY

During the course of the services the consultant may have access to, gain knowledge of or be entrusted with information of a confidential nature. In signing this contract, the consultant agrees, unless expressly authorised by a senior authorised person to so, will not disclose to any unauthorised person or organisation any such confidential information. The consultant agrees to store and process information in accordance with the Data Protection Act 1998.

Signature of Client

██████████.…………………………………………...Date: 13th September 2012

Signature of Consultant

██████████.…….………………………………….........Date: 14th September 2012

Smoking Cessation Intervention for a Socially Disadvantaged Population

A Case Study

Word Count: 4869

CONTENTS

The Importance of Smoking Cessation for Socially Disadvantaged Groups

Tobacco smoking has been identified as the UK's largest avoidable behaviour. It has also been recognised as the greatest cause of premature mortality, with a predicted figure of 102, 000 mortalities in 2009 due to smoking (Peto, Lopez, Boreham & Thun, 2012). Over half a century ago, the association between tobacco smoking and lung cancer was determined. Since then a vast amount of information has been evidenced on not only the health complications caused by smoking, but also the strong addictive aspect of the nicotine in cigarettes. Consequently smoking cessation is seen as a challenge, particularly for individuals with high dependency (Cancer Research UK, 2012). High rates of smoking dependency have been reported amongst socially disadvantaged groups compared to the general population, where smoking prevalence is declining (Bonevski, 2011). Social disadvantage may be defined in terms of low socioeconomic status (National Health Survey, 2004-05).

Unhealthy life style choices such as inactivity, poor diet and destructive habits such as drug use and excessive amounts of alcohol intake are also high among this group (Rogers, Robert & Charles, 2000). Smoking rates have been particularly high for people in prison, the homeless, low income-single mothers, vulnerable youth and individuals with mental health conditions (Cancer Council, 2006, 2011; Siahpush & Borland, 2002). This indicates that the most deprived and vulnerable members of society are the ones that may be more prone to smoking. They would be regarded as a high-risk group of developing smoking related diseases (WHO, 2001; Cancer Research UK, 2012). It has been identified through qualitative research that disadvantaged individuals find it more challenging to abstain from smoking, as they tend to associate and live with others who smoke (Laarksonen, Rahkonen, Karvonen & Lahelma, 2005). Smoking within this population have also been influenced by the individual's life trajectories such as experiences from their childhood and limited education (Graham, Inskip, Francis & Harman, 2006). Stress is often associated with smoking, where smoking is used as a coping mechanism to deal with stressful situations. Individuals from deprived socioeconomic groups are affected by stress greatly and therefore tend to have higher stress levels. As their lives have more stressful aspects to it, relapse can have a profound effect when trying to refrain from smoking (Siahpush & Carlin, 2006). Individuals from lower socioeconomic groups

have had the most failed attempts in an effort to quit smoking (West, 2006). This indicates that these groups may be in need for smoking cessation interventions that address specific factors in their lives (Bonevski, 2011). Determination and motivation to stop smoking has been found similar amongst socially disadvantaged groups compared to the general population of smokers (Connor, 2002; Arnsten, 2004). In spite of this, there are other factors involved in quitting smoking between socioeconomic groups. It has been noted that lower socioeconomic groups access quit lines less, employ less pharmacotherapies and tend to be given less medical guidance (Browning, 2008; Siahpush, 2007; Shiffman, Wakefield, Dpittal & Durkin, 2008). Through the rates of attempts to become smoke-free is similar across the population, individuals from lower socioeconomic groups struggle more to succeed with becoming a non-smoker (Kotz & West, 2008).

The Theory Underpinning the Intervention

Given that individuals from low socioeconomic groups find it more challenging to refrain from smoking, investigating readiness to change is an essential precondition for smoking cessation. An extensive measurement to assess readiness to change has been presented by the Transtheoretical Model (TTM). The model has been presented as an integrative framework for understanding, measuring and intervening in behaviour change. The model is specifically designed to foster interventions based on an individuals psychological and behavioural needs (Prochaska & DiClemente, 1983; 1985; Prochaska, DiClemente, Velicer, Rossi, 1993). The model describes how people cycle through a series of five stages in an effort to change a behvaiour. The five stages of change has been outlined as precontemplation (PC- no intention to change behaviour in the next six months), contemplation (C- considering to change behaviour in the next six months), preparation (PR- serious intention to change in the next 30 days), action (A- successfully changed their behaviour less than 6 months ago) and maintenance (M- maintaining behaviour change six months or more). Progression through the stages is not viewed as a linear process. The model recognises that individuals may need to cycle through the stages several times before maintenance is sustained. The strength of the model is its recognition of relapse. Relapse is not seen as failure, but rather as an opportunity to learn from pervious

attempts to change (Prochaska & DiClemente, 1983). Two other core constructs of the model include self-efficacy and decisional balance. The TTM has been successfully used as a framework to examine and understand behaviour change to several health risk behaviours amongst different populations (Prochaska & DiClemente & Norcross, 1992). The TTM has been widely applied to smoking cessation interventions (Prochaska & Di Clemente, 1983; 1985; Prochaska et al., 1993). The TTM is also the leading model in the field of addiction treatment (DiClemente, Crouch, Maurer & Velasquez, 2001). Several components of TTM have been used to understand mammography (Rakowski, Ehrich, Goldstein et al., 1998), HIV prevention (Collins, Kohler, DiClemente & Wang, 1999), exercise (Nigg & Courneya, 1998), diet (Bowen, Meischke & Tomoyasu, 1994), alcohol abuse (Snow, Prochaska & Rossi, 1994) and a few other behaviours. Despite some criticism (e.g. the use of time frames), smoking cessation has been promoted successfully based on TTM constructs. Interventions that have been adapted accordingly to the smoker's stage have been proven to be more successful than interventions that have not been tailored to the smoker's stage (Noar, Benac & Harris, 2007; Spencer, Pagell & Hallion, 2002).

To further understand health behaviour change Bandura's Social Cognitive Theory (SCT) includes environmental and social factors that may prevent an individual from changing. The theory has been used to explain health behaviours in terms of health promotion, prevention and changes of unhealthy lifestyles, across a range of health risk behaviours. SCT examines the thinking process and how an individual's thinking may affect his or her own behaviour (Perry, Baranowski & Parcel, 1990; 1997). An important concept of the SCT is the interaction between the individual, the behaviour and the environment. Once there has been a change in one of these aspects, the other two aspects will be affected (Bandura, 1977). SCT emphasises that the majority of behaviours are learned and can be changed. The theory highlights that learning behavioural and cognitive skills are both essential when coping with situations in order to make changes. E.g. a person who wishes to become smoke-free but lacks the behavioural and cognitive skills to cope with a stressful situation without resorting to cigarettes, will be less likely to succeed in changing smoking behaviour despite the motivation (Bandura, 1977). There are several concepts of SCT. The self-efficacy concept is one of Bandura's most recognised and important concept in the field of behaviour change (Bandura, 1977). Self-efficacy involves a person's judgment

regarding their ability to successfully carry out a behaviour (Bandura, 1982; 1986). Smoking self-efficacy is an effective way of predicting abstinence and relapse, and has been regarded as a greater predictor of cessation than e.g. expectancies concerning positive outcomes of smoking or physiological dependence (Lawrance & McLeroy, 1986). A person with low self-efficacy will be more likely to have lower expectations of their ability to change their behaviour and be more influenced by situational triggers. Whereas, a person with high self-efficacy will have more confidence to succeed and consequently be more prone to do so. The greater the smoker believes in their ability to become smoke-free, the greater the probability for success in becoming smoke-free (Brantley, Scarinci, Carmack, Boundreaux, Sttreiffer, Rees & Givler, 1999). Temptations in certain situations have been highly associated with self-efficacy. Smokers with a strong desire to smoke in specific situations would normally feel that they have less control over refraining from smoking when faced with those situations. Consequently, the greater the situation arises, the greater the temptation to smoke, the less chances that the smoker will attempt to quit or maintain smoking (Prochaska, Velicer, Guadagnoli, Rossi & DiClemente, 1991).

There have been identified multiple factors affecting a persons self-efficacy such as previous experiences with carrying out the behaviour, influences of others, observing other peoples behaviour and direct physiological feedback (Bandura, 1986). For instance a person will be more likely to attempt to becoming smoke-free depending on their past experiences of quitting; a nurse recommends they quit, they have seen others that have been able to quit, and/ or they have in past been able to cope with the nicotine withdrawal symptoms (DiClemente, 1986). Self-efficacy has been proven to play a major role in behaviour change, that confidence has been able to outperform past experience (DiClemente, 1986). The theory of self-efficacy has also been included into the stages of change model. For smokers, it has been found that that their confidence to refrain from smoking is dependent upon their stage. Individuals in the pre-contemplation and contemplation stage will more likely to demonstrate low measures, in comparison to those in the maintenance stage (DiClemente, 1986; Prochaska et al., 1991). High self-efficacy measures attained at the end of a smoking cessation intervention have shown to positively achieve long-term abstinence (Baer, Holt & Lichtenstein, 1986; Condiotte & Lichtenstein, 1981).

2.1a The Design & Implementation of Baseline Assessments of Smoking Behaviour Related to Health Outcomes

As there seems to be are a variety of factors influencing smoking and smoking cessation for lower socioeconomic groups, interventions tailored specifically to this group are highly recommended (Bonevski, 2011). Using services that these groups already access are regarded as suitable settings for reaching vulnerable groups (Bonevski, 2011). Based on the evidence of high smoking rates amongst this population, a smoking cessation intervention was carried out within a community drug and alcohol service. The service provides one-to-one counselling, therapeutic group sessions, key-work, drama therapy, and complementary therapies including: acupuncture, head massage and life coaching. The service also provides support with general life skills such as housing advise, benefits information, education/employment guidance and referral to other services as appropriate. Clients accessing the service have substance misuse problems, some still misusing substances whilst others in recovery. Most of the clients are unemployed, have low education and are on government income assistance. A proportion of the clients suffers mental health conditions and struggle psychologically. The majority of the clients face difficult living conditions, such as 'sofa surfing', temporary accommodation, sheltered housing, being at risk of eviction from their homes or waiting to be housed. Predominantly all the females that attend the service are single mothers, some involved with social services and the court system to regain custody over their children. It is important to highlight that all the clients accessing the service are there because they choose to and not due to court orders.

The majority of the clients accessing the service smoke cigarettes. On several occasions clients have been asked whether they wish to quit smoking. The responses have been varied. A number of the clients have indicated that they have other more important worries to deal with and smoking for them is a relief from stress, whilst others have stated that they have tried to quit several times in the past, but been unsuccessful. A few clients have shown further interest in stopping smoking and pointed out they would like support to beat their smoking habit. Following interest from clients, approval was obtained from the service manager for a smoking cessation

intervention to be delivered within the premises for clients who already access the service. In order to effectively deliver behaviour change techniques to smokers, I completed an evidence-based course on smoking cessation. The course was certified via the National Centre for Smoking Cessation and Training (NCSCT) consisting of Stage 1. knowledge base and Stage 2. practice base.

Five males and two females showed an interest and were assessed before attending the smoking cessation sessions. The assessment was based on completing a questionnaire pack to assess their nicotine dependency, stage of change and level of self-efficacy (Appendix A includes the questionnaire pack). To assess nicotine dependency the Fagerstrom Test of Nicotine Dependence (FTND) (questions 1-6 in the pack) was used. The FTND contains six questions including how often they smoke, what time of day they smoke the most and enjoys smoking the most, and how challenging it is for them to smoke during periods when smoking is prohibited or may be unpleasant (Fagerstrom, 1978). To assess what stage clients were at with their smoking, a measure of stages of change was used, modified by Etter & Sutton (2002) (questions 7-9 in the pack). The first question of the measure asks whether the person has smoked at least 100 cigarettes in their lifetime (this is based on WHO's definition of ever smokers, World Health Organization, 1996). The response option is based on a 'yes/no' format. Question two of the measure assesses the intention of becoming smoke free in the short or long term (e.g. 'I smoke but I seriously consider quitting smoking in the next 6 months'). The last question of the measure asks if the person have tried to quit smoking and succeeded in not smoking for at least 24 hours in the past year.

The Smoking Self-efficacy Questionnaire (SEQ-12) (question 10 in the pack) was used to assess clients' self-efficacy to abstain from smoking when facing a number of stimuli. The questionnaire contains two subscales; internal stimulus (e.g. 'when I feel very anxious') and external stimulus (e.g. 'when I am with smokers'). Each of the subscales includes six questions. The response options vary from 'not at all sure' to 'absolutely sure' within a 5-point Likert scale (Etter, Bergman & Humair & Perneger, 2000).

2.1b Evaluation & Formulation of Working Hypotheses of Smoking Behaviour Based on the Assessment

As there has been identified a range of stressors influencing the lives of this population, smoking prevalence have been proven to be larger amongst this group (Cancer Council, 2006, 2011; Siahpush & Borland, 2002). Based on the evidence, it was hypothesised that the clients would have high chemical dependency to nicotine and that their confidence in their own ability to refrain from smoking in high-risk situations when faced with internal and external stimuli will be considerably low. It is further predicted that readiness to change may be influenced by their self-efficacy. Clients in pre-contemplation, contemplation and preparation stage would be more likely to have low self-efficacy while clients in action and maintenance would be more likely to have high self-efficacy.

2.1c Feedback on the Outcome of the Assessment & Working Hypotheses

Based on investigations from the assessment, all the clients that took part in the assessment were smokers and had all smoked at least a 100 cigarettes in their lifetime. One client scored a 2 with very low dependency, (0- being very low dependency and 10- being very high dependency), whilst the remaining six clients scored between 6-10 indicating high nicotine dependency to very high nicotine dependency. This is consistent with previous evidence suggesting that individuals from lower socioeconomic groups have higher dependency rates, when compared to the general population and also more prone to develop smoking related diseases (Bonevski, 2011; Cancer Council, 2006, 2011; Siahpush & Borland, 2002). The measures from the assessment further revealed that three of the smokers had no intention to quit smoking in the next 6 months and were allocated to the pre-contemplation stage. One of these clients had at least one quit attempt in the last year lasting 24 hours. Three of the smokers considering quitting in the next 6 months were allocated to the contemplation stage. Two of these clients had at least one quit attempt in the last year lasting 24 hours. Lastly, one client had intended to quit in the next 4 weeks and had also had at least one quit attempt in the last year lasting 24 hours were allocated to the in preparation stage (see Table 1). Scores from the self-efficacy revealed that most of the

clients found it difficult to refrain from smoking when experiencing intrapersonal elements (e.g. depression, nervousness, anger, anxiousness), social factors (e.g. having a drink with friends, when celebrating something) and physiological factors (e.g. withdrawal symptoms, craving the nicotine). These results indicate that when they are faced with high-risk situations, their confidence in their ability to not smoke in a particular situation is quite low. Their self-efficacy is also dependent on previous quit attempts and expectations about quitting (Prochaska, DiClemente & Norcross, 1992; Ajzen, 1991). This justifies the importance of assessing self-efficacy for smoking cessation. A smoker's confidence in their ability to refrain from smoking predicts actual quitting, whereby a relapse after a quit attempt is more likely to be less frequent when the smoker's self-efficacy is high (Godin, Valots & Lepage & Desharnais 1992; Gulliver, Hughes & Solomon & Dey, 1995). The measures from the assessment were significant with the initial hypothesis. Six of the seven clients were in the highest category of nicotine dependence, varying between pre-contemplation and contemplation of readiness to change, and had low internal and external self-efficacy when faced with high-risk situations. These results were based on responses from their assessment. Given the fact that the smokers had low self-efficacy when facing intrapersonal, social and physiological concepts it would be important to address these aspects when designing the content of the intervention.

2.1d The Design, Planning & Implementation of the Intervention Based on the Assessment & Formulation

The intervention entitled two one-hour sessions spread over two weeks, tailored specifically for this group. Leaflets were produced to raise awareness of the sessions. There was a great emphasis on that clients could still attend the intervention, even if they were not sure whether they wanted to quit or not. Clients were reminded they were under no obligation to come to the sessions having stopped smoking. As further awareness was raised of the intervention, clients enquired whether they could attend the sessions to share their experiences and identify potential triggers for smoking. People were encouraged to attend the intervention despite their uncertainty of quitting smoking.

Though the intervention was based on the TTM and SCT, the PRIME theory of motivation was used to help inform the content of the intervention (West, 2006). There have been identified a range of factors affecting a smoker's motivation to smoke and quit (Laarksonen, Rahkonen, Karvonen & Lahelma, 2005; Siahpush & Carlin, 2006; Connor, Cook, Herbert, Neal & Williams, 2002). The PRIME theory highlights that for individuals to be motivated to change, the intervention should include elements that help lessen the frequency to smoke, increase the desire for abstinence, raise awareness of available medication and increase smokers self-control (Bonevski, 2011). The intervention utilised Motivational Interviewing in order to effectively assist with quitting techniques and to offer support in dealing with life stresses that adds to the great percentage of relapse amongst disadvantaged groups (Carpenter, 2006; Jarvis, 2003). Cessation research on disadvantaged client groups suggests that it is vital to take into account the clients specific circumstances (West, 2006; Mikhailovich & Morrison, 2008). Measures from the assessment survey including nicotine dependence, past quit attempts, readiness to change and confidence in particular circumstances was taken into consideration when creating the content of the sessions. The sessions were designed using various treatment manuals for smoking cessation and tailored accordingly to fit the clients' level of need.

The first session aimed to familiarise the clients with the cycle of change and allow each individual to identify what stage of the cycle they are at and explain why. The session also aimed to help them understand the nature of addiction; the chemical and the behavioural aspect of smoking addiction. Finally, the session aimed to help the clients to change smoking routines and cues associated with smoking behaviours. It was important to address how to make change happen by doing things differently to break the behavioural aspect of smoking. Clients were also given out different hand-outs that was spoken about during the session and more importantly to take away with them as a reminder of the techniques discussed. It is interesting to note that three clients in the pre-contemplation stage became quite involved and considered utilizing some of the tools to change smoking behaviour. The second session aimed to identify high-risk situations and management strategies to replace smoking behaviours. Topics included stress management when faced with negative feelings, problem solving skills when faced with situational triggers, changing unhelpful thoughts into helpful thoughts and practising smoking refusal skills using different communication styles.

Clients were additionally handed out slides for discussion and to take away as reminders.

2.1e Evaluation of Outcomes Based on the Intervention

All clients attended the second session apart from two, due to other commitments. Two new clients were assessed and attended the second session for the first time. At the start of the session, clients were given time to share their experiences from the last session and share specific situations they found difficult. They also identified how they each dealt with particular circumstances by e.g. not having their cigarette with their coffee in the morning. Some of the clients proudly shared that they had reduced their cigarette intake and planned to set a quit date. Positive encouragement on the progress they had achieved was reinforced throughout and clients that had made changes to their smoking routine were also positively praised.

To measure the efficacy of the intervention, an outcome evaluation form was distributed at the end on the intervention. The outcome evaluation form measured the same elements that clients were assessed on prior to the intervention, including nicotine dependency, stage of change and self-efficacy. Five clients completed the outcome evaluation form. The measures revealed the following: one particular clients level of dependency decreased from a score of 2 to 0, indicating very low nicotine dependency. This client moved from contemplation stage to preparation stage by the end of the intervention. Two of the clients moved from very high dependency (scores of 8) to high dependency (scores of 6). This suggests that they made an effort to reduce their cigarette intake. However, their stage of change (preparation and contemplation) remained the same before and after the intervention. The remaining two clients had no change in nicotine dependency (scores of 6 and 7) and also stayed in pre-contemplation stage before and after the intervention (see Table 1). It is important to note that these two clients with no change in dependency or readiness to change, only attended the last session of the intervention. Based on these measures it is possible to state that the length of the intervention may play an important part in behaviour change, as the clients that attended both sessions of the smoking cessation seemed to benefit greater, than the clients that attended a single session. The self-efficacy measures also increased for four of the clients. Their confidence in their

ability to refrain from smoking increased particularly when faced with external stimuli such as social situations (e.g. when celebrating something). Interestingly, the client that moved from contemplation to preparation stage, moved from high self-efficacy to low self-efficacy by the end of the intervention. When examining the scores in detail, it is apparent that the he had high self-efficacy when faced with external stimuli. However, this decreased to approximately half, lowering his confidence to refrain from smoking when faced with social factors (e.g. having a drink with friends, when celebrating something) and physiological factors (e.g. withdrawal symptoms, craving the nicotine). The decrease in self-efficacy within these elements could be due to the fear of preparing for the changes, thus lowering his confidence in his ability to succeed in these situations.

Overall it appears that the intervention was effective in a number of ways. It had a positive effect on the clients and encouraged them to change, evident through their confidence to resist smoking in certain situations and the decrease in cigarette consumption over the cause of the intervention. The intervention was directed at a vulnerable group resistant to change in spite of the increase of anti-smoking campaigns and cessation support. It targeted a group with greater unhealthy lifestyles that could benefit from improving their lifestyles and reducing health inequalities through changing their behaviours. Secondly, the intervention had a client-focused approach. The multiple interacting influences (e.g. stress) that cause smoking amongst this population were taken into consideration when designing the intervention. Thirdly, the low education level of this group was taken into account. Some clients had learning difficulties such as reading and writing, therefore verbal communication was used rather than pure written materials, which may be less than ideal. The written materials that were provided were read out by clients who felt confident enough to read them out load. A range of examples was used throughout the intervention to illustrate how certain situations could be dealt with. Finally, the intervention was conducted in a setting that was easily accessible to this group.

Behavioural support was key throughout the intervention, as it addressed the triggers associated with the desire to smoke, as well as increasing the element of self-control. However, it has been proven that pharmacotherapy is an important part of cessation care, particularly with high dependency smokers (West, 2006; Cancer Council, 2006). Throughout the intervention pharmacotherapy options were discussed and clients

shared their experiences of what they had previously tried. Clients interested in pharmacotherapy were referred on to their local stop smoking clinic alongside those who wanted continued support in quitting smoking.

Follow-up two weeks post intervention was conducted individually with five of the seven clients that attended parts or the entire smoking cessation intervention. Two of the individuals (attended session 1 and 2) in preparation stage had set a quite date and stopped smoking at the time the follow-up was conducted. One of these individuals had opted to receive further support from the local stop smoking service and had taken the option of Nicotine Replacement Therapy (NRT). These two clients were amongst the ones that attended both sessions of the intervention with effective end-of-treatment smoking cessation, in comparison to the ones that attended one session of the intervention. This finding is consistent with previous research regarding the benefit of smoking cessation interventions with greater intensity including longer duration, and a combination of behavioural and pharamacotherapy components amongst a vulnerable population (Selby, Voci, Zawertailo, George & Brands, 2010; Okoli & Khara, 2011). Though there were positive changes amongst these two clients, it is difficult to comment on the sustainability of any changes associated with smoking. It is also not possible to comment on the outcome processes for two of the individuals that attended only the first session, as they did not return back to the service at the time the intervention was carried out. Additionally, it is not possible to discuss the degree to which clients derive positive or negative feelings and consequences from smoking (decisional balance), as the current intervention did not investigate this aspect. It would have been interesting to determine whether the pros outweigh the cons of quitting during the later stages of the intervention.

Conducting a smoking cessation intervention within a disadvantaged group has been challenging. Several services involved with disadvantaged groups were contacted in an effort to provide smoking cessation support, however very little interest was shown from the smokers themselves. The hesitation to change for these groups may well be tackling more immediate worries than becoming smoke free. Smoking unfortunately is still considered as a way of coping with stressors affecting their life (Lawlor, Frankel, Shaw, Shah & Smith, 2003). It is important to note that most of the clients that attended the intervention had a substance misuse addiction. Their recovery time

from their substance addiction also influenced their readiness to change in quitting smoking. This was reflected in the feedback from the clients. Clients in early recovery may have found it difficult to deal with their substance addiction and change their smoking behaviour at once. Individualised sessions may have been beneficial as they can potentially be tailored around the clients' recovery stage and their specific set of circumstances. Though there are several advantages of one-to-one support, a group smoking cessation intervention was chosen, as it has been associated with increased motivation and interaction. Group sessions also provide enjoyment via peer encouragement (McDevitt, Snyder, Miller & Wilbur, 2006). The group format allowed clients to share their experiences to one another and discuss how they dealt with difficult situations in which they resisted the urge to smoke.

Completing the evidence-based course on smoking cessation, provided me with the necessary knowledge base foundation to deliver evidence-based behaviour change techniques. It also guided me how to use appropriate skills when interacting with smokers. Although, I already have experience in delivering behaviour change sessions across a range of topics, smoking cessation was the least I had experience with. I therefore found the course incredibly useful, which was reflected in the delivery of the sessions. Much attention was given to planning and organising the intervention, which I found was evident through the structure of the sessions. The undertaking of the intervention has been extremely rewarding, especially the positive feedback of the usefulness of the intervention, as well as the changes the clients preformed in an aid to change their smoking behaviour, despite their difficult circumstances.

Table 1. Pre-intervention and Post-intervention results on nicotine dependency, stage of change, quit attempts in the last year and self-efficacy

	Pre Intervention					**Post Intervention**			
Completion	Clients	Nicotine dependency	Stage of change	Quit attempt in the last year	Self-efficacy	Nicotine dependency	Stage of change	Quit attempt in the last year	Self-efficacy
Session 1 & 2	Male	2	Contemplation	Yes	41	0	Preparation	Yes	24
Session 1 & 2	Female	8	Preparation	Yes	21	6	Preparation	Yes	38
Session 1 & 2	Male	8	Contemplation	Yes	21	6	Contemplation	Yes	34
Session 2	Male	6	Pre-contemplation	Yes	24	6	Pre-contemplation	Yes	36
Session 2	Male	7	Pre-contemplation	No	48	7	Pre-contemplation	No	48
Session 1	Male	10	Pre-contemplation	No	12				
Session 1	Female	10	Contemplation	No	12				

Nicotine dependency scores (0-10) show dependency levels of 10 being very high and 2 low dependency, stage of change measuring readiness to change, quit attempt in the last year and succeed in not smoking for at least 24 hours, and the mean score for self-efficacy (the greater the mean score the higher the self-efficacy).

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Smoking Assessment Questionnaire

Date of birth: _____
Gender: _____

1. How soon after you wake up do you usually smoke your first cigarette?

☐ Within 5 minutes
☐ 6 - 30 minutes
☐ 31 - 60 minutes
☐ After 60 minutes

2. Do you find it difficult to keep from smoking in places where it's forbidden?

☐ Yes
☐ No

3. Which cigarette would you hate to give up?

☐ The first one in the morning
☐ All the others

4. How many cigarettes a day do you smoke?

☐ 10 or less
☐ 11 - 20
☐ 21 - 30
☐ 31 or more

5. Do you smoke more frequently during the first hours of waking than during the rest of the day?

☐ Yes
☐ No

6. Do you smoke if you are so ill that you are in bed most of the day?

☐ Yes
☐ No

7. Have you smoked AT LEAST 100 cigarettes in your life-time?

☐ Yes
☐ No

8. Which of the following statements describes the best your current situation?

☐ I smoke and I have NO intention to quit smoking in the next 6 months
☐ I smoke, but I seriously consider quitting smoking in the next 6 months
☐ I smoke, but I have decided to quit smoking in the next 30 days
☐ I am an ex-smoker, I quit smoking LESS than 6 months ago
☐ I am an ex-smoker, I quit smoking MORE than 6 months ago

9. In the past 12 months, did you try to quit smoking AND succeed in not smoking for at least 24 hours?

☐ Yes
☐ No

10. The following are some situations in which certain people might be tempted to smoke. Please tick whether you are sure that you could refrain from smoking in each situation:

	Not at all sure	Not very sure	More or less sure	Fairly sure	Absolutely sure
1. When I feel nervous					
2. When I feel depressed					
3. When I am angry					
4. When I feel very anxious					
5. When I want to think about a difficult problem					
6. When I feel the urge to smoke					
7. When having a drink with friends					
8. When celebrating something					
9. When drinking beer, wine, or other spirits					
10. When I am with smokers					
11. After a meal					
12. When having coffee or tea					

Case Study

&

Teaching Plan For Childhood Obesity

Word Count: 2334

Case Study for Teaching

I have chosen to provide a detailed reflective account of one part of my teaching and training record. This case study will demonstrate my ability to place my own teaching in the context of a wider educational theory and good practice, taking into account the perspectives and experiences of the learners. The learners in this case are MSc health psychology students. I have chosen this aspect of my teaching, as it has been a relevant new experience for me, which has proven to be a valuable and rewarding undertaking.

Since engaging in teaching, it was important for me to develop an awareness of the various learning styles. Learning styles are defined as "characteristic cognitive, affective, and psychological behaviours that serve as relatively stable indicators of how learners perceive, interact with, and respond to the learning environment" (Felder & Brent, 2005, p. 56). I found it important to understand what type of learner I was and my preferred way of learning. Based on Mumford's (1997), four styles of learning ('activist', 'reflector', 'theorist', and 'pragmatist'), I believe that I am a pragmatist. Pragmatists are often interested in learning and trying out different experiences. They are more practical and learn best when there is an association between the topic and the job and when they have been demonstrated an example they can follow. They tend to learn less when there are no guidelines to follow, there is no obvious benefit to the learning, and when the learning is all theory. Though, I do feel that these have been the characteristics of my learning from an early age, more recently I have also developed the reflector style of learning. The reflector finds it helpful to view a situation from different angles. Reflectors like to gather information, evaluate it, and think about it before making a decision. They tend to learn best when they are observing others and least when they are completing tasks with no preparation time at hand (Mumford, 1997). Though these are my preferred learning styles, I found it useful to familiarise myself with the activist and theorist type of learners, in order to understand how other types of learners preferred to learn. I developed a further understanding in that individuals gather and interpret information in many different ways. Some learners prefer visual representation of information such as pictures and diagrams, whilst others opt to learn via written information or

verbal explanations. It is believed that for a teacher to be successful and effective, the teacher should respect the individuals learning style, be responsive to the different learning styles and utilise a variety of activities to promote learning (Cheminais, 2002). Given that learners have various levels of motivation, different attitudes regarding teaching and learning, and a range of responses to particular teaching practices (Felder & Brent, 2005), it was important for me to understand the differences in order to meet the diverse learning needs of the students. To effectively enhance the learning, I used different tasks and activities in my sessions, explained in more detail in my teaching plan on page 185.

There are a variety of learning theories in how people learn. The applications of learning theories were taken into account when considering how students learn and how learning theories would influence my teaching style. Sensory stimulation theory is a traditional theory, which explains that learning initiates when the senses are stimulated (Laird, 1985). It is proposed that adults learn mainly through seeing (75%) and then through hearing (13%). It is further proposed that smell, taste and touch accounts for 12% of human learning. This theory suggests that by stimulating the senses, particularly the visual sense, more learning is developed. To stimulate the visual sense, I used a range of techniques in how I presented the information in my teaching session. For example the PowerPoint presentation had vibrant colours, large statements in places, short and clear points, pictures and graphs. Throughout the session I also used reinforcement theory by B.F. Skinner (Laird, 1985; Burns, 1995). Within this theory it is believed that learning is enhanced if a positive reinforcement (includes rewards or verbal reinforcement) is followed by a behaviour. I used verbal reinforcement within the lecture, particularly after discussing an activity they were set out to complete. I used comments such as 'that's great' or 'good work'. I felt that this motivated and encouraged the students to share their insights. Cognitive-Gestalt approaches highlight the importance of problem-solving and the development of insights (Burns, 1995). The approach demonstrates how learners have their own personal interpretations and responses in the learning environment. It was useful for me to be aware of this approach, as I did have a couple of students who had different opinions to a visual figure I presented in the teaching session. I respected their interpretation and asked them to elaborate on why they had that particular response. I

think it is useful for students to voice their response, as this may prompt further discussion around the specific topic being raised.

The facilitation theory (humanist approach) by Carl Rogers further supports the notion of students feeling comfortable enough in the learning environment to raise their ideas, without feeling threatened by external factors (Laird, 1985). This can be achieved by the teacher taking the stance of a facilitator and provides a comfortable atmosphere for students to be able to impose their ideas (Laird, 1985). I feel this theory is effective in a number of ways. It not only allows students to share and develop their ideas within the learning environment, it also enhances learning. Ideas and suggestions may evolve that the teacher may not have considered. It also adds to discussions and reflections about a particular subject matter. I used this theory to reflect back to my experiences of the teachers I have had along my educational journey. The teachers that portrayed as the expert teachers and interacted the least with the students, did not motivate me to learn, but rather created a barrier to my learning. Whilst the teachers that had the balance between the two; who showed some authority, but also interacted with the students and showed interest in the students views, I felt were more approachable and created a relaxed learning environment. I didn't feel threatened by raising my ideas and bringing it forward for discussion. Not only did this give me confidence to at times challenge the learning material, but also made me eager to learn more. Reflecting back to my experiences and the facilitation theory, I tried to use my experiences to my advantage in my teaching session. I felt more comfortable taking the role of a facilitative teacher and realised that this was a teaching style I started to lean towards.

I believe I interacted very well with the students, where I felt comfortable in the way I presented my self. It is extremely important for me to feel comfortable within my teaching style, as it ultimately affects how I present the information to students and how they absorb the information being delivered. I was more of a facilitator who guided the session. Though I had my opinions and ideas, it was more important to listen to the students' views. Not only does that show interest in the students' interpretations and shows that I value their opinion, but also builds a positive relationship with the students, that can enhance further learning. Incorporating this approach into my teaching style also allowed me to accept feedback whether positive

or negative by using it constructively to look at myself, and how I come across to others. Using the facilitation theory into my teaching style also encouraged the students to take some kind of responsibility for their learning, by learning through their input. I believe this approach additionally helps students reflect and self-evaluate their learning, by bringing their experiences to the learning environment. Reflecting on ones learning experience is a fundamental process in education. The process of reflection is highlighted in Kolb's four-stage learning model often referred to experiential learning. This model demonstrates that without the individual engaging in reflection it could potentially mean that mistakes continually recur (McGill & Beaty, 1995). I believe this model is useful for both the students and the teacher. By reflecting on my teaching experiences and the way I teach, I can only improve myself and develop more self-awarness, as the element of self-awareness is constantly changing through new experiences we endeavor.

In fulfilment of my teaching obligation, I had to consider the professional and ethical issues relating to teaching. The National Education Association (NEA) code of ethics stresses that the teacher must accept the responsibility to adhere to the highest ethical standards of teaching, including commitment to the student and to the profession (NEA, 2013). As we all learn and process information differently, treating the student with dignity and respect, and providing equal educational opportunity to all, were crucial points I took into consideration. I demonstrated this by for example not judging a students opinion, or excluding any student from participation in the learning, or treating students differently based on their sex, race, social or cultural background. To allow students to share and discuss their experiences within a safe environment, it was fundamental that the principals of trust, privacy and confidentiality were attained and maintained to the highest possible degree.

Teaching Plan for Childhood Obesity

This teaching plan aims to demonstrate how one part of my teaching was planned in a systematic way, taking into account the learning needs of the students. It will highlight the learning outcomes of the session, teaching methods and the teaching materials used. Finally, it will contain a rationale for the choices I have made about how to organise and deliver the teaching. I have chosen to provide a detailed teaching plan for this particular session, as it was a topic I had less familiarity with, compared to a previous session I have taught, where I was able to relate the contents of the session to the work I carry out on a daily basis. The current session was delivered to the health psychology MSc students. The session formed part of their module 'Health Across the Lifespan from Birth to Death'.

The aims of this specific session was for students to:

- Develop an understanding of the psychological and physiological effects of childhood obesity
- Develop a comprehensive understanding of the primary factors associated with childhood obesity
- Develop an awareness of the prevention and treatment of childhood obesity

Kolb experiential learning model identifies that individuals learn in four ways, including learning through experience, through observation and reflection, through abstract conceptualization, and through experimentation (McGill & Beaty, 1995). Taking into account these learning styles, I attempted to use a variety of materials and delivery techniques in order to allow students to at least have their learning style preference partly addressed.

I introduced the information via the traditional lecture method. Lectures can sometimes appear as a one-way directive talk. However, how they are presented is crucial. I used the lecture method to build upon the students' knowledge. Before starting the lecture, it was important for me to present the lecture at the students' level. I carried this out by asking the students what they already briefly knew about the topic, and whether they had any experiences in working within the field of

childhood obesity. This allowed me to relate the information I was presenting to the students' context by providing examples relating to their experience. I used PowerPoint as the lecture guide, which included short and clear statements that I elaborated further on. I used pictures and figures to make the content more appealing and to illustrate the points I was making. Throughout the lecture I asked questions to check if the students were following what I was saying and I also encouraged the students to ask me any questions. Furthermore, I was constantly showing interest in the students' opinions by asking them whether they agreed or not with a particular statement, and further encouraged them to share their thoughts on it. This at times progressed into a discussion, which I believe is useful, as it engages the students to challenge aspects of the material. I also found that the discussions in the lecture helped relate the material to everyday issues by the illustration of examples.

I used group discussions and case studies in order to include a different form of learning. I asked the students to form small groups and provided them with an outline of a case, where I asked them to discuss and reflect upon in the groups they formed. This allowed them to share their own ideas and views, and also encouraged problem-solving, an important element in learning. The various case studies given out at different times through the lecture was also a way of allowing me to establish how much they had learned in the session. Once they had discussed it amongst them, I gave each group time to share what they had discussed, and how they each went about solving and analysing the case. This then went on to being a class discussion for further elaboration and thought sharing, in which demonstrated their knowledge of the topic. By incorporating the group discussions, it also allowed the students who didn't feel as confident to speak up in the class, share their ideas and thoughts within a small group. I noticed that the student's who were more reserved to speak up in class, actually did speak up after the discussions had taken place. Overall the students appeared to be engaging and were responding well in the session.

Evaluation forms were distributed to the students at the end of the session, to allow me to gain general feedback of the lecture. The responses were all very positive, including the lecture content and the overall presentation of the session. It was great to see so many positive responses, as it certainly boosted my self-esteem within a field I am still learning to find my way through.

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Teaching Evaluation

Based on Lectures for Health Professionals

Word Count: 2214

The current teaching evaluation will cover two lectures I delivered to the MSc health psychology students on 'Substance Misuse & The Stages of Change' and 'Childhood Obesity'. I have chosen to evaluate this part of my teaching and training, as it has been a relatively new experience for me. Reflecting and evaluating the lectures both from my perspective, student feedback and observer's feedback will allow me to identify my strengths and weaknesses within the teaching field. It will also help me to improve the design or delivery of future teaching and possibly increase the percentage of retention gained by the learners.

The initial idea of teaching made me feel anxious, particularly teaching professional adults, as this was an area I was least experienced with. My main fears were failing to present the information in a professional academic way, seeing that I would be expected to pitch the lecture to a high academic level. I feared that I might be asked questions I could not answer. I dwelled on these thoughts for months, until I realised that I had to change my thinking to help ease my nerves. Given the fact that the students were all adult learners, they already had a great deal of experience to bring to the learning environment (Knowles, 1990). I tried to use and incorporate the students' knowledge as much as possible into the lecture, rather than putting myself under pressure to know everything. Establishing prior knowledge from the learners by asking them about their knowledge and experiences of the topic, allowed me to gage the lecture more effectively, in terms of pace and time spent on activities/tasks. I found this process rewarding, as it developed a positive interaction between the students and myself. It also showed that I was interested in their experiences and views, which could also be seen as a gentle ice-breaker.

Another characteristic of adult learners I found useful was that they are self-directed in what they learn. Ultimately, they initiate their learning needs, set learning goals, identify sources for learning, choose and set learning strategies, and assess their learning outcomes (Knowles, 1975). This process is quite student-centred, which provides the learners with choice in how they direct the teaching and learning element. Initially, my impression was that I had to cover all elements of the given subject in detail. However, I soon realised that they are capable of finding out information for themselves. I also started to accept that as a teacher, I would not know everything, even if I take on the role of a teacher. The learners may at times know

more than me. In my second lecture, I used the students' knowledge to my benefit, where I would for instance say, "great, tell me more about what you know" or "can you tell the others what you think". For example in the lecture on childhood obesity, a student in a group discussion discussed how she struggled to get her teenage daughter to engage in physical activity. She had some real life examples to bring to the learning environment. I therefore asked if she wanted to share it with the class. Her experience added to the learning, as it started a class discussion. Bearing in mind that she was sharing her personal experiences initially within a small group, taking into account the ethical aspect of this, I did not share her experience with the class without her consent. I also respected her decision either way, by making it clear to her that she was under no pressure to do so, if she was hesitant.

As my expectations gradually changed with regards to my teaching, I noticed I became much more relaxed during the whole process from preparing the lecture to delivering it. I began to draw on my prior experiences, building connections between my group-facilitator role at work and teaching, to which the only difference was the audience that I was communicating with. It has been pointed out that taking on the facilitator role, creates the conditions for learning, but not the learning itself. The learners ownership of knowledge is crucial and (inter)activity can be seen as a way to strengthen that ownership (Jacobs & Murray, 2010). Though the facilitator role helped me further understand my role in teaching within the context of higher education, I found it very easy to fall back to the one-way communication aspect of it. Reflecting back, this may have been a way to deal with possible discomfort in situations I was unfamiliar with. I challenged the learners less when discussing areas I lacked experience in. This is an area I aim to improve upon, as I now believe that teaching is as much about delivery and the understanding of learning styles, as well as learning from your audience and their experiences.

Another part of teaching I was concerned about was the time allocated for a given lecture. I was sceptical as to how I was going to deliver a 3-hour lesson on my own. I opted to aim for the dialogical learning environment, rather than the pure knowledge base learning environment. Biggs (1999, p.44) states: 'The greatest enemy to understanding is coverage' and according to Moon (2000, p. 182), 'Time allocated to thinking or reflection is easily lost when there is active teaching competing with it'. I

therefore incorporated a range of interactive activities for the learners to be given time and space for dialogue and reflection to relate to the theory. I found the interactive aspect of the lesson effective, as it guided the learners to learn through peer discussions and problem-solving activities, such as the various case study scenarios. The case studies that were completed during the lessons also allowed me to establish whether the outcomes for each lecture had been meet. The outcomes for the 'Substance Misuse & The Stages of Change' lesson were to 1. demonstrate an awareness of the stages and development of addiction, 2. demonstrate a comprehensive understanding of the psychological and physiological effects of addiction and 3. explain the application of the stages of change model as a framework within interventions for substance addiction, and the outcomes for the 'Childhood Obesity' lesson were to 1. demonstrate an understanding of the psychological and physiological effects of childhood obesity, 2. demonstrate a comprehensive understanding of the primary factors associated with childhood obesity and 3. demonstrate an awareness of the prevention and treatment of childhood obesity. I also found the discussions and activities I facilitated formed part of the assessment, as they allowed me to assess how much they had taken away from what was learned during the lecture. However, I feel that at the end of each lecture I could have pointed out the learning outcomes, and asked the learners to indicate whether *they* felt that the learning outcomes had been meet. This will certainly be a method I will use in future teaching sessions.

An important and fundamental strength I believed I had from the start was that I was organised. I planned my lecture ahead of time, which gave me enough time to review and reflect on my teaching plan. If I needed to make any changes or add further elements I had time to do this, without feeling rushed and stressed. For each lecture, I wrote a lesson plan for all the activities I plan to deliver on the day. I felt this helped greatly, as I managed to use all the allocated time without going over or under the time. This to me shows that I have structured the lecture well and followed a plan. At the start of each lecture I gave an outline of what I intend to do, to give students an indication of what to expect. I also inquired when they preferred to have their breaks, to give an element of choice. I felt the breaks were useful as they provided some relaxation time, as well as an opportunity to change the setting and atmosphere for the learner, as well as the teacher. It can be very easy to feel restless when you have to sit,

listen and engage for too long (talking from my own experience!). Additionally, the breaks gave students time to informally discuss the ideas that were presented. The lectures I taught were all in the afternoon; a time students can particularly feel tired and sleepy. The breaks gave them some time to grab something to possibly keep them awake! Although I had a plan, I also kept room for flexibility and kept an open mind to change the plan, if there was a need.

I found being more relaxed before the sessions, helped me present the lecture in a slow, calm paste. The observer highlighted in her report:

"Good introduction, nice tone and pitch of voice. Good to check in and give the students the 'shape' of the lecture at the beginning with regard to breaks and activities".

I didn't feel I was rushing through the material. At times I also allowed for a few seconds of silences, before I moved on, to give students time to absorb the information and allow some time for thoughts and questions. I also tried to respond to each question or thought in a way that lets the learner know that I appreciate that he/she has asked the question, such as "that's an interesting observation". There was an instance where I was asked a question and I wasn't sure on the answer. I responded by saying: "That's a good question I have not thought about…does anyone have any thoughts about it?" I responded honestly and asked around to see if anyone else knew. I felt I dealt with it quite well, given my initial fear of being asked a question I couldn't answer. The observer also felt I responded well when I was asked/challenged. Based on the observer's report, it was pointed out that some of the group exercises may have been easy, and that I could have pitched the lecture a bit higher. Although, I had set up a range of problem-solving activities, they may have been less challenging to the learners. In my second lecture, I tried to challenge the students further, to allow room for more critical thinking. However, I would like to find further ways to challenge students by including activities that require a higher level of thinking.

The feedback forms I gave out to the students were mainly to help me improve the content and the presentation of future teaching. I asked students to rate my presentation based on how informative it was, how organised it was, whether I used enough teaching, and to give an average rating of the presentation. I also asked students to rate the facilitator based on knowledge and ability to explain information clearly, preparedness, encourages student participation and an overall rating of the facilitator. From a scale of 1-4, 1 being poor and 4 being excellent, I received an overall rating between 3 and 4. I felt that the responses were great and really gave me that extra confidence I was striving for. Other questions in the feedback form included whether the session helped their understanding of the topic, whether they found the content interesting/useful, and whether they found the material presented in a manner that facilitated understanding. The response option included a likert scale from 1-5. Again, the responses were very positive. However, I found that I didn't leave any space for additional comments. This is an important part of the feedback, as it allows the students to express elements about the session whether, this is positive or negative. I only gave them questions where they could only rate their response. A combination of open-ended questions in which they can express their views, would have been more effective in terms of providing rich feedback. Comments or written responses provide more detail that I can use and reflect on to improve my teaching. They can also be helpful to find out what elements of the session were useful.

Overall, I feel that I have enjoyed parts of the teaching. I have mainly enjoyed delivering the sessions and the interactive dynamic of the sessions. I have least enjoyed the planning and organisation aspect of teaching. I felt a slight nervousness at the beginning of each lecture, but quickly started to feel comfortable in the classroom. I felt this comfortness when the students particularly started to show interest and engagement. The first lecture I delivered was on a topic I was very familiar with. On that note the observer stated in her report:

"Good to draw on examples from work, gives an applied context for an otherwise theoretical discussion".

"Once the class gets a bit more chatty and challenging you engage very well, you are clearly comfortable with your material".

The familiarity of the topic was a large contributing factor to my increase in comfort and the development of my own personal style. This was also clearly reflected in the confidence it gave me with the second lecture I delivered, around a topic I was less familiar with. Through teaching, I found that becoming a good teacher is the result of careful reflection. I found myself learning a lesson every time I engaged in teaching, by evaluating my position, and using these evaluations to improve on.

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Reflective Commentary

On

Teaching DVD

Word Count: 859

The current reflective commentary is an appraisal of a 10-minute recorded teaching session on '*Substance Misuse and The Stages of Change*', which forms part of the module 'Cognitive and Emotional Influences on Health and Addiction'. The learners are MSc Health Psychology students and MSc Mental Health and Addiction students. The aims of this commentary are to identify my strengths and weaknesses, by reflecting and evaluating on the teaching session, taking into account the different perspectives and experiences of the learners, and drawing attention to professional and ethical issues, such as audience participation.

During the first 10 minutes, I presented how one-to-one counselling and group therapy is used for substance addiction. Before talking about it, I ask around to see if anyone had any experience with this type of work. I did this to get an idea of the type of involvement they have and to understand how much they know about the subject. When a student shared the type of work she does, she did not disclose what kind of people she worked with. Instead of asking her directly what field she worked within, in which she may have felt uncomfortable to share, I asked whether it was in substance addiction. This left her with a yes/no response. It also gave her an option to disclose the type of people she worked with if she wanted to, without feeling pressurised to do so.

Though, I am using PowerPoint to direct the lecture, I feel that I am talking around the slides by providing a range of examples and referring back to the work I carry out within my work place. Given the fact that the lecture was on an area I am familiar with, I felt less experienced with the teaching process itself. I have notes on the table that I am at times looking down at. These notes served as 'crutches' for me, in case I got stuck. Although, I am using them to help me remember the main points, they were at times also a distraction, as I found myself looking down on the notes, even if I was very familiar with the content. However, when using the notes, I am still elaborating further using examples to demonstrate the points. For future teaching sessions, I would like to rely less on these assisting notes.

I felt that I tackled a few challenges well. I was asked a question that I did not know the answer to. I was honest about not knowing much about it and allowed some time for discussions to take place around the question, as other students may have more

knowledge. Furthermore, a student spotted a wrong date on the slide. I felt I responded well to the comment by not feeling embarrassed about it, as mistakes can happen!

I feel that I am quite engaged with the audience. For example I asked to see who was familiar with the stages of change model. I also gave them a chance to share what they know. This creates further participation from the learner's side. Additionally, I took short pauses from time to time, to allow the information to be absorbed before moving on. This also gives me some time to figure out what to say next. However, I could have been a bit more proactive with asking if they had any questions or any thoughts, or perhaps just checking in with them a bit more as I am going along. I feel that I have a nice clear tone of voice and I am always looking around and making eye contact with the audience. My body language is quite varied and at some point I moved away from the desk when I was talking through an activity carried out at my work place. This shows that I am stepping away from the structured content of the lecture by sharing information that relates to my work. It also illustrates that I am trying to get a little bit closer to the audience, showing I want to engage with them. When I am explaining the stages of change model, rather than standing behind the desk talking about it, I could have positioned myself closer to the visual figure on the PowerPoint and pointed out what I was referring to.

I used evaluation forms to generate feedback of the outcomes for the teaching session. The evaluation forms helped me determine whether the session helped the students' understanding of the topic, whether they found the content interesting/useful, and whether they found the material presented in a manner that facilitated understanding. Receiving feedback from the students has been helpful, as it allowed me to use their session evaluation to improve the content and presentation for future teaching, as well as highlighting the areas I can further develop on.

On the whole, reflecting on a recorded teaching session has been a valuable experience. It has allowed me to identify my strengths and weaknesses, as well as observe and reflect on my teaching performance in detail. I found it particularly useful to reflect on the experience of what is actually happening, as this has caught my attention on areas for possible improvements.

Professional Skills in

Health Psychology

A Reflective Commentary

Word Count: 3318

CONTENTS

The aim of the current reflective commentary is to provide a detailed description of my experiences and learning as a trainee health psychologist. I will outline how I have worked through to meet the professional competence within the discipline of health psychology. I will demonstrate how I have used my professional skills to practise within the legal ethical boundaries, the strategies I have employed to engage in continuous professional development, and how I have used concepts and evidence derived from health psychology within my personal and professional development as a health psychologist. For the past two years of my doctorate I have worked for a community drug and alcohol service as a key-worker and group facilitator. I have chosen to structure this commentary in sections to give a clear description of the professional skills I have demonstrated for the duration of this doctorate.

Professional Autonomy

As a practitioner it is important for me to respect, uphold the rights, values, dignity and autonomy of every client I am in contact with. I follow these principals according to the Healthcare Professionals council, the British Psychological Society, the Deviation of Health Psychology and the procedures within my work place regarding treating every client fairly and equally, without prejudice or bias. I am careful to practise these principals in a non-discriminatory manner at all times, regardless of the client's, gender, race, age, nationality, faith, sexual orientation, physical ability and other relevant considerations. I am aware of my own conduct towards clients, in which I ensure that the client's interests always come first. Due to the nature of my day-to-day work it is essential to take into account the client's vulnerability as a consequence of their ill health, financial circumstances, past experiences and current situation. Understanding the need to maintain high standards of personal conduct also includes acting in the client's interest, even when I differ in my belief or personal view from the client.

As a trainee health psychologist, I have an obligation to maintain fitness to practice. I am therefore aware of maintaining my health in terms of managing the physical, psychological and emotional impact as a result of my practice. I exercise this by

seeking regular and consistent clinical supervision, in which I have been engaging in for the past two years. During these supervision meetings I talk about specific incidents, clients or other work related matters that I feel would affect my well-being. I use these meetings to reflect on my professional practises, whether these are progress within my professional development or any challenges I may encounter. As these meetings take place within a safe and confidential environment, I find it particularly helpful to take advantage of these meetings as a means to 'off load' on matters I feel the need to share. This has been extremely useful, due to the severe vulnerability of the clients I work with. I have also developed other strategies to cope with challenges by seeking and using appropriate management and professional support including placement supervision, as well as additional training.

Working with Clients

I have worked with a range of clients, including service users, managers, lecturers, teachers, assistants, therapists and housing staff. I have had to constantly adjust my communication style taking into account the audience, client or situation at hand. The context of my communication is important to consider, as this makes a difference both in the way I engage with others and in the way they interpret my communication. For example the way I engage and interact with a service user in a group setting is different to the way I interact with a service user on a one-to-one basis. Within a group context, there are many different individuals present, all with different personalities and needs. As the service users I have worked with have a range of physical and mental health conditions, taking into account the literacy level has been important, by for example selecting words they understand and connect with. Being aware of my body language and also paying attention to the service users body language has been crucial. For instance if the person looks confused, I would try to explain my point again, but in different words. I found using a range of real life examples helpful to demonstrate my point more clearly.

Working with professionals has also involved adjusting the way I communicate, whether this is in person, by phone or email. Communicating politely and

professionally has been key to all types of communication, as this ultimately affects the working relationship between us. For example when carrying out consultancy with various services, the communication process has been so important, that it has directed how the relationship has devolved. I have noticed that my use of language comprises a large part of the first impression on clients. For instance when I was consulting, this at times involved talking about subjects to people whom may not have a background in these areas. This has required me to break down and simplify ideas in such as way that the client understands what I am describing. Additionally, when I was working with a number of clients at the same time, I had to gain an understanding of the background and knowledge of my audience, in order to be able to provide the most meaningful advise possible. I have also found using effective listening skills when interacting with all clients has helped me to meet the needs of the clients. Gaining feedback from clients has further aided me to identify my strengths and weaknesses. Feedback has allowed possible room for improvement, which in some cases has improved the working relationship.

Management Skills

Working collaboratively as a member of a team, but also independently has resulted in developing my own way of working within the procedures of the service, while at the same time taking responsibility for my own caseload. As a trainee health psychologist within my workplace, I have a wide range of responsibilities. Understanding my exact role and responsibilities at work has helped me manage my work skills effectively, as I know what is expected of me. I feel that I am highly organised which I consider to be a positive strength I hold. Being organised is a trait that I have always had, which I have found has helped me within my workplace. Working in the drug and alcohol field requires organisation and structure, due to the chaos that service users often bring. Being organised has allowed me to develop a routine at work, in which I tend to set my main goals for the day and prioritise the main tasks I need to complete. However, often other events not scheduled in for the day may take place that are out of my control. This can be distracting at times, particularly when I am focusing and working on other tasks. Sometimes conflicts

between service users who are still struggling with abstinence take place. More than often this is unplanned and requires my attention immediately. Conflicts and issues that arise between service users or even between a member of staff and a service user may need myself or other members of the team to manage the situation there and then. This is very important, as conflict for service users more than often leads to relapse and where resentments are allowed to grow, service users struggling in their recovery, will often relapse at a later date if there has been no resolution to these issues. When such unexpected matters arise, my initial plans for the day change drastically, and I have to adapt my plans in order to deal with the issues as they arise.

Therapeutic Relationship & Process

I engage with clients in different capacities and settings, from one-to-one support to therapeutic group work. Either case, any form of successful therapy or support is grounded in the genuine therapeutic relationship between the practitioner and the client. Rogers refers to this as the 'Helping Relationship' (Rogers, 1957). I believe there are several elements that that need to be present for a therapeutic relationship to work. For example the practitioner's genuineness within the helping relationship is important. Rogers points out the importance of the practitioners to be able to 'freely and deeply' be themselves, in which the practitioner is a "real" human being, with their own problems, feelings and thoughts (Rogers, 1957). He states that practitioner is not an all knowing, powerful and controlling individual (Rogers, 1957). Taking these elements into consideration, I feel that over the past two years, I have had to really be aware of and develop an insight into my own wellbeing. Becoming more self-aware of my own feelings, thoughts and problems is a process that I am constantly exploring. I have found reflecting on these concepts during clinical supervision to be extremely rewarding, as I am able to explore for instance my own feelings relating to a particular incident that may have taken place, or a particular feeling that I carry, and how that feeling affects my therapeutic relationship with a client. I am quite an emotional person, and at times I have found it very difficult to sit with a person who is sharing a story relevant to an event in my life. The client's story has on several occasions touched my emotions. However, as a professional

practitioner I have learnt to separate my feelings from the client's stories and emotions, by taking my emotions and thoughts into the clinical supervision room to reflect upon and explore. During supervision I have realised how detrimental it can be for a client if I was to get emotional, whilst they are sharing their story. This can have a negative affect on the relationship, whereby the client may not feel safe to share their experiences in order to avoid upsetting me. This in turn can hinder the therapeutic gains for the client.

Through experience I have found setting clear boundaries and being professional at all times are key factors in building and maintaining the therapeutic relationship. These boundaries also help balance and separate my issues from the clients'. However, that is not to say being cold and rigid. I believe that building the relationship based on good rapport, understanding, trust and empathy are necessary for an effective therapeutic relationship to be established. Developing an empathetic understanding of the client's experience is crucial in a therapeutic relationship (Rogers, 1957). I have learnt to move away from sympathising for the client, but empathising for the client, in which I am able to enter and comprehend the client's perspective, without judging their feelings or thoughts. I have found that the therapeutic relationship is more effective when I am able to empathise in terms of noticing that the client is more willing to comply with guidance and support when they feel that I understand their needs.

Reflective-Practitioner Stance

Being able to reflect on my abilities and skills has allowed me to take a critical stance by thinking about my learning through my experiences. Reflecting on my professional practise has not only enabled me to identify my strengths, but also my weaknesses and areas for development. Biggs points out "A reflection in a mirror is an exact replica of what is in front of it. Reflection in professional practice, however, gives back not what it is, but what *might* be, an improvement on the original" (Biggs, 1999: 6). Being able to reflect on my professional practice has not been a natural characteristic I hold, but a process that I have gradually developed over the years,

whilst finding my way and identity as a trainee health psychologist. It has taken time and practice and I have had to utilise various techniques to help me be more reflective in the work I do. I keep a log for all the activities I carry out on a daily/weekly basis. I have been consistent with my logging, which has been an extremely effective way to sit down and review my own thoughts. I find that questioning my thoughts, actions and behaviours, allows me to explore what I know and what I do not know. It has also allowed me to look at previous experiences and how I have developed and moved on from them. Receiving feedback on my logs from my supervisors has further helped me to reflect and evaluate on my experiences.

Within my professional practice, I have learned to assess a situation, determine what could be done to deal with the situation and take appropriate action. However, from experience certain situations are not always planned, and at times this has required me to think on my feet and go with what feels right at the time. This would involve making a decision 'on the job', particularly when there is a crisis taking place with clients. Being able to exercise personal initiative, by using my skills and knowledge to act in a situation, allows me on reflection to understand and make sense of the experience. When working in situations of uncertainty, using reflection to make sense of the experience has been valuable, as I am able to explore other options I may have adapted to deal with the situation at hand. As a trainee health psychologist, I have had to also know the limits of my own practise, and assess when I need to seek advice or refer to another appropriate professional. Referring to other professionals has also allowed me to build and sustain professional relationships with others in the community.

Professional & Ethical Issues

I have had to be aware of the ethical issues I face as a professional, when working with vulnerable individuals in sensitive situations. On a daily basis I deal with confidential information, whether this is updating client files, adding personal information on a database, or communicating via email about a particular client with other colleagues. Assuring that client files and information are kept and stored

confidentially at all times is of major importance. Generally, personal information about clients must be confidential to the service, however there have been some exceptions to this. In cases where for example children may have been at risk or a client is self-harming, it has been a duty to disclose this kind of confidential information to other services, as this can prevent further serious harm. Disclosing information is also another way of referring a case that needs specialised attention. However, when clients are initially assessed, it is an obligation to let them be aware of both the requirements and limits of confidentiality.

Within my role as a trainee health psychologist, I also have other roles integrated in other capacities such as a practitioner, consultant and researcher in which I work with informed consent. Clients, participants and other relevant individuals engaging in psychological services have the right to be informed of what is being offered, what to expect and potential risks involved. They are also entitled to know that they have the right to refuse or withdraw engagement in the service. When I have had participants engage in research, or when assessing clients, I always make sure I follow these procedures, not only to protect the clients, but to also to protect myself.

As a professional and ethical practitioner I am additionally aware of issues relating to difference and power. The role of power must not be taken advantage of particularly when working with clients who have mental health conditions, learning difficulties, emotional insecurities, legal proceedings and other characteristics, as they are more likely to be in a vulnerable state. Acting in the best interest of the client is something I highly value and practice.

Evaluation of Own Learning Needs

As a trainee health psychologist, I am constantly learning new skills through my day-to-day experiences and interactions with others. I feel that I have grown in confidence, developing my own professional identity. Receiving feedback from my supervisors has enabled me to identify areas that I can develop and improve on. For instance due to the large emphasis of the work I carry out on a one-to-one basis, I felt

that I needed further specialised counselling skills training. Since evaluating my own learning needs, I have been on two types of counselling skills training; Solution Focused Brief Therapy (SFBT) and Cognitive Behavioural Therapy (CBT), including CBT for depressed and anxious people. I found these courses sufficient in length and provided me with the skills I need to apply in the work I carry out with clients. I am also registered to start a six-month counselling skills course during the autumn of 2013. This course is more geared around self-awareness, which is another important element to be aware of when working on a one-to-one basis. By undertaking this course I hope to develop more self-awareness regarding my own attitudes, values and beliefs, in order to allow me to further enhance my therapeutic skills over time.

Dealing with Issues

During my professional practise, I have encountered a range of issues relating to the group work I carry out. Delivering therapeutic group sessions takes place daily within the service. Myself and other members of the team are each responsible for delivering certain group sessions in the week. Sometimes events occur that mean I will be delivering another team members session at short notice. This has at times made me feel put under pressure, as I do not have much time to prepare before facilitating a group. I have had to learn to adapt to circumstances as they arise, which involves accepting that I may not always have time to prepare. I have used placement supervision to reflect and discuss how I can manage these situations when they occur.

On several occasions when facilitating a therapeutic group session, tensions between clients have taken place. Initially, during the early stages of my training, I would get quite nervous when this happened, as I do not like conflict. I would avoid addressing the issue during the group, but rather after group with the particular clients that were involved. However, each time this has happened, I have had to take it away and think about how I could deal with it differently. I have had to learn to overcome my fear in dealing with situations I find less comfortable. I have received support from my clinical supervisor, where I have been able to talk about what exactly I feel uncomfortable with and how I could find ways to manage it. I have also received

support from my practice and line manager how to effectively deal with issues, which require immediate action. Gradually, I have started to address any tension that may occur between clients, there and then. I have also realised that it is important to deal with issues as they arise for the clients, because if they can learn to sit with uncomfortable feelings and work it through, they will be more likely to be able to cope with other conflicting issues that may arise outside the service. For me, dealing with tensions as they arise in-group, has slowly given me confidence in tackling these issues more often.

Other issues I have had to deal with are disappointment. I have found it challenging to adjust when things do not go to plan. This has occurred when carrying out interviews in research, sessions with clients or relevant appointments set up. It has at times been a struggle to stay positive. However, staying proactive and keeping an open mind to other opportunities has helped in this process. Learning from my experiences has involved looking back on a situation, thinking about it, learning from it and using the new knowledge to help me succeed in future situations. This process has not only increased my professional knowledge and skills, but also affected the way I work with and engage with clients and other professionals. Being able to see a personal and professional transformation as an independent practitioner and as a professional health psychologist has been a rewarding and valuable experience.

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