A PORTFOLIO OF ACADEMIC, THERAPEUTIC PRACTICE AND RESEARCH WORK

Including: An Exploratory Investigation into Therapists' Experience and Perceptions of Working with Anorexia Nervosa Sufferers

By

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**Statement of Anonymity**  
The confidentiality of clients and participants has been upheld throughout this portfolio. Whenever client or participant material is referred to, names have been replaced with pseudonyms and identifying information changed or omitted to preserve anonymity.
Introduction to the Portfolio

This portfolio comprises a selection of the work I have completed during the course of my Counselling Psychology training. Contained within it are three dossiers: academic, therapeutic practice and research, which highlight my academic and research interests, and are linked by both clinical and personal experiences. I have included within each dossier facets of my training that I have found particularly influential in my development towards becoming a Counselling Psychologist, and it is hoped that these papers will illustrate an overview of the range of skills I have developed and the means by which I have integrated these components into my clinical practice.

To contextualise my training and provide background to the portfolio, my interest in developing a career in psychology began during my teens, when I was living and schooling in Singapore. As part of the curriculum, we were provided the opportunity to do ‘community service’ which involved working voluntarily with children in ‘special’ schools, and I chose to gain experience working with children and adolescents with cerebral palsy, liaising closely with an educational psychologist. This experience heightened my awareness of numerous issues and I developed personal and professional interest in the pursuit of a career in psychology. In Singapore ‘difference’ is actively shunned from society. You would never see an individual with a learning or physical disability on the streets. I was to discover a number of appalling reasons for this, including certain religions believing that these ‘inflictions’ were due to a ‘bad’ past life and therefore one should not show generosity or consideration to these individuals as they needed to be ‘punished’ to enter the next life ‘unblemished’. Thus some of the work of the educational psychologist was to assist parents and families in showing kindness and caring to these ‘afflicted’ children, and trying to reveal these children’s strengths rather than an almost exclusive focus on their weaknesses. I remain highly attuned to society’s influences on individuals’ experiences and to consider with the client the system in which they live as well as their individual difficulties.
I truly appreciated this experience and continued to work at the ‘Spastics School’ during vacations from university. I gained a great deal from my experiences but did feel somewhat inept and wanted to be able to do more. For instance, working with adolescents, they would see family members gaining qualifications, going to university, getting jobs etc, and they would remain ‘stuck’ in their current position with apparently very little hope for a better future. It was incredibly frustrating only to be able to listen to these experiences and not be able to assist them toward any level of change. These experiences stimulated my interest in wanting to learn about human behaviour and psychotherapeutic practice.

I decided to read psychology at university as a direct result of my work with these children and adolescents and completed my first degree in psychology at Bristol University. Through this, although I gained knowledge at a theoretical level, I recognised the need for further training in order to respond effectively to those with psychological difficulties. I decided to train further in child psychology and completed my master’s course at the University of Nottingham, after which I worked as an assistant psychologist at a diagnostic and assessment centre for children with communication difficulties (predominantly those who would be diagnosed with autistic spectrum disorders). This was exceptionally interesting but, again, I felt quite frustrated by not being able to make a longer commitment to those I was working with (half a day seemed insufficient). I continued by gaining further experience at a residential community for adults with various learning difficulties which I found to be exceptionally interesting and rewarding work. I very much appreciated the ethos of this community in that it attempted to create a situation in which individuals could live as independently as possible. For instance, those who were able would live in supported accommodation locally rather than within one of the houses on site, and all were actively encouraged to contribute to the community, thereby drawing on and appreciating people’s individual strengths.

I was drawn to a career in Counselling Psychology as an opportunity for both personal and professional development. There were a number of elements that especially drew me towards this particular training. I welcomed the inclusion of personal therapy as part of the course; it provided an ideal opportunity to gain greater self-awareness and
understanding, provided me with one model of working and ways of being in the therapeutic relationship, and I feel my practice has been enhanced significantly by the experience of being in the client’s chair. I was also excited by the breadth and depth offered in terms of theoretical models of practice, with a value base of ‘being with’ rather than ‘doing to’. In therapeutic practice I was provided the opportunity to take this breadth and depth of training further by working in a variety of therapeutic settings and across the lifespan. Research provided me with the opportunity to explore in an in-depth manner one area of psychology that has held fascination and intrigue for me for many years, and I remain committed to addressing the issues raised in my research into eating disorders further in my continued professional development.

In terms of the course itself, I began on a full time basis but two serious health conditions forced me to break from training for a significant period of time. I recognised an ethical dilemma faced by professionals in terms of fitness to practice and acknowledged the necessity of returning to full physical health prior to completing training. However, although frustrating and upsetting for me personally to have to place my career development on hold, in retrospect I believe this interruption enabled me to consolidate my learning and developed my ongoing commitment to a career in Counselling Psychology. I believe that my professional identity, self-awareness and understanding have, in fact, been enhanced as a direct result of my personal crises.

I hope the work in my portfolio reflects this ongoing process. I continually work towards incorporating new material I have learned and will progress in my career development through greater theoretical understanding, enhanced therapeutic practice and the incorporation of research into my identity as a Counselling Psychologist.

**Introduction to Academic Dossier**

This dossier contains three essays submitted over the course of my psychotherapeutic training. The first essay is concerned with a critical discussion of a proportion of Winnicott’s theoretical writings on human development. At the time I was working within a child and family consultation service, working with children and adolescents
from a psychodynamic theoretical orientation. I found myself drawn to Winnicott’s innovative ideas but felt I needed to provide myself with an opportunity to explore his conceptualisations further. Thus, this essay provides some critical discussion of a necessarily limited exploration of some of his theoretical writings, particularly those which I was drawn to in working with children therapeutically, namely the individual’s growth towards independence and early relationships, the concept of ‘good enough’ parenting and his conceptualisations of the ‘corrective emotional experience’ that therapy could offer. The second essay is concerned with a description and evaluation of some of the work of Kohut, and his contribution to the development of my own therapeutic practice. I found his writings particularly useful in the transition from a humanistic to psychodynamic paradigm, and this essay is included because his writings assisted me in the process of development towards a personal integrative therapeutic practice. The third essay is concerned with a critical analysis and exploration of schema-focused therapy. At the time of writing I was working within a specialist eating disorders service for adults suffering from bulimia nervosa and/or anorexia nervosa. Although there was some research evidence to suggest that cognitive-behavioural therapy was the most appropriate form of therapeutic intervention for bulimia nervosa sufferers there was, and still is, a dearth of research into appropriate interventions for anorexia nervosa sufferers. Personally, from experience I feel cognitive-behavioural therapy can be helpful in alleviating symptoms of eating disorders but I do not think it is sufficient in itself. Thus, I explored schema-focused therapy further as this more integrative stance was more in line with my personal epistemology, and seemed more appropriate in working with those with complex and long-term difficulties.

Introduction to Therapeutic Practice Dossier
This dossier contains descriptions of my placements, during the course of clinical training, in addition to my final clinical paper. For the first half of my first year’s training I worked in a psychological service for older adults, providing weekly therapy for individuals, which was conducted in their own homes. For the second half of the first year I transferred to work at the local Community Mental Health Team and had the opportunity to work with adults with a variety of psychological difficulties. For my second year, I chose a placement working individually with children and
adolescents at a child and family consultation service. For my third year, I chose a more specialist setting and gained experience working with adults suffering from bulimia nervosa and/or anorexia nervosa, providing both group and individual therapeutic intervention. Returning to training after the necessity of an extended break, my final placement concerned working at an out of hours' service within a Community Mental Health Team, providing individual therapy for those who would otherwise be unable to access the service, either because of child care difficulties or due to working full time and thus being unable to attend sessions.

To provide a brief introduction to my final clinical paper, this explores my developmental journey through these placements, and discusses the ways that I have increasingly drawn on different theoretical frameworks and therapeutic interventions, incorporating and drawing on research to enhance my clinical practice. I also explore my personal development through the course through personal therapy and the impact of impaired physical health leading to a prolonged break from training.

**Introduction to Research Dossier**

There are three reports included in the research dossier, all concerned with examining issues associated with working with individuals suffering from eating disorders. The literature review sets the scene for the two empirical pieces that follow. It examines three theoretical models of anorexia nervosa and highlights the difficulties associated with the dearth of research into this complex and life-threatening psychological condition, and the desperate need in the field to develop and provide research evidence for clinically proven, effective therapeutic interventions. As a direct result of this, the first study explores the subjective experiences and perceptions of therapists who specialise in working with anorexia nervosa sufferers. This empirical study highlights guidelines that these individuals work by, as well as ongoing difficulties and frustrations associated with working with this client population. The second study takes a different stance by considering the effectiveness of an integrative approach to therapeutic practice for anorexia nervosa and bulimia nervosa sufferers in a specialist outpatient eating disorders service. Further, it explores a case study analysis of one individual's experiences of anorexia nervosa and the general processes provided by therapeutic and external support that have enabled her to negotiate towards a life
removed from her eating disorder. This dossier also highlights an area of special
interest for me as both clinician and researcher, and I will endeavour to continue to
work therapeutically within this field, as well as aiming to develop vitally needed
research into effective practices to working with this client population.
ACADEMIC

DOSSIER
Critically Discuss One Psychoanalytic Model of Human Development

In considering psychoanalytic models of human development and the relevance of theoretical writings for personal therapeutic practice with children and adolescents, one theorist that has been particularly influential is Donald Winnicott. His theory is especially useful when attempting to make sense of issues surrounding the early lives of children. During the course of my work with this client group, I found that a significant number of the children I saw for individual therapy came from families in which the father was either physically absent or unavailable in other ways to the family. Thus, I needed to explore the impact this may have had on these vulnerable children and Winnicott's explanations regarding early childhood relationships proved particularly useful in this respect.

This report aims to consider only a small proportion of Winnicott's theoretical writings on human development as there is not the space here to consider the extent and diversity of his concepts and ideas, that were developed throughout his career. The use of 'theoretical writings' rather than 'theory' is utilised with reference to Winnicott because of the fact that he did not develop an all-encompassing grand scheme of human development. As Jacobs (1995) comments, it would not be possible to describe a 'Winnicottian analyst' because to do so would leave considerable gaps in both theory and practice. Rather, his writing consists of a compilation of novel ideas that are written independently of each other, to convey new theoretical concepts based on his observations.

Winnicott's principle method of working and thinking was to "gather this and that, here and there, settle down to clinical experience, form my own theories, and then, last of all, interest myself to see where I stole what" (Winnicott, 1975, p.145). Winnicott developed his theory of human development through two distinct sources: through direct observation of infants and children and those who cared for them; and indirect observation made during the course of psychoanalysis of patients of all ages. His conceptualisations were developed throughout his career, primarily through the observation of a vast number of infants, children, adults, parents and families.
Within this report, Winnicott’s theoretical writings of early human development will be considered in some detail, particularly the early mother-infant relationship, and how these have been influential in this author’s practice, with children and adolescents.

Winnicott was both an individual and creative thinker and, although initially a member of the Kleinian group, he was too individual to be considered Kleinian and therefore became identified with analysts from the independent or middle group in Britain, which followed a more eclectic developmental model than Freudians and Kleinians. Winnicott was also influenced significantly by Darwin in his consideration of the individual gene as having to adapt to its environment through the process of natural selection. Winnicott argues that the baby’s mother (who in the early weeks of life is the baby’s environment) has to adapt to her baby. The baby will then gradually be aided in his or her adaptation to the wider environment beyond the mother.

In his theory of human development, Winnicott attempted to explain how the individual grows, through dependence towards independence, arguing that independence is never absolute because the healthy individual does not become isolated. Instead, the individual becomes related to the environment in such a way that the individual and his or her environment can be said to be interdependent. Further, he concentrated on the way an individual develops towards a personal way of being, of how the individual becomes distinctive according to the sense he or she has of him/herself, and the ways in which the early environment makes this possible.

What was of particular interest, when beginning the process of working with and attempting to understand issues related to childhood development, was Winnicott’s theory of the early mother-infant relationship and the effects of this on the development of the child. Winnicott suggested that there was no such thing as a baby, that “if you show me a baby you certainly show me also someone caring for the baby, or at least a pram with someone’s eyes and ears glued to it. One sees a nursing couple” (Winnicott, 1964, p.88). Thus, he understood that a baby cannot survive in isolation, only as a part of a relationship and the most important relationship, particularly in the earliest developmental stages, was that of mother and infant.
Winnicott suggests that in the weeks leading up to and a few weeks after the birth, the mother enters into a state of 'primary maternal preoccupation'. At this stage of absolute dependence, the mother becomes preoccupied with her child to the exclusion of all other interests, in a 'way that is normal and temporary'. In terms of the baby, he or she has no way of knowing about maternal care, in relationship to what is done well or badly; he or she is only in a position to gain profit or suffer disturbance.

The mother's most important function during this stage of development is 'holding'. Firstly, holding keeps the baby safe from unpredictable and therefore traumatic events that interrupt going-on-being. Secondly, holding involves caring for the baby in terms of meeting all his or her physiological needs through empathy. Winnicott argues that reliable holding enables the immature and weak ego of the infant to become strong, through the ego-support provided by the mother.

The second stage is that of relative dependence, in which the infant can learn about maternal care. The main characteristic of mothering during this stage is to gradually present the world to the child in doses that are manageable, as well as minor failures in her adaptation to the infant which are not overly traumatic. Winnicott suggests that, as the infant attains knowledge concerning dependence, he or she also knows when his or her mother is absent and thus experiences anxiety. From the mother's perspective, these absences and losses might be minimal but they also need to be kept within the boundaries infants are able to cope with. Gradually the infant gains knowledge about the mother's personal and separate existence.

Winnicott argues that the transition from absolute to relative dependence is potentially very painful for the young infant. During the stage of absolute dependence the infant is provided with the illusion of omnipotence, of having created what there is to be found. Maternal adaptation provides the brief period of omnipotence. Through minor failures of the mother during this stage, the infant is gradually disillusioned and learns to accept the reality that he or she is not omnipotent, and thus the infant adapts to external reality.
Winnicott transforms the concept of illusion radically from the conceptualisation provided by Freud. In Freud’s view, illusion represents the fulfilment of early desires. Illusions are considered to be examples of erroneous thinking, which are also emotionally charged by the desire for wish-fulfilment. His aim would be to replace illusion with reality testing and rational thought. However, for Winnicott, illusion is conceptualised as a way in which the young infant is able to gradually relate to others and the external world. Each disillusion provided by the mother is replaced by another form of illusion; Winnicott suggests that the capacity of illusion remains throughout life in the healthy individual, and provides the person with a positive way to meet new situations. He further considers that reality is not discernible and, as a result, we live in a world of shared illusions.

The third stage of ‘towards independence’ is never absolute, as mentioned above.

Thus, within Winnicott’s theory of human development he is concerned with the healthy individual’s development towards maturity, which is enabled by there being a ‘good-enough’ as opposed to ‘not good-enough’ mother available to the infant in early childhood. The ‘good-enough’ mother is able to understand the infant’s subtle gestures and knows about her child intuitively, without having any intellectual appreciation of what is happening. Winnicott argues that this can only be arrived at without interference from professionals, that the ‘good-enough’ mother should be recognised and appreciated for who she is and therefore be left alone and given full responsibility for her child. However, it should also be recognised when a mother is ‘not good-enough’; she will repeatedly fail to meet the infant’s spontaneous gesture and will, as a result, not be able to meet the infant’s needs. This is considered to lead to compliance on the part of the infant, and provides early indications of the development of a false self.

It does seem that Winnicott provides us with a somewhat idealised view of the good-enough mother, which places pressure on her to carry the majority of responsibility for care of the child. Further, it also places on her the sole responsibility for the development of the child. However, this does appear somewhat paradoxical in the fact that he also suggests that a good mother will know naturally how to be a mother
by following her instincts. Thus, on the one hand mothers are considered responsible for the “orchestration of a highly complex developmental sequence from an initial sustaining of the infant’s omnipotence to organising a graduated failure of adaptation to its demands” (Parker, 1994, p.6). On the other hand, no-one is able to assist in this process as the ‘good-enough’ mother is expected to rely on her instincts. Further, is it not possible for the father or other primary carer(s) to be a good-enough parent? It could be argued that, rather than concentrating on the mother as essential in early development, it is the characteristics of the early relationship that are important, such as consistency and continuity of care and devotion towards the young infant.

The father is considered important in the process of development from dependence towards independence, in that “he can help provide a space … Properly protected by her man, the mother is saved from having to turn outwards to deal with her surroundings at the time when she is wanting to turn inwards” (Winnicott, 1964, p.25). Winnicott argues that the father’s role is to provide a facilitating environment for the infant. Winnicott provides a model of the father as a person who takes a back seat in his child’s development, a person who provides moral support, a sense of law and order and, later, a model of the world of work. Further, he suggests that “it is the mother’s responsibility to send father and daughter, or father and son, out together for an expedition every now and again” (1964, p.118).

This is a somewhat archaic view of the role of father in the family environment, although it must be recognised that Winnicott was writing during a time when the principle role of the father was to make a living and provide an environment of comfort and stability for the mother and child. It was a great deal rarer for a mother to be the primary wage earner in the family during the mid-sixties. However, from the perspective of this century, Winnicott’s dearth of consideration of the father’s role in his child’s emotional development creates a great weakness in his theory of human development and is an area of concern. It seems that, by focusing almost exclusively on the mother-infant relationship, Winnicott has ignored the importance of both the father and the wider family in the development of the young child. However, by holding one variable element constant, the formulation of theory is made simpler.
Although there are criticisms of Winnicott's conceptualisation of the mother-infant relationship, his ideas are useful in understanding the child's presentation in therapy. Further, by transferring the understanding of how a mother might have lacked the capacity for providing an environment in which natural development can take place, for instance because of external factors or mental illness, Winnicott argues that it is possible to provide this environment for the child in the therapeutic situation.

In the therapeutic endeavour, Winnicott views the main role of the therapist as providing a means for children's natural developmental processes to take place. Good technique may provide the individual child with a 'corrective emotional experience'. For instance, it may be the first occasion in which he or she has received undivided attention for fifty minutes, the first experience of reliability etc, but this is not the primary aim of therapy. Instead, Winnicott argues that the child will experience failures of adaptation by the therapist/analyst and will then have the opportunity to hate him/her for this failure, the early environmental failure being repeated in the transference. He argues that, in the end, therapists succeed by failing their patients. Winnicott continues that the child will test whether the therapist is going to be a reliable person or one who will repeat the traumatic experiences of the past. Thus, a vital aspect of therapeutic intervention is providing a holding and containing environment.

As Winnicott summarised: "you get to know what it feels like to be your client. You become reliable for the limited field of your professional responsibility. You accept love, and even the in-love state, without flinching and without acting-out your response. You accept hate and meet it with strength rather than with revenge. You tolerate your client's illogicality, unreliability, suspicion, muddle, fecklessness, meanness etc and recognise all these unpleasantnesses as symptoms of distress" (1965, p.229).

As mentioned earlier, Winnicott's theory of early development has been extremely useful in understanding the early issues of young clients. To provide an example, 'Natalie' was a 10 year old girl who was referred to the Child and Family Consultation Service with anxiety and behavioural problems (being physically and
verbally abusive towards adults and children) and was consequently diagnosed with Attention Deficit Hyperactivity Disorder, for which she was prescribed Ritalin.

Natalie was the middle of three children, having two half brothers. Natalie’s older sibling, William, was born three years before her, by a different father. The pregnancy was unplanned and Ms Francis, Natalie’s mother, had no further contact with William’s father. One year later Ms Francis met and married Natalie’s father, Mr Andrews. Natalie’s pregnancy was also unplanned and Ms Francis wanted to have a termination; however, she felt pressurised by her family and husband to keep the baby. To exacerbate the situation, Mr Andrews was an abusive alcoholic, who became extremely violent towards Ms Francis; she described being ‘regularly beaten up’ by him, both during and after the pregnancy. Eventually, after two years of physical abuse, Ms Francis left her husband and has remained a single parent since.

Thus, from Winnicott’s perspective, it seems that Natalie’s early childhood was overly traumatic. It seems that her mother was unable to bond with her either during pregnancy or after birth and therefore did not develop the ‘natural primary maternal preoccupation’, so important at the beginning of life. Further, because of the trauma of being physically abused, Ms Francis was also unable to adapt to Natalie’s needs and provide her with a containing and holding environment. She was also both unstable and unreliable because of the lack of a supportive environment for herself and her child. Natalie’s father did not provide even the most basic of secure and stable environments for mother and child. It seems that this early environmental failure led to a high level of anxiety but, further, after Ritalin was introduced, she became overly compliant which was a sign of the development of a False Self.

From this conceptualisation of Natalie’s difficulties, it was possible to provide a holding and containing environment for her within therapy, being emotionally available and reliable until a trusting, developmentally needed relationship had been achieved. From providing Natalie with this new experience it was then possible for her to utilise minor failures in a less traumatic way, with the aim of enabling natural developmental processes to take place.
By concentrating on only one aspect of Winnicott's theoretical conceptualisations in detail it has not been possible to consider other important and influential ideas. A more extensive report would include consideration of transitional objects and phenomena, his concept of play and creativity, internal and external reality, techniques such as the Squiggle game, among others. However, it has not been possible to do justice to these concepts within the space provided.

It should be noted that, although his conceptualisations are useful in understanding and working with children, Winnicott's influence is much more limited than Freud and Klein, mainly being confined to more specific areas of psychotherapy, psychology, education, social work and other forms of child care. Although there is considerable criticism of his ideas in the field of psychoanalysis, his ideas have been inspirational in other areas, and many of his conceptualisations of child development and technique remain influential in contemporary thinking, especially in child psychotherapy, social work and education.

As Davis and Wallbridge summarised, "there is no doubt that we owe much to thinkers in the round – to those who have had the courage to expose themselves, to risk the I AM of setting out for us a whole way of looking at the world, without tacking or trimming, and in spite of those self-doubts which are inevitable in the integrated person and in the person of integrity. To this achievement Winnicott has added a generosity of spirit not always found in writers on human nature. He has not said to us, 'I am telling you how the world is, so you must think what I think'. He is rather saying, 'on the basis of what we share, and on the basis of how we differ, I may be of use in your own creation of the world.' He wanted to be 'created into and with', to be 'found and used'. He hated the idea of being imitated" (1981, p.172).
References


Describe and Evaluate the Work of One Psychoanalytic Theorist and Illustrate the Usefulness of His or Her Ideas for your own Therapeutic Practice

Through reading about a number of psychoanalytic theorists and discussing the relevance of their clinical writings for personal therapeutic practice, the one that has been deemed most useful thus far has been that of the work of Heinz Kohut, who developed his theoretical stance by combining humanism and psychoanalysis. Kohut’s work has proved extremely controversial with “those who see him as a destructive heretic and those who see him as the messiah” (Kahn, 1991, p.87). Kohut, while he thought initially that he was merely expanding psychoanalysis, later on delineated his work and therapeutic approach as psychoanalytic self-psychology, and it is often still distinguished as such.

Psychoanalytic self-psychology is a ‘structured’ psychology. It places subjective experience at the centre of its clinical and theoretical concerns. Kohut’s concept of the structures of the self assisted him in formulating a theory of how and why individuals change from moment to moment, situation to situation, relationship to relationship, as well as how and why, in certain predictable ways, individuals stay the same.

Self-psychology can be distinguished from other psychoanalytic approaches by its method of data-gathering. The analyst becomes involved in sustained empathic immersion in the subjective experiences of his/her client (especially in his/her transference experiences), which is described as an ‘experience near’ approach to practice (Kohut, 1971). Further, understanding and explanation (the two steps involved in the interpretation process) are also considered from the client’s subjective perspective. Kohut placed empathy at the centre of his clinical method, whereas other psychoanalytic approaches tend not to regard empathy as fundamental to the analytic process.

Within this clinical approach, Kohut formulated a new developmental theory; a novel conceptualisation of the nature of psychopathology as well as a new perspective on the process of cure.
Thus Kohut, whilst remaining within classical psychoanalysis initially, gradually and carefully distanced himself from the psychoanalytic context, seemingly to provide as much expression for his new formulation as was possible. As time went on, he did step out of the traditional psychoanalytic context gradually, as and when his clinical experience demanded it.

It could be argued that self-psychology departs significantly from Freudian theory by recognising the importance of people’s inherent need for relationships, which provide certain types of experiences during growth and maturation. Kohut proposed that enough of these ‘selfobject’ experiences when the infant and child are developing assist in the formation of a strong, cohesive self, which is considered the core of the individual’s personality and character.

It is not possible to discuss the wealth of Kohut’s contributions in the space available in this paper, thus the essential aspects of his theory (as outlined by Kohut) will be elaborated, with illustrations as to how these have been relevant to my therapeutic practice. Thus, the areas of empathy, the need to be mirrored, the need to idealise and the need to be like others will be discussed.

The integration of empathy as central to the analytic process could be considered the most important of Kohut’s contributions. Kohut remained extremely concerned throughout his career that his colleagues had misunderstood his conceptualisation of empathy. Thus, he concentrated a great deal of his later career working towards explaining his theoretical stance on this subject. In his paper ‘On Empathy’ written in 1981, he again outlined his position on empathy within therapeutic practice. He explains this concept on several levels. Firstly, he explains empathy as the definer of a particular psychological field. As Siegel (1996) summarised, “empathy is the means by which the psychological observer gathers information about he inner world of human experience. Empathy is the data-gathering instrument. It defines the field the psychologist studies ... If histology is that field accessible to study by the microscope, psychology is that field accessible by empathy” (p.187).
The second level of empathy is defined as an informer of appropriate action. He explains that, if one wants to know how to act toward another person, it is essential to be able to put oneself in their shoes so to speak. Kohut suggests that analysts used empathy for the purpose of both knowing their clients as well as using it as a tool to inform their analytic action (Siegel, 1996).

Although empathy informs the analyst in terms of taking the most appropriate action, Kohut does not describe it as an action in itself. Thus, empathy is the tool which enables the analyst to decide upon the most appropriate therapeutic interventions for a particular client. It is beneficial therapeutically in terms of acknowledging the existence of the other person; in other words, verifying their humanness. This is where Kohut’s approach appears to differ from classical psychoanalysis, which does not necessary acknowledge the client’s humanness. Rather, not responding to the client is considered important so as to provide a forum for free association and expression of the unconscious. However, it could be argued that, by not taking the humanness of the individual into account, further problems could be created for an individual who is already feeling alone and isolated.

In therapy, Kohut describes a gradual movement away from lower level empathy toward higher level empathy as the client matures emotionally. Kohut explains empathy as a developmental process that occurs throughout life but is particularly important in childhood. Developmentally, the parent provides empathy by touching and holding their child, before language and more subtle forms of expression can be understood. As the child develops, the parent gradually provides higher level empathy by, for example, smiling with encouragement as their child leaves their side to explore the environment. Kohut explains that a similar process occurs in therapy. At first, the analyst provides empathy and understanding through the experience of being ‘held’, termed ‘experience-near’ empathy. The ‘experience-distant’, higher level empathy occurs when the client is ready, by providing explanation alongside understanding. For instance, conveying a deep level of understanding by providing explanation of how the complex story of the past is still alive in their sensitivities, hurts and reactions in the present. It is this second explanatory aspect of empathy that is considered to make the intervention analytic.
It seems that the use of empathy in therapy is extremely important, if not essential, and Kohut's explanations and descriptions of the theory behind the nature of this have been extremely influential in terms of therapeutic practice, particularly in terms of one client I have worked with; a fifty-five year old gentleman who will be named Mr S.

Briefly, Mr S was adopted at the age of three months. His natural mother had had an affair during the war and became pregnant. Mr S had always remained grateful to his adoptive parents for providing a roof over his head and moral guidance, but he never felt loved by them. They had both died and, after years of searching for his natural mother, he found that she had also passed away. On coming to therapy, Mr S was very depressed, anxious and suicidal. What became evident time and again was that Mr S had never felt he had been provided with any form of emotional support and had therefore repressed all feelings associated with the 'abandonment' and 'rejection' he felt, both by his natural mother and adoptive parents. It seemed as though he was desperately searching for someone to truly understand the pain and anguish associated with these experiences. Thus, for the first few sessions my interventions were purely reflective, showing him that I was attending to the hurt and anger he felt towards those he thought he should have been closest to. Thus, I remained in an 'experience-near' relationship with him until I felt he was truly ready to begin the process of exploring the reasons for his current psychological distress. I gradually moved towards an 'experience-distant' empathic stance, explaining what I felt to be the underlying causes of his current psychological difficulties and, through exploration of these explanations together, Mr S gradually became able to internalise these interpretations and understand and explore the emotions pertaining to this. Following this form of intervention for the majority of therapy proved successful in this case.

Another essential aspect of Kohut's theoretical contribution is that of 'needs'; the 'need to be mirrored', the 'need to idealise' and the 'need to be like others', all of which are considered developmentally necessary for the construction of a healthy self.
The 'need to be mirrored' is considered the first need of the growing child, and described as a 'grandiose exhibitionist need'. Kahn (1991) provided a clear account of the theory behind this conceptualisation, explaining that every child has the need to be seen as exceptional and remarkable by his or her parents. Kohut proposes that children learn how their parents perceive and value them through subtle verbal and non-verbal cues. Kohut refers to this parental reaction as 'mirroring'. On occasion, parents will fail to mirror their child adequately; if this is not too frustrating or traumatic, the child will gradually learn to take on the mirroring function for him or herself, if only briefly. Kohut used the term transmuting internalisation to describe this process. These internalisations create "new structures that assume the same psychological functions previously performed by the idealised object" (Siegal, 1996, p.71). Thus, through this process the child is believed to develop new psychic structures which have the effect of him or her no longer needing to know how special his or her parents believe he/she is as he/she has developed a strongly rooted self-esteem.

However, problems are considered to occur when the child has not been mirrored or when failed mirroring creates intense frustration and trauma. As a result, Kohut proposed that the child’s grandiose exhibitionist needs would be repressed when he or she comes to believe there is absolutely no hope of these needs being satisfied. Kahn (1996) explains that this would be exemplified in an adult who was suffering from feelings of insecurity and a sense of worthlessness.

The second form of need is that of the ‘need to idealise’. A strong need in the developing self is the need to idealise at least one parent (the idealised parental imago). Kohut proposed that each child needs to perceive at least one of his or her parents as omnipotent, calm and confident thereby rescuing him/her when the outside world seems too complex or confusing, or when internal life appears to be too chaotic for the child’s immature ego to manage. Again, sometimes the parents will fail in this respect and, through transmuting internalisation, the child will gradually learn to cope with the pressures and conflicts that are part and parcel of everyday life. Kohut explained that, through this process, the child will mature into a confident person who can manage various difficult situations effectively.
This aspect of Kohut’s theory again makes a great deal of sense. I recall as a child experiencing my own father as powerful and a rescuer in times of distress, providing solutions to problems and difficulties that seemed overwhelming to a young child. (It was quite a shock to gradually realise that he was actually human with vulnerabilities just the same as everyone else).

However, this aspect can also be problematic according to Kohut. He explained that when there is no potential for idealisation, the child cannot develop the ‘confident’ aspect of the self and therefore will develop into an individual lacking in vitality and a zest for life.

The final aspect is the need to be like others, the ‘twinship’ need. Kohut taught that children need to experience a sense of belonging and therefore need to feel they share some important characteristics with either or both parents. If this is not provided, the child will grow up feeling somehow a stranger, a person who does not belong.

One of the main criticisms of Kohut’s theory is that, by introducing humanism into psychoanalysis, he has created a situation in which he does not provide optimal frustration for the client to work through unconscious processes. However, he has developed strong and clear arguments to counteract these criticisms. Kohut apparently believed that frustration developed out of not providing the gratification the individual needed; rather, he felt it important to communicate empathically the understanding of that person’s need to be gratified. However, through communicating a true understanding of that individual’s need, he or she may possibly be able to explore what that specific need means to them and learn new and more mature ways of obtaining gratification. For instance, during three sessions with one young woman who had been suffering from anxiety for eight years, there was a constant underlying need for reassurance that she was not ‘going mad’ or ‘falling apart’. It seemed that, by accepting and understanding this need, while reflecting this back to her, she was able to work through these feelings without my having to provide that level of reassurance for her.
Kohut’s major contributions to psychology have been to conjoin humanism and psychoanalysis, emphasising the requirement of a therapist as to empathise fully with the client in terms of understanding him/her in terms of his/her subjective experience, as well as explaining (interpreting) the complex nature of their difficulties from a historical standpoint, but again from his/her personal perspective. Secondly, Kohut has also provided a clear and logical account of how disorders of the self may develop and how, through the transference relationship, the nature of these can be understood. Further, he describes possible therapeutic interventions to assist the individual in working through these difficulties.

This paper has evidently been somewhat uncritical and rather positive in its evaluation of both Kohut’s theory and clinical method. However, the focus has been on those aspects considered most directly translatable to clinical work. The areas elaborated on have been extremely useful in relation to personal and therapeutic experience and have assisted in explaining the complexity of the underlying difficulties some clients have brought to therapy. However, there are, understandably, some areas of difficulty, particularly in relation to structure building and how frequently and easily this can be seriously affected through lack of gratification of needs by parents. This would appear to have serious repercussions for the generation of children that are now being placed in child care from an extremely young age. It would seem that, within this, there would be increasingly less opportunities for child to build strong structures as, when with a group of other children, they would have less one to one interaction with their carers at this developmentally important age. For instance, if two carers are looking after ten children, there will not be the time to provide gratification of the needs of all these children as and when it is required. This would have serious implications for the future in terms of the possibility that these youngsters may develop disorders of the self. On the other hand, it may be that the perceived level of gratification required, as outlined by Kohut, is actually considerably less than he originally conceptualised.
References


The Usefulness of Schema-Focused Therapy for Therapeutic Intervention with Eating Disorder Sufferers

During the course of training, numerous theoretical and therapeutic models have proved influential when considering working within different frameworks. However, the process of transition from one model of working to another has proved more challenging and with each year there was a sense of starting again, both in terms of working within a different theoretical framework and with different client populations. Thus, I have found that theorists who incorporate more than one school of thought into their framework useful in assisting this development through different ways of conceptualising and working with clients.

To expand, in the first year I worked with both older adults (aged sixty-five and over) and adults (aged eighteen to sixty-five). This first year of training was predominantly humanistic, with an emphasis on client-centred and experiential psychotherapy. Briefly, theoretically, the ‘fulfilment model’ (Maddi, 1989) views the individual as “striving to create, achieve or become” (McLeod, 1996, p.135), thereby understanding human experience through the concepts of process, reflexivity, self, organism and experiencing. As such, rather than attempting to instigate movement towards change, it is the role of the therapist to attend to the internal and external factors of the individual’s situation that prevents change from occurring. Thus, when working within the humanistic paradigm, I understood that the fundamental aim of ‘being with’ a client was to gain as great an understanding of the experiential world of the client as possible – to both accept and value the meaning or content of what the client was discussing, and to facilitate the process of exploration further.

During my second year I worked within a child and family consultation service within a psychodynamic theoretical framework. I found the transition from a humanistically oriented therapy to the more interpretative and ‘neutral’ stance associated with the psychodynamic paradigm quite demanding. For instance, as mentioned, the fundamental task within the humanistic framework was to explore the ways a client might be denying certain aspects of his/her current awareness and attempt to explore with them strategies to become more attuned to their experience. However, within a
psychodynamic framework there was a shift of focus towards attempting to gain insight into repressed childhood events that were associated with the individual’s current disturbance, through interpretation and the development of the transference relationship.

One influential theorist who seemed to effectively transcend these two seemingly opposed perspectives of human experience was Kohut. By bringing together psychoanalysis and humanism it was possible not to be, in a sense, forced to put the learning of humanism behind me in order to work effectively in a psychodynamic placement. I found that an insight-oriented therapy that recognises the importance of childhood experience on current functioning beneficial in conceptualising an individual’s current psychological distress, but recognising the importance of the power of the unconscious and the necessity of analysing the transference within the therapeutic relationship seemed a necessary but not sufficient condition to enable the process of change. From a Kohutian perspective, this was believed to lead to emotional unavailability which may cause the therapist to appear cold and judgemental. Kohut believed that understanding the client’s experience as profoundly as possible through the utilisation of empathy, and then conveying this understanding to the client, was an essential component of therapy. Thus, recognising that the individual was the expert of him/herself (as in humanism) and then attempting to understand and then explain what was occurring within the relationship (as in psychoanalysis), was the stance I found most helpful when working with vulnerable children and adolescents.

For my third year placement I worked in a specialist setting, working with adults with anorexia nervosa and/or bulimia nervosa. Again, a change in client population and the movement to working from a cognitive-behavioural theoretical framework proved quite daunting. From the process of drawing on a variety of theoretical bases to conceptualise and work with the idiosyncratic needs of the individual, being constrained within a particular paradigm ran contrary to my learned way of working. Perhaps this was more problematic because of the nature of the placement, working with individuals suffering from eating disorders, many of whom had highly complex
and long-standing difficulties, for who their eating disorder had become a chronic problem.

Although possible to identify problems that can become the focus of treatment (as necessary for cognitive-behaviour therapy), I have found through experience and reading the associated literature on eating disorders, that there may be numerous factors that may require attention in therapy, including difficulties from childhood, familial problems, relationship difficulties, intrapsychic conflict, among others, as well as the actual symptoms of anorexia and bulimia nervosa. Thus, I found it necessary to consider a more integrative model of working that incorporated aspects of cognitive-behaviour therapy but that could also take into consideration the long-standing and highly complex nature of these individuals' difficulties as and when this was deemed necessary.

Schema-focused therapy (Young, 1990, 1994) was particularly useful in this respect because it is an integrative approach that draws on techniques from cognitive-behavioural therapy, psychoanalytic therapy, Gestalt therapy, among others. Fundamentally, this approach is designed to break lifelong patterns of thinking and relating and is considered beneficial for clients who have complex difficulties such as personality disorders, long-term depression, substance abuse and relationship issues. The main concepts associated with this form of therapy will be considered and how these assist in conceptualising clients' difficulties in a more flexible and adaptive manner.

Fundamentally, there are four central concepts associated with schema theory which include: early maladaptive schemas, schema domains, coping styles and schema modes. On consideration of these aspects of the model, it becomes evident that Young attempted to incorporate both the early history and moment-to-moment functioning of individuals, which I found helpful in working with this client population. The aim of schema-focused therapy is, therefore, to assist clients in recognising and working through maladaptive coping styles which have developed at an earlier developmental stage, thereby getting back in touch with their core affects. Further, there is an emphasis on attempting to heal early schemas, to learn how to
move out of self-defeating schema modes as quickly as possible, through the recognition and insight developed within the therapeutic context, and eventually to have their affectual needs met in everyday life.

One of the most important aspects of the model and one in which it differs significantly from CBT, is the recognition and acceptance that those individuals with more complex Axis II (DSM-IV) conditions will need to explore the early childhood origins of their difficulties. As a result, Young (1994) introduced the concept of 'early maladaptive schemas' in considering such clients. Whereas traditional cognitive therapy concentrates mainly on two levels (automatic thoughts and underlying assumptions), the schema-focused approach argues that the most important emphasis of therapy is concerned with this deepest level of cognition.

Fundamentally, early maladaptive schemas are broad and pervasive themes concerning the individual and his/her relationships with others, which have developed during childhood and have evolved during his/her life, which are dysfunctional to a significant extent (Young, 1994). It is argued that schemas form an interplay between the child's innate temperament and his/her ongoing and damaging experiences with parents, siblings and/or peers. Negative schemas are conceptualised as developing as a result of severe deprivation, abuse, instability, criticism and so forth. As these schemas develop early in life, it is considered that the individual will perceive them as familiar and comfortable, thereby distorting his/her perception of events so as to maintain the validity of his/her schema.

From the perspective of experience of working with clients with eating disorders, consideration of these early maladaptive schemas seemed imperative in both conceptualising individuals' psychological difficulties as well as working towards change in therapy. Moreover, 'schema processes' (maintenance, avoidance and compensation) and their associated cognitive, affective and/or behavioural components aided my understanding of how schemas function within a given individual and provided a structure from which to develop therapeutic input.
For instance, Ms D was referred because of long standing anorexia nervosa, stemming back twenty years. Although a ‘normal’ weight, her self-evaluation was almost exclusively related to weight and shape. Through the development of a ‘limited parenting’ (McGinn & Young, 1996) relationship and exploration of her developmental history, it was possible to ascertain that she had developed strong beliefs that she was unlovable, that she would be abandoned and that her needs would never be met. This was discussed in terms of relationships within the family in which she felt herself to have been both emotionally neglected and criticised by her mother who abused alcohol. Her father was unavailable and, when she did attempt to elicit his support, this was not forthcoming leading to a sense of abandonment. She was severely bullied at school but had, by this stage, recognised that she would not receive the support she required of her parents which led to her being withdrawn and socially isolated. She also described a volatile relationship with her ex-husband, who attempted suicide on more than one occasion during their marriage. Thus, it seemed that these experiences had caused the development of ‘abandonment’, ‘emotional deprivation’ and ‘defectiveness’ schemas.

As a result, we worked together on a number of levels. We used some standard cognitive techniques to assist in the process of challenging her thoughts and perceptions regarding herself (ie automatic thought records, recognition and development away from the tyranny of the ‘shoulds’, assertiveness work); we incorporated behavioural techniques such as ‘time out’ for herself in which she could experience being alone; we explored together her recognised underlying schemas in therapy so as to experience her affects in a safe and secure environment. Also, due to the fact that she believed herself to be unlovable and would ultimately be abandoned, I attempted to counteract this, albeit in a limited way, by developing a relationship in which I was nurturing and attuned to her needs. These and other interventions assisted her in being more in control of both herself and her life and she felt more positive about continuing to progress once therapy had ended.

Thus, there are a number of aspects – cognitive, behavioural and affective – that occur in the here and now that prevent early painful schemas from being altered and prevent individuals’ from attempting to alter their current state of functioning. This is where it
may be argued that CBT is not always beneficial for those who have long-term difficulties. If the individual’s core difficulties are not recognised and worked through, any cognitive-behavioural strategies for change will be deemed ineffective or only superficially effective. For real and enduring change, it seems necessary to consider the individual’s childhood experiences so as to identify whether any maladaptive schemas have been developed to cope with certain situations. If that is the case, however painful it may be for the individual in question, it seems necessary to consider these maladaptive coping strategies within therapy.

Implicit within this theoretical framework is the importance of a strong therapeutic relationship. Especially if painful experiences and memories are to be triggered both within and outside of therapy, the individual must have: a good understanding of the reasons for change; trust in the therapist that the level of negative affect is necessary for this change to occur; and recognition that their life will be more fulfilled and satisfying when working from more adaptive schemas.

Unfortunately, there is currently little research into this approach to working with clients with complex and longstanding difficulties. However, from personal experience of this approach, I have found it useful for understanding the underlying difficulties faced by clients, as well as their current modes of functioning. Finally, although a variety of strategies are utilised within this form of therapy (thus making it sufficiently flexible and adaptable to meet the idiosyncratic needs of the individual), none of these would be possible without a strong bond between therapist and client, and I have found the approach of ‘corrective emotional experience’ through ‘limited parenting’ a useful means of considering the therapeutic relationship.
References


Description of Placements

Placement 1a
For the first half of the first year's training I worked within a busy Community Mental Health Team, which was part of a large NHS trust, in the department of psychological services for older adults. The setting of the placement was in a day hospital, where assessments of the psychological and physical functioning of clients were carried out. The client group with whom I worked were aged sixty-five or over, although assessments were carried out with clients younger than this, if there was a referral questioning whether an individual was suffering from dementia or Alzheimer's disease.

There were a variety of professionals within the team including: one clinical psychologist, consultant psychiatrists, community psychiatric nurses, speech therapists, occupational therapists, care workers and physiotherapists. There were team meetings twice a month in which new referrals were discussed, as well as continuing care plans for clients already within the service. Referrals came from a variety of sources including: self-referral, familial referral, GPs, social workers, care workers among others.

The clients seen by the team had varying degrees of psychological and/or psychiatric difficulties from depression to relatively severe dementia. Generally, clients diagnosed with Alzheimer's disease or similar severe and long-term difficulties would be assessed by the service and then referred to a more specialist service. In the majority of cases, clients were seen in their own homes because of the difficulties associated with travelling to the centre. This was quite helpful, as I found a great deal can be learned about an individual through providing therapeutic support within their own environment.

The supervision on this placement was of a very high quality. My supervisor worked integratively and I learned a great deal through theoretical discussion of client material, incorporating this understanding into my work with clients as and when it was deemed to be helpful and assist with the therapeutic process.
**Other Placement Activity**

Aside from working therapeutically with individual clients, I attended regular fortnightly team meetings and, when necessary, discussed issues pertaining to my clients, as well as providing reports to referring agencies to update on progress.

I was also provided the opportunity to observe my supervisor in carrying out assessments, which was invaluable in terms of my continuing professional development, through consideration of how to conduct in-depth psychological assessments.

**Placement 1b**

For the second half of the first year I transferred to a busy Community Mental Health Team within this large NHS trust, in the department of psychological services for adults between the ages of eighteen and sixty-five.

As within the previous placement, I worked as part of a multi-professional team, comprising social workers, community psychiatric nurses, a clinical psychologist, community support workers and consultant psychiatrists. Apart from the psychiatrists, all members of the team were based at the service; the two consultant psychiatrists were based at the local hospital and held clinics at the CMHT once a week.

Prior to my arrival, there were regular meetings in which psychologists from all areas of the trust met to discuss issues or developments. However, due to a merger with another trust, these were postponed until the reorganisation had taken place. Within the specific CMHT, weekly allocation meetings were held to discuss new referrals and to consider which professional would be able to provide the most appropriate support according to the client's needs.
The clients seen by psychologists had varying degrees of psychological difficulties, from depression to schizophrenia. Personally, I had the opportunity to work with individuals with a variety of difficulties, including problems associated with symptoms of anxiety, eating disorders, addictions, grief, depression and difficulties associated with coming to terms with being adopted. After assessment, a formal referral to other professionals would be made, if this was deemed in the best interests of the client.

In terms of supervision, my supervisor came from a cognitive-behavioural theoretical orientation and therefore the majority of supervision concerned interventions associated with this theoretical framework. However, when it seemed necessary to develop a more insight-oriented approach because of the nature of a client’s difficulties, my supervisor was open to consideration of other theoretical positions.

**Other Placement Activity**
I had regular meetings with social workers and consultant psychiatrists as and when necessary, to meet the needs of individual clients, so as to provide a consistent approach to their overall care whilst adhering to issues of confidentiality.

**Placement 2**
My second year placement involved working as part of a psychotherapy team in a Child and Family Consultation Service (CFCS) in a large NHS trust. The CFCS was based in the grounds of a hospital but in a separate building and acted quite independently of other departments.

The team was multi-professional comprising consultant psychiatrists, psychotherapists, social workers and nurses. Although there was one clinical psychologist working within the team, this was a short-term contract and it was proving difficult to incorporate psychology into the team permanently, owing to financial constraints.
In terms of clients, families with children from the ages of 0 to 19 were invited to utilise the service. However, the majority of the referrals were for children between the ages of 11 and 16, from a variety of cultural and social backgrounds. Family therapy, work with parents, individual psychotherapy, psychiatric assessments, walk-in brief counselling (3-4 sessions) for 14 to 16 year olds, and home support by social workers and nurses were offered. However, within the discipline of psychotherapy, the emphasis was placed on individual work with child clients, with support provided for parents if this was deemed necessary.

The CFCS was going through significant changes with the introduction of relatively new legislation concerning a tier system for therapeutic services for children and adolescents. It was decided that this particular CFCS would become a tier three service, thus referrals being for more long-term and complex cases, which required multi-professional input to support the whole family system. Although this was seen as positive in the long-term, the development was causing some difficulties in terms of the length of the waiting list, which was increasing because the cases referred required longer term treatment with more extensive professional input.

My supervision was psychodynamic in theoretical orientation, drawing on various theorists to understand the individual client’s needs, and to assist in further exploration and insight of the material brought to therapy.

Other Placement Activity
When required, I wrote to other professionals regarding assessments, referrals, and updates on individual clients’ progress. I also liaised with other professionals regarding clients I was seeing, including meetings at school and subsequent reports to parents regarding action to be taken as a result of these meetings. I met regularly with a social worker who was working with the parents of a child I was seeing for individual psychotherapy, and together we met with the family to discuss progress and ongoing professional support.
Placement 3
My third year placement involved working within a specialist eating disorders service. The unit was set up to assess and treat clients with major eating disorders – anorexia nervosa and bulimia nervosa – on a day unit and outpatient basis. The fundamental purpose of treatment was to prevent the necessity of hospitalisation for all but the most dangerously ill individuals and those with highly complex difficulties. In addition to working with those referred to the service, another key function for professionals was to provide advice, support, clinical supervision, training and education, and a consultation service to clinicians in primary and community care who were working with clients with eating disorders.

As eating disorders are complex, often very serious and multi-faceted (involving family, social, psychological and physiological difficulties), the service adopted a multi-disciplinary approach to assessment and treatment. The team worked closely together to provide a consistent, co-ordinated treatment approach and comprised a variety of disciplines including psychology, psychiatry, dietetics and nursing.

Individuals were referred to the service by the clinician in secondary mental health care agencies (eg CMHT) as it was a specialist service which provided therapeutic input for those who had already received some level of support in primary care by their GP and secondary care by a psychologist, psychiatrist etc.

Programmes were varied according to the individual’s needs. Through discussion with the team, the most appropriate approach was considered. This could include individual therapy with a psychologist or psychiatrist, nutritional input, day care (for those who were of an extremely low body weight who might otherwise have been referred for inpatient treatment), and a variety of outpatient therapy groups. The groups offered included a bulimia therapy group which was cognitive-behaviourally oriented. There was also an outpatient support group, the purpose of which was to provide assistance and support in maintaining weight gain after long-term therapy and/or to assist those with chronic anorexia nervosa to live and function with their condition.
My supervision was integrative reflecting the complex and diverse difficulties experienced by those suffering with anorexia nervosa and bulimia nervosa.

**Other Placement Activity**

I attended weekly 'day review' meetings, the purpose of which was to discuss each of the day patients' progress, and consider treatment options and managing associated difficulties. In addition to individual therapy, I also:

- co-ran a cognitive-behaviourally oriented 12 session outpatient group for bulimia nervosa sufferers
- co-ran a body image group for individuals attending the day service
- set up, ran and evaluated a self-esteem group to which any individual attending the service could be referred (thus the group participants could be day patients or outpatients and was attended by bulimia and/or anorexia sufferers)
- co-ran a psychoeducation group for day patients attending the service
- ran a relaxation training group for day patients
- co-ran an outpatient support group for long-term anorexia nervosa sufferers who were unable to engage in active treatment
- provided written reports to other professionals involved in the care of clients I was seeing for individual therapy
- gave a seminar presentation at the Specialist Interest Group for Eating Disorders, concerning the management of, and support for, long-term anorexia nervosa sufferers, describing the outpatient support group and opening a general discussion pertaining to supportive strategies for this group of clients, who were not in active therapy but required input from the service

**Final Placement**

My final placement involved working in an out of hours' service within a Community Mental Health Team. This additional service was developed for individuals who would otherwise be unable to access psychological services, either because of difficulties with arranging childcare during the day, or because they were working full
time and would therefore have been unable to attend sessions. The service ran from 5pm until 8pm, one evening a week.

Although part of the Community Mental Health Team, there was little opportunity to work directly with other professionals involved in the service because of the nature of this placement. However, this CMHT offered a range of services, including individual psychology and psychotherapy, assessments with onward referrals to specialist services when deemed necessary, family therapy, group therapies, addictions services and a women’s service. Thus, it was possible to refer individuals to these services if additional support was needed.

As there was little opportunity for verbal contact with other professionals, regular written reports were provided for others’ involved in an individual’s care, so as to give regular updates on progress.

My supervision was based around the cognitive analytic and cognitive behavioural models, as those referred often had complex and long-term difficulties that required a flexible and adaptable approach.

Integration as an Outcome of Training

Introduction
My training towards becoming a qualified Counselling Psychologist has been a journey of both personal and professional growth, whereby I have developed both a greater degree of self-awareness, understanding and maturity, as well as a keen appreciation for others’ experiences. I consider the therapeutic relationship to be central to the therapeutic endeavour, over and above models, techniques and theories I may utilise within my clinical practice. My training has provided me with theoretical and experiential grounding in three core paradigms: humanistic, psychodynamic and cognitive-behavioural. I found it especially helpful to develop a good theoretical grounding within the course but, as will become evident through case vignettes, utilising these theoretical approaches in a ‘pure’ form within clinical practice proved problematic for me. Through clinical experience and the use of supervision, I found myself continually drawn towards a more integrative approach to practice, so as to meet the idiosyncratic needs of the individual client.

This paper will argue why I believe that an integrative approach to therapeutic practice is the most useful, and is structured in the following way. Firstly I will outline my understanding of what it means to ‘become’ a counselling psychologist and how this fits with my personal epistemology. I will then outline my approach to personal practice through the integration of theory and research into therapeutic practice. To elaborate further, I shall provide an account of the process of my development towards this integrative stance regarding therapeutic practice through experience obtained on varied placements and the contribution of supervision. Explicit within this account is the importance attributed to, and complexity of, the therapeutic relationship which I consider to be at the heart of the therapeutic endeavour. I finally turn to the issue of personal development and the importance attributed to my own therapy experiences, both as a means of developing and enhancing self-awareness, as well as in managing difficult personal circumstances.
What does it mean to be a counselling psychologist?

Counselling psychology is based on phenomenological and humanistic philosophies (Mcleod, 1994; Woolfe, 1996), espousing the importance of the individual at the centre of the therapeutic endeavour. As commented in the definition of Counselling Psychology provided in the Professional Practice Guidelines (BPS, 2004), an essential aspect of practice is “to know empathically and to respect the first person accounts as valid in their own terms … not to assume automatic superiority of any one way of experiencing, feeling, valuing and knowing” (p.1-2). I essentially understand this in my own practice as an attempt to step into someone else’s shoes so as to understand the individual’s experience as intimately as possible, but with the shoelaces undone so that I am not so immersed in the other’s material that I lose myself and therefore my professional capacity to provide understanding of this experience and consider means by which we may work together towards the process of change.

Counselling Psychology also highlights the centrality of research in the therapeutic endeavour, for “the scientific demand for rigorous enquiry with a firm value base grounded in the primacy of the counselling/psychotherapeutic relationship” (BPS, Division of Counselling Psychology, 1998, p.3). This will be considered at greater depth when discussing the integration of research into my therapeutic practice, and the experiences associated with conducting my own research.

A third essential practice comprises “recognising social contexts and discrimination” (BPS Professional Practice Guidelines, p.2), thereby understanding the environmental influences on individuals’ past and current functioning, as well as the relationships they have developed. Through personal and clinical experience, this is especially important in working with clients through their trauma and distress. To elaborate, psychology/psychotherapy has, in the past, focused almost exclusively on the individual and/or the individual in relation with the therapist, largely ignoring external influences that may encroach on their ability/motivation to change. I am particularly sensitive to this because of my own experience with coming to terms with the possibility of becoming permanently disabled. For example, people in general would
either respond by being overly caring and sensitive, viewing my disability as a tragedy, or ignoring the impact of the disability on my life. In societal terms, there still seems to be disregard for the needs of individuals with disability. One only has to look at the underground system in central London to see that most stations have no access/limited access to wheelchair users and, for myself, having to learn to negotiate stairs on crutches in the midst of rush hour with people pushing past me was a traumatic experience. I welcomed the current debate in The Psychologist (July 2005), highlighting the need for a change in societal attitudes towards those with both physical and psychological disabilities.

As a result of training and personal experience, these three essential qualities all fit well with my 'implicit theory' (Wilkinson and Campbell, 1997) or personal epistemology of human nature. Human beings are highly complex creatures. You merely have to observe three children brought up in the same environment with similar styles of parenting provided, only to receive three very different narratives concerning their upbringing. What has become evident through the process of training in various theoretical models, and from the associated literature and research, is that no single approach is suitable for all clients, problems and situations. As Austen (2000) argues, no one approach contains an objective ‘truth’ about reality. Furthermore, I agree with Clarkson (1995) when she comments that post-modern approaches have argued against the scientific positivistic approach of there being an objective truth that exists and can be understood through the use of reason. It seems quite evident that meaning is created by ourselves and influenced by social and cultural factors (Berger and Lindeman, 1966).

Thus, each individual’s reality needs to be appreciated and understood in its own right, with therapy then co-constructed in the areas the client feels require attention/alteration, or through negotiation from recognition of difficulties within the assessment and formulation process. As Austen (2000) comments: “knowledge of a client’s reality and difficulties is ever-evolving and never fully created. Assessment is therefore an ongoing process” (p.128).
Further, as mentioned, as Counselling Psychology knows, the therapeutic relationship is without doubt the most crucial aspect of therapy. Both from my own personal epistemology and research evidence, ‘the therapeutic relationship’ is the central tenet of therapy. There is a growing body of evidence to suggest that it is the psychotherapeutic relationship rather than diagnosis or technique which potentiates the beneficial aspects of psychotherapy (eg Horvatch & Greenberg, 1994). In a review of the evidence, Bateman (2002) observed that the ‘alliance’ is common to all therapies, encouraging change through a positive emotional relationship. As Clarkson has summarised, “research results consistently show that the choice of a particular psychotherapeutic method appears to have little discernible influence. That is, success in therapy can best be predicted by the properties of the patient, therapist and their particular relationship” (1995, p.149).

Although the therapeutic relationship in all its guises is central to my clinical work, it is necessary but not sufficient for eliciting change. In terms of my own practice and through training I have also sought the opportunity to “try different approaches to find the one(s) in which (I) am most effective” (Shapiro et al., 1989, p.385), through a process of discovery through knowledge of theoretical perspectives and therapeutic techniques that have personal meaning and congruence with my personal epistemology.

Thus, I will now consider briefly the issues associated with working towards my own personal approach to integration, including the importance attributed to the process of assessment, the integration of my own personal epistemology when considering theoretical and therapeutic approaches to practice, and the utilisation of the scientist-practitioner model as the basis of this endeavour.

**Psychotherapy Integration**

From my own epistemology, training in various theoretical models of practice, and from the associated literature and research, no single approach is suitable for all clients, problems and situations. To reiterate Austen’s (2000) comment, there is no objective ‘truth’ about reality. From the start of training it was evident that a thorough assessment of past history and current functioning was imperative in order to gain as
full a picture as possible of an individual’s difficulties. This then naturally leads to a formulation which can take into account vulnerability factors, temperament, personality traits, traumatic experiences, chronic life difficulties, family, social history, as well as current problem/s and perpetuating factors. Thus, I take a holistic approach in which the client and I are able to negotiate the course of therapy, based on the material they have brought.

In terms of the development towards a personal integration, Fear and Woolfe (2000) proved influential in that they argue that the therapist is attempting to achieve integration of both one’s personal and professional selves. I have therefore found it important to discover an individualised mix of therapies which suit my own personality type, philosophical beliefs, client population and preferred style of working. Further, when considering incorporating techniques, theories and/or interventions, it is evidently important to consult research evidence both in terms of their effectiveness generally and, if necessary, for different client populations (as argued by Ballow, Hayes and Nelson, 1984).

Thus, the utilisation of the scientist-practitioner model is central to my practice, but has not been without its own difficulties, as it seems to be in opposition to the core philosophy of Counselling Psychology (Spinelli, 1996; Woolfe, 1996). It seems that the model was fundamentally developed in relation to Clinical Psychology and firmly embedded in a positivist empiricism, thereby running contrary to Counselling Psychology’s value base of phenomenological and humanistic philosophies. However, this has been overcome to a certain extent by the value based on qualitative approaches to research, thereby placing the subjective experience of individuals at the heart of the research endeavour.

When conducting my own research into eating disorders (see Research Dossier), I found Barkham’s (1996) discussion in relation to research within Counselling Psychology helpful and in line with my own integrative stance, highlighting methodological plurism and the incorporation of both qualitative and quantitative methods, selecting “the approach which is most appropriate to the question being asked” (p.23). I would also argue the relevance of this approach to therapeutic
practice, utilising the most appropriate theoretical approaches and practice interventions to meet the idiosyncratic needs of the specific individual.

**Professional Development**

To elaborate on these issues, I will now turn to my clinical training to demonstrate the ways in which I incorporate theory and research into my professional practice. This has been a developmental journey and thus I will explore this in relation to the pathway through my placement experience, providing case vignettes and drawing on experiences of supervision and personal therapy to give substance to this journey.

Overall, training has provided me with a means of approaching all knowledge through the spirit of creative inquiry. As Clarkson comments, “the main sensitivity of a training structure is not to discount people’s experience but to allow them a place where they can bring it, make sense of it, and integrate or relinquish what they no longer need” (1995, p.280). I would agree that training involves the movement “from the state of unconscious incompetence to the more painful awareness of conscious incompetence, and then (hopefully) with training towards conscious competence” (Connor, 2000, p.299). This has been the central tenet of my journey and I have found it extremely useful to refer back to this when negotiating my way through the three core models, culminating in an approach to integration based on ‘conscious competence’.

**Placement 1**

During the first year of training I worked in a psychological service for older adults which I found particularly fascinating. I worked with individuals from varied cultural backgrounds and with diverse difficulties. After six months I transferred to work within the trust’s community mental health team (CMHT), thus I had the opportunity to work with both older adults and adults with varied psychological difficulties. Working with individuals in their own home (as was necessary for older adults who had difficulties in travelling to the centre) was enlightening as I found the individual’s environment highly reflective of underlying psychological difficulties. On the other hand, my experience working in close liaison with other professionals within the CMHT was extremely useful in developing my understanding of the various roles
within a multi-disciplinary team and how each can contribute to the overall quality of an individual's care.

My theoretical orientation throughout the year was predominantly humanistic, focusing on Roger's (1951, 1957, 1961) theoretical perspective, which argues that human beings are inherently driven towards self-actualisation and growth, as well as emphasising the uniqueness of the individual. The importance of positive regard during development is seen as central and, therefore, the capacity to feel positive about oneself is highly dependent on the quality and consistency of positive regard shown by others. Psychological difficulties are said to arise in an individual's present life when he/she denies or distorts awareness of significant experiences which results in an incongruence between self and experience. This theoretical perspective evidently lends itself well to my own personal epistemology in terms of its emphasis on respect for the uniqueness of the individual.

I found the theory an optimistic one and the techniques straightforward to understand but more difficult to utilise in practice. The emphasis on the 'real' or 'person-to-person' relationship and conditions of therapy including 'unconditional positive regard', 'empathy', and 'genuineness' remain part of my integrative stance. The fundamental difficulty for me was associated with the apparent disparity between this theoretical framework and the in-depth assessments required by the demands of the course that, as has been mentioned, emphasised a holistic approach to the individual, taking account of both past and current functioning.

The training within this model did assist my understanding of the process of therapy in the appreciation of moment-to-moment interactions, the importance of the development and maintenance of a strong person-to-person or 'I-thou' (Buber, 1958) therapeutic relationship, and the need to provide a supportive environment in which to explore current difficulties and move towards change. In supervision we considered ways in which additional frameworks could be incorporated into the approach so as to complement the work, and to take into consideration the specific needs of individuals. It did seem that, on occasion, the work of therapy with certain clients did require a more flexible and adaptive approach, which led me towards a period of 'technical
eclecticism' (Hollanders, 2000), in which I drew on techniques and interventions from different psychotherapeutic systems systematically and sequentially to meet the idiosyncratic needs of the client. To expand on this, I would like to introduce my work with Mrs L, a 76 year old lady who was referred to psychological services because of symptoms of anxiety and low mood, leading to panic attacks and a developing agoraphobia.

Briefly, through assessment, it seemed that Mrs L's symptoms had exacerbated since the death of her husband (two years previously), and these worsening symptoms seemed related to a sense of isolation she felt since his passing. Through further exploration, she explained that her feelings of anxiety had developed at an early age. She described being molested as a child and, when she attempted to elicit support from her father, he responded negatively, leaving her feeling ashamed, rejected and abandoned.

As with all my clients, developing a trusting relationship with Mrs L was a crucial aspect of therapy. To begin with this was not straightforward, which I believe was due to Mrs L perceiving me as another child to take care of. In the early stages of therapy she would call me 'dear' and offer me tea and something to eat, thus resembling the relationships she had with others entering her home in a social context. I was highly attuned to not colluding with this and through reiteration of the purposes of therapy, continually turning the conversation back to her experiential frame, and utilising the core conditions of a humanistic approach, she soon became able to appreciate the time as being something for herself, rather than her continual people pleasing approach to relationships. I knew a breakthrough in the therapeutic relationship had occurred when I entered one day and she had not tidied and cleaned before my arrival, had left papers in disarray and had left washing up in the sink. I knew then that the process of therapy was truly beginning.

Through this process we were able to explore Mrs L's sense of social isolation and helplessness, which seemed to lead to a vicious cycle of despondency and despair. However, the therapy became 'stuck' with little room to manoeuvre. I felt that we were both becoming frustrated and, taking this to supervision, we explored how I may
resemble the ‘rejecting and abandoning parent’ by not attending to the underlying distress she had described at our assessment session, pertaining to her unresolved childhood experiences. Thus, we moved toward a more dynamic psychotherapeutic stance so as to explore these traumatic experiences at greater depth. At first she was able to appreciate her childhood distress at an intellectual level, thus I would respond through interpretation of the transference, to explore these experiences at the emotional level.

I also gained experience of an ethical dilemma when, due to unforeseen circumstances, therapy had to be terminated earlier than expected. In order to assist Mrs L in alleviating her symptoms of anxiety within the short period of time remaining, it was necessary to alter the direction of therapy, thus our final sessions became more cognitive-behaviourally oriented, so as to provide her with specific techniques and strategies to combat her anxiety. These techniques proved beneficial and by the time we finished our work she was more able to manage these symptoms. Thus, the alteration of direction of therapy had achieved positive benefits. Through this experience, I learned that integration does not only occur at the intrapsychic and interpersonal levels. For numerous reasons therapy may have to end earlier than expected, and my approach has become one of being adaptable and flexible with regards to taking account of an individual’s environmental circumstances, so as to tailor my approach to meet these extraneous variables.

Placement 2

I entered my second year psychodynamic placement eager to explore dynamic therapy, both because of my experiences of beginning to work within the transference relationship in the first year and to put the theoretical psychodynamic concepts learned in the previous year into practice. Although I found the Kleinian approach beneficial for a quite powerful explanation of an individual’s inner conflicts, I felt it inappropriate to be as ‘silent’ in the room as I should have been from a more ‘classical’ stance. I felt this to be both unnecessary and potentially punitive for children who were already anxious and distressed. I was thus drawn to the ‘experience near’ approach of Kohut (1971), involving open and accurate empathy with clients. This approach also enabled me to combine the humanistic work of the
first year with the great insights that can be provided through the psychodynamic theoretical approach (for a more detailed perspective of Kohutian theory, please be referred to my essay in the Academic Dossier). Thus, for me personally, it felt quite authoritarian to focus almost predominantly on interpretation and, through supervision, it was evident that I was drawn to the more 'romantic', optimistic theorists who, although recognising the importance of intrapersonal conflict, place greater emphasis on interpersonal interaction in early infancy, as the precursor for psychological difficulties later in life.

To illustrate, Hannah was a ten year old girl referred to the child and family consultation service by her GP because of difficulties relating to her parents acrimonious divorce. She was anxious and suffering from irritable bowel syndrome, leading to fears of leaving the house. Through assessment it was evident that she blamed her mother for the relationship breakdown whilst idealising her father. It seemed that she was in the paranoid-schizoid position (Klein, 1946), and splitting her parents into the idealised good object (her father) and frustrating bad object (her mother). It appeared that her parents had over-compensated for the difficulties in their relationship and, instead, gave her all their attention. Thus, it proved an immense shock when this apparently 'perfect' environment was destroyed by her mother.

The main crux of therapy was concerned with the realisation that dichotomous thinking regarding her parents was unhelpful, causing her high levels of frustration and anxiety. Thus we worked toward enabling her to differentiate along a continuum (rather than splitting) and so to be able to tolerate ambivalence and anxiety as well as to internalise part-objects into whole objects. We began to work through this within the transferential relationship, in which I would oscillate between being 'idealised' and 'hated'. It was often quite hard to bear this alternation between these two positions, which would happen on a number of occasions within sessions. I would often feel exhausted and confused at the end of our sessions, and I wondered in supervision whether this was occurring because I was being overly interpretative and thereby not assisting her effectively in reducing her level of conflict.
As a result of this I became more empathic and supportive in our work together, initially by accepting the reality of managing two parents in conflict with one another, and the grief and sadness she felt at losing an integrated family. Through this I was aware that I was perhaps becoming a ‘good enough’ object (Winnicott, 1964) for Hannah. I was not overly indulgent or intrusive, I did not judge her or place her under any pressure, but wanted to provide her with the experience of ‘being with’ an accepting and understanding other. Through the utilisation of this approach, it was possible for Hannah to explore her intrapsychic conflict and she began to recognise her perception of others as either idealised or hated, both through discussion of her relationships with her parents and within the transference relationship.

Placement 3
The development from a psychodynamically oriented way of working to the more directive cognitive-behavioural (CBT) approach was initially quite challenging, although I quickly came to appreciate this approach in assisting quite rapid alleviation of symptoms of psychological distress (Beck, 1976). There is also substantial literature on the benefits of this time-limited approach for a variety of psychological difficulties. My placement was based in a busy eating disorders service and, through an initial investigation of the literature, it seemed that this approach was the most appropriate in alleviating the symptoms of bulimia nervosa, although there was scant research on anorexia nervosa (see my Research Dossier for a detailed discussion).

However, through experience, I have found this directive approach to therapy necessary but not sufficient for enduring change to occur. For instance, in co-running a CBT group for bulimia, utilising food diaries, thought records, discussion, assertiveness training, and dietetic input, it was evident that this approach was useful in alleviating symptoms of bulimia but did not consider the reasons why an individual was self-harming in this manner; ie what had happened in their past that had caused them such an elevated degree of distress that they felt the only means of alleviating this trauma was to abuse their bodies? After this twelve session group, each client was provided individual follow-up and I found that the majority required further individual therapeutic support to consider the underlying causal mechanisms associated with their suffering.
I thus became drawn towards the schema-focused approach (Young, 1990, 1994), and entered into a ‘common factors’ integrative stance (Hollanders, 2000). Through this I found myself able to draw on concepts from both cognitive and behaviour therapy, as well as psychoanalytic therapy and Gestalt therapy. I also found the concept of ‘limited parenting’ useful, which is akin to the Rogerian (1961) notion of the ‘corrective emotional experience’.

To illustrate this integrative approach, as well as evaluation of client work, I will describe some of the therapeutic work with Ms D, who had suffered from anorexia nervosa for many years prior to seeking therapeutic support. Although now a ‘normal’ weight, she evidently still suffered from severe difficulties associated with anorexic cognitions and associated problems with self-esteem, assertiveness, self-directed hostility and anxiety as weight and shape dominated her thinking and self-evaluation. These difficulties were highlighted further with elevated scores in these areas on completion of the Stirling Eating Disorders Scales (SEDS) and the Beck Anxiety Inventory (BAI), which individuals entering the service complete at assessment and on completion of therapy.

I adopted a cognitive-behavioural approach to therapy, integrating schema-focused and psychodynamic concepts when deemed appropriate. There were extremely limited outcome studies recommending a treatment approach for anorexia, but theoretical discussions seemed to highlight a complex interplay of underlying mechanisms, which illustrated a need to adopt a flexible approach to work with this client population. The importance of a flexible approach to practice with this client group was highlighted within my research regarding therapists’ experiences and perceptions of working with anorexia nervosa sufferers (see Research Dossier). I felt that a Kohutian approach (1977) would be helpful in providing ‘mirroring’ and validation that seemed to have been lacking in her childhood owing to her discussion of feeling unsupported by her parents in her formative years. She had described her mother as emotionally vicious and unavailable owing to alcohol addiction and, although she described her relationship with her father in more positive terms, he was absent a significant amount of the time owing to work commitments.
In terms of the therapeutic relationship, although this was initially framed within 'collaborative empiricism', thereby negotiating our therapeutic approach and setting agendas for sessions, this developed towards 'limited parenting' so as to help Ms D in rebuilding her self-esteem and to enable her to experience an accepting, non-judgemental and nurturing relationship, rather than the apparent withholding and critical parental experience she had described as a child. Through this more insight-oriented approach, we were able to explore these early experiences and it was then possible to make sense of her perception of the world. It seemed that she had developed a 'false' self (Winnicott, 1964) and was almost chameleon-like in interaction with others, altering her 'self' to fit in with the supposed expectations others had in relation to her. We explored this further within our relationship, and she gradually came to recognise when she was not relating authentically and, through elevated self-esteem, came to begin to risk integrating her 'true' self in relations with others. Towards the end of therapy we returned to a more collaborative cognitive-behavioural approach, utilising thought records, assertiveness training, working on coping strategies and problem solving, as well as role plays to practice ways of 'being' in social relationships.

On evaluation of the work at the end of therapy, Ms D's scores on the psychometric tests were sub-clinical and we explored whether this was a true reflection of her perceived level of progress (thereby being able to evaluate the work both in an objective and clinically significant manner). It seemed that she was more compassionate and accepting of herself, recognising her self-worth and becoming more authentic in her interaction with her self and others.

Use of 'self' in therapeutic practice
To elaborate on my therapeutic practice further, it seems important to consider my own experience and the use I make of it, i.e. the so-called use of 'self' in the therapeutic endeavour. I will consider this in a chronological way, starting with issues associated with assessment, then the process of therapy, and finally in terms of evaluation of therapeutic practice. Necessarily, I will only be able to focus on a limited number of experiences due to the limited space available.
Often, when about to undertake an assessment, I find myself in a position of being both curious to meet the client but also somewhat nervous and apprehensive concerning whether I will be perceived as someone who is sufficiently trustworthy to be able to disclose potentially sensitive information. Thus, to essentially ground myself and overcome this apprehension, I tend to guide the assessment sessions initially, explicitly stating that I will be asking questions and probing issues to glean sufficient information to write an accurate account, but that I will become less directive as therapy progresses. I think this approach is helpful for myself and my client in that it provides some direction for the initial stages of therapy, as we are both getting to know one another and finding a means of exploring difficult issues. However, on occasion, this interest and curiosity in wanting to understand the client as fully as possible means that I can rush in too quickly, which can lead to me being perceived as insensitive to the issues the client is presenting. Paradoxically, I can sometimes be in a position that I was actually attempting to avoid.

There is a tension in me between wanting to gain trust and information on the one hand, and not wanting to gain too much information that the client is overwhelmed by what they have imparted. As a result, I can sometimes by overly cautious in my approach, especially with individuals who have a history of overdosing or are self-harming. In these circumstances I do find myself fearful of probing sensitive issues, especially during the early stages of therapy, because of the possibility that the person’s emotional responses are so overwhelming to them that they will utilise these coping strategies during the forthcoming week. I find it difficult to attain the correct balance of not colluding with avoiding difficult issues but also keeping the individual safe. I remain aware that this approach may be experienced by the client as my finding certain issues/emotions too difficult to bear, and their experiences too awful to explore, thus I will try to be as open and honest as possible in explaining my reasons behind postponing the exploration of these sensitive issues – that developing with the client more adaptive ways of coping may be beneficial prior to an in-depth exploration of this particular issue. From a humanistic perspective, it could be said that I attempt to be as congruent as possible with my clients, by remaining genuine, empathic and authentic in my communication and relationship with them.
Throughout therapy I will continually question myself to try to discover whether my reactions and responses may be due to the client’s affect, the way I characteristically respond to a specific presenting issue, whether this would be a natural response by any individual given the person’s particular circumstances, and whether my responses resemble those of others in the individual’s life thereby saying something about the client’s relationships outside the therapeutic environment. I will take these personal reactions to supervision to ascertain which is the most accurate and to consider ways in which these can be explored with the particular client. Here it could be said, from a psychodynamic perspective, I try to gain an awareness of my countertransfertential responses to the client and his/her material, by taking the time to explore them with another professional. Through this I have found a tension that is important in terms of continual professional development – how much I expose the client’s thoughts and affects and at which stage of therapy parallels how much I am willing and able to expose myself, and is something which I am continually reflecting on. For instance, is it sometimes me that is overwhelmed by the client’s material and level of affect rather than the client him/herself?

Finally, one of my predominant means of assessing ‘success’ in therapeutic outcome is when the client him/herself feels that they have made sufficient progress and that he/she no longer requires therapeutic input. I therefore find it difficult and somewhat frustrating when organisational policy prescribe a specified number of sessions, and I feel that the time was not enough to assist a client in reaching this level. I do at these times feel I have let the client down and take space to explore this in supervision to focus final sessions on the progress that has been made, and how the client may continue the work of therapy.

**Personal Development**

I turn now to my personal development in training as this has had a significant impact on the development of my professional identity and my stance on therapeutic practice. My professional development has been hindered by personal ill health and I was eventually forced to take an extended break in training in order to focus on my physical recovery. Briefly, an accident left me with a nerve disorder (Reflex...
Sympathetic Dystrophy) and it took five years to learn to walk again; secondly, I was diagnosed with Crohn’s disease and spent the best part of a year and a half in and out of hospital, at the time without a successful outcome. Thus, I recognised that my ‘fitness for work’ was compromised and it took a significant amount of time to build up the physical and psychological strength to return to my training. During my own hospitalisation and subsequent outpatient treatments, I was forced to become firmly embedded in the biomedical model. I felt treated as a disease rather than a person, with an emphasis on treatment adherence and compliance. This, to me, resembled the cognitive-behavioural approach to therapy. Although based on a firm therapeutic alliance, I find it to be similarly directive and based on a ‘disease’ model. To expand briefly, an individual is assessed for clusters of ‘symptoms’ which leads to ‘diagnosis’, and ‘treatment’ will then be based around alleviation of these negative ‘symptoms’. To me there seems to be too little consideration of the individual as a person within this, and an implicit assumption that if one adheres to the treatment protocol then he/she will ‘recover’ from their ‘disorder’. This runs contrary to my underlying value system.

The process of coming to terms with a chronic condition within which I may have remained permanently disabled was difficult to bear. Personal therapy proved invaluable through these initial stages in which I felt that my entire identity was being threatened. My therapist and I worked through the negative societal beliefs concerning disability, and I found it extremely enlightening to consider any prejudices I may hold about no longer being ‘able bodied’. We also contracted to complete a course of autogenic training and self-hypnosis in order to attempt to manage the pain more effectively. This meditation is something I have utilised ever since – remaining with very difficult emotional states and experiences, not being frightened of them but accepting them, letting them dissipate as and when ready. My own experiences have made me more determined than ever to succeed in my career as a Counselling Psychologist.

This acceptance of varied and seemingly intolerable emotional states has proved extremely beneficial in returning to clinical practice this year. During this time away I began to read about Cognitive Analytic Therapy and became drawn to this form of
integrative therapy. Within the overarching theoretical framework I found there to be sufficient flexibility, creativity and adaptability to meet the individual needs of the client. Further, it embraces the utilisation of the transference relationship and appreciates the impact of society's influence on the individual. Finally, it is developing a good research base with findings suggesting its success in the treatment of a variety of psychological conditions. Although I am still in the initial stages of implementing this approach to practice, I find its honesty and genuineness alluring. On returning to clinical work, I was initially anxious regarding whether I would still be an effective therapist. Although initially a little 'rusty' I was surprised at how one does not simply forget how 'to be' with a client and I am extremely confident and competent in my clinical work. As a result of my experiences of both working with, and conducting research into, those suffering from eating disorders, I will hopefully be able to continue in this field, and make a real difference to those suffering from these serious and sometimes life-threatening conditions.

Concluding Remarks
This paper has attempted to highlight various factors that have influenced my personal and professional development towards my integrative approach to clinical practice. I agree with Bion (1975) when he argues that 'becoming' is an evolving and never ending process. I think it will be imperative to remain flexible and open in my approach so as to incorporate novel conceptualisations and interventions when these prove effective, and I believe that my training has provided me with invaluable clinical experience, proficiency in research and theoretical understanding to guide this process forward. Through this thorough grounding I will continue in my development towards 'conscious competence'.
References


British Psychological Society, Division of Counselling Psychology (2004) Guidelines for Professional Practice of Counselling Psychology. BPS: Leicester


RESEARCH

DOSSIER
THEORETICAL MODELS AND CURRENT APPROACHES TO THE TREATMENT OF ANOREXIA NERVOSA – WHERE DO WE GO FROM HERE?

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Running Head: AN: MODELS AND TREATMENT
THEORETICAL MODELS AND CURRENT APPROACHES TO THE TREATMENT OF ANOREXIA NERVOSA – WHERE DO WE GO FROM HERE?

Abstract

Objective: Anorexia nervosa (AN) is an extremely complex psychological condition; it has the highest mortality rate of any of the psychiatric illnesses. This literature review considers three of the major therapeutic approaches to AN, both in terms of theoretical frameworks and the efficacy of their treatment approaches, by considering various evaluative studies that have been carried out. Cognitive-behavioural approaches, family therapy and self-psychological approaches are discussed, the empirical studies that have been carried out in relation to these, as well as their advantages and disadvantages.

Method: the literature was searched for in Psychlit, Sociofile and Medline. Articles that seemed most pertinent were selected for discussion. Discussion: what seems clear is the fact that a great deal more empirical, evidence based research needs to be carried out to discover the effectiveness of various treatment approaches as well as the effectiveness of the various techniques employed within these therapeutic interventions.
THEORETICAL MODELS AND CURRENT APPROACHES TO THE TREATMENT OF ANOREXIA NERVOSA – WHERE DO WE GO FROM HERE?

Anorexia nervosa (AN) is an extremely complex disorder and there is very limited research concerning the efficacy of the varying treatment approaches. In terms of psychiatric disorders, AN has the highest mortality rate with between 5 and 15% of sufferers dying from the illness. Crisp et al. (1992) suggest a mortality rate as high as 20% after carrying out a 20 year follow up study. As Lemma (1996) states, “therapeutic failures, reports of deaths and therapeutic pessimism are by no means uncommon in the literature on eating problems” (p144). This high mortality rate suggests that the current medical and therapeutic interventions for this complex disorder are not as effective as they should be, and yet there is still limited research and understanding of this psychological illness.

AN sufferers have gained the reputation of being difficult to ‘treat’. There are many examples of professionals finding work with anorexics both difficult and wearing, perhaps because anorexia follows such an unremitting course or because of its ego-syntonic nature (i.e. the person cannot see that they have a problem because the anorexic perceives her beliefs, behaviours and goals to be desirable). The sufferer will use a variety of means so as not to put on weight and therefore she will also have the reputation of being ‘manipulative’, ‘devious’ and ‘deceitful’ (Lemma, 1996). As Garner et al. (1997) comment: “these patients have been labelled as resistant, stubborn, defiant and intractable. They can generate ‘strong feelings of aggression in the therapist’ (Selvini Palazzoli, 1978, p128) and ‘intense emotional reactions … perhaps the most intense encountered in a therapeutic relationship’ (Cohler, 1977, p353). Perhaps these reactions have been responsible for the malevolent and punitive forms of treatment occasionally reported” (Garner et al., 1997, p100).
DSM-IV states the following criteria for the diagnosis of anorexia. Firstly, “the individual refuses to maintain a body weight over a minimum ‘average expected body weight’ (AEBW) calculated on the basis of age, sex and height”. The individual must be significantly underweight but it is not stipulated how underweight she needs to be before being diagnosed with this disorder. However, DSM-IV suggests a guideline that the sufferer is expected to weigh less than 85% of her AEBW. Secondly, “there is a disturbance in the way in which the individual’s body weight, size or shape is experienced; for instance, the person claiming to feel fat when emaciated or believing that one area of the body is too fat even when clearly underweight”. Thirdly, “the individual experiences an intense fear of gaining weight or becoming ‘fat’ even though s/he is actually underweight”. Sufferers are often extremely concerned that they will become obese if they stop making vigorous efforts to keep their weight under control. What is particularly striking is that this fear of becoming fat usually intensifies as more weight is lost. Lastly, “in women, the absence of at least three consecutive menstrual cycles when otherwise expected to occur”. Usually, those who suffer from AN have entered into puberty and have started menstruating.

Additionally, the ‘anorexic attitude’ has been written about for many years. For instance: the sufferers avoidance of food has been considered “studied and purposive” (Russell, 1970) and their attitude to food and control of body weight has been described as immutable and “implacable” (Feighner et al., 1972). Bruch (1978) has described this attitude as a “relentless pursuit of thinness”. However, it seems that the above statements appear to presume that the person is autonomous in deciding or wanting to starve herself, which is a harsh viewpoint. Perhaps when discussing AN, it would be more profitable to consider the underlying causes of the disorder, rather than the symptoms that are presented. It may be more appropriate to view the anorexia sufferer as a person who desperately needs approval from others, or a person who has fixed beliefs about being unattractive, which may lead to an obsessive concern about weight and shape. This concern will lead to her starving herself in order to achieve an ever smaller body size. The sufferer exhibits an apparent lack of concern about her undernourished state, perhaps
because this is the only way she can maintain a level of control over feelings of unworthiness and over fear of failure. AN should be treated as a serious psychological disorder and not a self-inflicted disease.

In terms of treatment approaches and theoretical frameworks of AN, there have been ‘significant’ developments. From 1940-1960 the understanding and treatment of this disorder was dominated by classical psychoanalysis. The theoretical underpinnings were based on a “specific constellation centring around symbolisation of pregnancy fantasies involving the gastrointestinal tract” (Waller et al., 1940). Classical psychoanalysis was considered the treatment of choice during this period but has since been seriously questioned in terms of its effectiveness and appropriateness in the treatment of AN. For instance, Bruch (1973) suggested that the process of analytic interpretation may be traumatic for some sufferers as it implies that other people understand their emotions better than they do. This may then reinforce the sufferers sense of lack of control and, consequently, exacerbate her problems.

Bruch (1970) has had a large impact on the way that modern psychotherapy is carried out with people suffering from AN; she provided a new theory of AN which moved away from the drive-defence model of classical psychoanalysis. Fundamentally, this model of AN viewed the refusal to eat as a symbolic expression of denial of sexuality, particularly fantasies and wishes concerning oral impregnation. Bruch concentrated on psychological deficits that had developed due to the ‘mother’ being perceived as over-controlling and intrusive. Therapy was based on listening closely to the client’s story, and assisting her in defining and understanding her internal experiences. Thus, she moved away from a classical interpretative approach which aimed to uncover experiences at an unconscious level. Instead, Bruch argued that what was important was to enable the AN sufferer to develop her sense of self-awareness and self-expression. Krueger (1987) suggested a self-psychological model for AN which contained many similarities to the ideas developed by Bruch, in terms of the importance of the centrality of deficits in the sense of self, identity, autonomy and personal effectiveness. The AN sufferer is viewed as a
person who has not developed the capacity to provide for her own validation, self-regard, and so on, and is unable to regulate her own self-esteem, tension and mood. As a by-product of these incapacities, the sufferer does not believe she has the right to have a self that occupies physical and psychological space.

In the 1960s there was a movement towards conceptualising AN in behavioural terms. Theoretically, anorexia was considered to be either a weight phobia or fear of psychobiologic maturity; or a form of avoidance or specific learned behaviour that was maintained by environmental factors. Operant conditioning techniques were considered to be the most appropriate form of intervention. Although these were often successful in terms of short-term weight gain, they did not appear to be particularly beneficial in terms of long-term maintenance of these gains.

In the 1980s cognitive approaches to AN began to develop, as a result of the cognitive model developed by Beck and colleagues for the treatment of depression and phobic disorders. The cognitive techniques employed were mainly aimed at altering pathologic attitudes towards the self, eating and weight. At a similar time structural family therapy (based on a family systems model) was introduced. Within this approach, the key aspects of family functioning were challenged, especially the transactional characteristics of enmeshment, overprotectiveness, rigidity and lack of conflict resolution (Minuchin, 1978). These characteristics were deemed to be central to the development of AN; the family were considered to be too close, the child was overprotected by her parents which meant that she was unable to develop as an independent individual and, although the family appeared to be in harmony on the surface, there were considered to be underlying conflicts that were not allowed to be discussed openly. This will be discussed in more detail in the ‘family therapy’ section.
This review aims to consider three of the major therapeutic approaches to AN, both in terms of their theoretical frameworks and the efficacy of their treatment approaches, by considering the various evaluative studies that have been carried out, however limited. Cognitive-behavioural approaches, family therapy and self-psychological approaches will be discussed, the empirical studies that have been carried out in relation to these, as well as their advantages and disadvantages. It should be noted that the female form is referred to throughout, as 90-95% of sufferers of anorexia are female.

COGNITIVE-BEHAVIOUR THERAPY FOR AN

The central disturbance behind the cognitive-behavioural model of AN concerns the individual’s overvalued ideas about weight and shape. All other aspects of the disorder are believed to be secondary to this. Therefore, from this perspective, the individual will evaluate herself in terms of weight and shape, prevent weight gain, and concentrate her energy on controlling food intake and weight (Fairburn and Garner, 1988). There is also a sociocultural perspective, within the cognitive-behavioural model, that postulates that these individuals are particularly influenced by society’s standards for weight. Sufferers will regard control of weight as the solution to the personal distress they are currently experiencing. The nature of the person’s absolute beliefs about weight and shape reflect certain dysfunctional types of thinking, such as overgeneralisation, personalisation etc. The beliefs, behaviours and effects of starvation together have a spiralling effect until thinking about shape, weight and food intake controls most of their cognitive experience, to obsessive levels. Slade (1984) considers the perpetuation of starvation in terms of a ‘whirlpool’ or spiral. This approach concentrates on the intellectual and emotional changes during the course of starvation and, further, on the way these changes affect the ability of the anorexia sufferer to make decisions and judgements. It also considers the nature of these decisions in terms of both maintaining and intensifying the control of food.
AN: models and treatment

Slade argues that, as starvation continues, the number of categories the anorexia sufferer can utilise diminishes considerably, as it has been proved that a reduction in food leads to a progressive decline in intellectual capacity. The first of the higher mental functions to be lost is that of abstract thinking. As the illness (and starvation) continues, the capacity for engagement in any complex activities slowly diminishes until the sufferer is unable to cope with any challenging situations. As the impairment proceeds, and starvation continues, less complex mental functions also diminish until the individual’s memory is affected, as is the ability to know where she is in relation to the physical world. As such, thoughts become extreme or polarised, making everything appear black or white, an all or nothing approach to life. Being so in control creates the sensation of relief from the confusion, which has been previously suffered, and from the overwhelming complexity of life. The anorexia sufferer is not aware that she has reduced life to such a small range of categories, but only the ease with which she is able to make judgements, decisions and choices. This clarification is believed to come from food intake control. To lose control of this aspect of life means a reversion from a ‘good’ person to one who is absolutely ‘bad’. There can be no intermediary stage between the two because of the effects of polarisation.

The fundamental goal of cognitive-behaviour therapy, for AN, is to help the individual recognise and then alter cognitive distortions and behaviours that are associated with their abnormal eating patterns. This will include modification of abnormal cognitions concerning the personal significance of body shape and weight, and achieving more ‘normal’ eating and activity patterns.

Cognitive-behaviour therapy will follow certain stages. Firstly, the disorder is not recognised as a problem by the sufferer because the anorexic perceives her beliefs, behaviours and goals to be desirable. The client must firstly appreciate that there is a problem, before it is possible to develop the treatment programme. As Garner et al. (1997) state: “enlisting motivation for treatment can be difficult with eating disorder patients with any diagnosis. However, those with AN are particularly reluctant to commit
to the main goal of treatment – namely, weight gain. Thus, a key ingredient in the initial phase of treatment for AN is cultivating and sustaining motivation for change” (p95). Secondly, the aim is to fight starvation and concentrate on any other physical complications that require attention. Thirdly, problematic behavioural symptoms associated with anorexia, such as obsessive exercising, laxative abuse, purging etc, and attitudes towards weight and shape need addressing. Fourthly, general psychological symptoms such as affect and obsessions need to be attended to. Finally, relationships within the family, including interpersonal functioning, will be disturbed and therefore is also an area of concern (Fairburn & Cooper, 1989).

The main emphasis of treatment pertains to addressing cognitive distortions, mainly in relation to weight and shape. The client will be introduced to the cognitive-behaviour model early in therapy. This will include: the collaborative nature of the treatment, the importance of self-monitoring, the concept that treatment includes learning a set of skills which help the client take control over the illness, to name but a few. However, it is felt that cognitive restructuring techniques will be relatively ineffective until the process of acceptance and weight restoration (ie the effects of starvation) have been overcome.

Freeman (1995) discusses the processes involved in restructuring. Firstly, an explanation of automatic thoughts. Secondly, the anorexia sufferer will be assisted in monitoring these thoughts, replacing them with more productive ones using a variety of cognitive techniques. In other words, the person recording their thoughts in order to identify their problematic thoughts, so as to challenge them in therapy. Thirdly, detecting and challenging the basic schemata is considered important. Schemata are cognitive, mental plans that are abstract and serve as guides for action. In the case of AN, a schema may be the belief that ‘I am special if I am thin’, or ‘if I’m not in complete control, I lose all control’, or ‘if I can’t master this area of my life, I’ll lose everything.’ The anorexia sufferer may be given assignments aimed at eliciting cognitive distortions, in order to record the thoughts perceived whilst eating avoided food. Arguments and evidence which both support and refute these thought processes can then be discussed and worked
through in the therapeutic session. The aim of this therapeutic approach is to help the client firstly understand where the problems lie, and then assist her in changing her behaviour.

Collaborative empiricism is perhaps the most important aspect of cognitive-behaviour therapy. This describes a "therapeutic alliance in which the client, closely assisted by the therapist, investigates bases in reality for personal hypotheses concerning the world" (Freeman, 1995, p310). Gaining the client’s trust is a vital component of any therapeutic intervention for AN. By enabling the sufferer to remain in control, the therapist can encourage her to begin to test her own reasoning and beliefs at a pace she feels comfortable with.

Within the cognitive-behavioural framework, for the treatment of AN, there are a number of positive components. For example, overvalued ideas concerning weight and shape are fundamental within the DSM-IV diagnostic criteria for this disorder. It seems that this characteristic forms the basis from which to discover the underlying difficulties experienced by the client. By concentrating on weight and shape, therapy can progress into other areas. It can be argued that the sufferer develops anorexia in order to channel various aspects that are causing distress into one area they feel they can control, ie weight and shape. With the assistance of the therapist, and through collaborative empiricism, the client can work towards her own personal goals, which in turn could lead to the discovery of other aspects causing distress, that are covert and not as obvious as issues surrounding weight and shape. For instance, psychosocial stress has been thought to play a role in the onset of AN (Horesh et al., 1995); problems with sexuality have also been considered in the aetiology of anorexia.

As a result of starvation, the AN sufferer may have difficulties in relation to abstract thinking (Slade, 1984). Thus, with its very straightforward and structured approach, cognitive-behaviour therapy may be the most appropriate form of intervention, particularly when the client is at a low weight.
Although there is reason to believe that cognitive-behaviour therapy may be effective, there is extremely limited research into the efficacy of this approach for AN. Despite the importance of empirical evidence, there is a dearth of research into its efficacy for this disorder. On the other hand, cognitive-behaviour therapy for bulimia nervosa has been complemented by a great deal of research, over the past ten years, and has proved to be successful and thus the most appropriate treatment for this disorder. As Gamer et al. (1997) have stated: “research on the effectiveness of cognitive-behavioural therapy for AN has been conspicuous by its absence”.

One piece of empirical research which has been carried out by Channon et al. (1989) compared behaviour therapy, cognitive-behaviour therapy and an unspecified ‘treatment as usual’, to consider which treatment was more beneficial. It was found that, at the end of six months of therapeutic intervention, and at a six and twelve month follow-up, all groups showed significant improvement, although no group had fully recovered from the disorder, and there were no significant difference between the groups. Cognitive-behaviour therapy was viewed as the most acceptable intervention by the participants, which meant that there were higher rates of patient compliance. However, there were many methodological problems with the study, thus no real conclusions were drawn. For instance, there were only twenty-four participants (eight in each group); the duration of treatment differed from that recommended for cognitive-behaviour therapy for AN (one to two years); and Channon was the only therapist for the behaviour and cognitive-behaviour conditions, as well as the only evaluator, thus there may be problems of bias. However, even though cognitive-behaviour therapy was viewed as the most acceptable treatment modality, the study provided no evidence of the superiority of the approach over the other modalities.

Cognitive-behaviour therapy appears to gradually be moving away from an entirely ‘purist’ form and some therapists are moving towards introducing other techniques, although remaining in a cognitive framework. For instance, Garner et al. (1997) discuss
the importance of developing an interpersonal focus in therapy as well as involving the family in the therapeutic process. In terms of an interpersonal focus they explain

“Eating disorder symptoms often carry an interpersonal message or serve an interpersonal function. They may be a relatively ‘safe’ way to communicate anger or elicit signs of support. Problematic interpersonal situations can also be triggers for eating disorder symptoms. These interpersonal markers can allow access to beliefs and assumptions about the relationships that may have been short-circuited in the past by symptoms. Then the process of identifying and changing dysfunctional interpersonal schemas is similar to … cognitive restructuring” (p133)

Thus, these authors are concerned with examining interpersonal schemas to discover recurrent interpersonal patterns as well as allowing clients to make sense of their current dysfunctional interpersonal schemas. In terms of the involvement of the family, it is argued that the conceptual framework of systems theorists can be directly translated into terms associated with cognitive theory. The cognitive therapist will work with the family towards identifying dysfunctional interactions or conflicts, through questioning and the prescription of behavioural change. Garner et al. (1997) argue that the purpose of including the family is to identify and then alter the complex and multilevel meaning systems operating within the family. A more detailed exploration of the issues in family therapy are discussed in the next section.

Unfortunately, there is currently little or no empirical evidence to either support or refute the efficacy of cognitive-behaviour therapy for AN, including family and interpersonal factors. There are a number of arguments that suggest cognitive-behaviour therapy should not be used exclusively. Overvalued ideas concerning weight and shape are important but there are more complex underlying issues that need to be considered to gain a balanced understanding of this complex disorder. As mentioned earlier, the illness may
be partly a result of psychosocial or life stresses, or of a fear of sexual development, to name but a few.

Currently, research is being carried out by Garner et al., which will hopefully provide the much needed data on the effectiveness of cognitive-behaviour therapy.

FAMILY THERAPY FOR AN

Family therapists have discussed work with sufferers of AN for many years. There has been agreement that certain problems are exhibited in families of sufferers and acceptance that there is a potential place for family interventions in the treatment of AN. In terms of theoretical models developed to consider the implications of difficulties within families, Structural, Strategic, Milan Systemic and Post-Milan models have been utilised.

These models have quite distinct views on the nature of family therapy and the techniques that effect change, although it should be noted that there is also considerable overlap between the different schools. This discussion will be based on the Structural and Systemic approaches to family therapy for AN.

The most dominant figures in the development of structural family therapy was Minuchin and colleagues in the 1970s who, along with Selvini Palazzoli, argued that there were certain quite specific characteristics of families in which AN developed in one of the members. The basis for structural family therapy for AN has developed from the ‘psychosomatic family model’.

“This model holds that three factors in conjunction are necessary for the development of severe psychosomatic illness in children. First, the child is physiologically vulnerable; second, the child’s family has the four following transactional characteristics: enmeshment, overprotectiveness, rigidity, and lack of conflict resolution. Third, the sick child plays an important role in the family’s
pattern of conflict avoidance; and this role is an important reinforcement for his symptoms” (Minuchin et al., 1975, p1032)

The fundamental assumption, within this model of AN, is that the family is perceived as dysfunctional and, therefore, the aims of therapy are to both identify and alter these dysfunctional patterns. There is also the assumption that ‘physiological vulnerability’ is important as an underlying cause of the disorder, but it is unknown what this stems from; for instance, whether the vulnerability is genetic or a chemical imbalance. However, it is believed that environmental factors trigger the disorder; physiological vulnerability is not sufficient in itself for the onset of AN.

Through observation, it is considered possible to discover in what ways the family is dysfunctional. For instance, if the family is perceived to have difficulties in resolving conflicts, this is the aspect that would be concentrated on. Similarly, if there is seen to be a strong alliance between a parent and one of the children at the expense of the relationship between the parents, then directive interventions would be considered the most appropriate intervention, in order to develop a stronger alliance between the parents.

An observational opportunity that is deemed particularly useful in the process of discovering and working through the dysfunctional aspects of the family organisation in AN is that of meal times (Dare and Eisler, 1997). Meal times are particularly conflict-inducing as the AN sufferer finds this especially stressful. The therapist will intervene in order to attempt to break the habitual patterns of interaction that develop before and during the meal. Parents are encouraged to take control of the symptom (not eating) in this situation, which both requires them to form a strong alliance against the symptom as well as distancing themselves in their relationship to her. This intervention is considered to often have quite powerful effects on the way the family organises itself around the symptom.
A number of empirical studies have aimed to evaluate the efficacy of this approach. For instance, Minuchin et al. (1978) carried out a detailed study of 50 families, analysing their outcome in terms the course of treatment and follow-up. 25% of the group were preadolescents, 31% were adolescents (with an age range of 13-16), and 15% were aged between 17 and 21. The median interval between onset of the illness and starting family treatment was 6 months (ranging from 1 month to 3 years). The family therapy was conducted on a weekly basis, the median course of treatment being 6 months (ranging from 2-16 months). With the preadolescent group, there were no individual sessions provided and the primary goal of therapy was to increase parental effectiveness, control and strengthening the parental coalition. For the adolescent group, the majority of the sessions involved the family, although there was a gradual move towards individual therapy. The primary goal for this group was to develop autonomy, individuation and independence. For the older group, there was a quick move from family to individual sessions, which focused primarily on issues of separation from the family.

Therapeutic outcome was evaluated in two areas: firstly, clinical assessment of the degree of remission of anorexic symptoms and, secondly, clinical assessment of the psychosocial functioning of the clients in relation to home, school and peers. Outcomes were either good (the client returning to normal patterns of eating as well as good adjustment in other areas of their life); fair if some symptoms still remained and the person had not adjusted satisfactorily in one or more areas; and unimproved if the person did not respond to treatment.

Minuchin et al. reported a good outcome in 80% of the cases available at follow-up (which was carried out between 6 months and 7 years). On the surface this appears to be extremely positive. However, there were a number of problems. The majority of participants were young and had a recent onset of symptoms. It can be argued that the anorectic behaviours and family organisation had not been established and therefore the group could be easier to work with. Furthermore, although family therapy remained the treatment of choice for the younger groups, individual therapy was evidently more
acceptable with the older group. Also, given that 20% did not improve, it cannot be stated that family therapy was the cause of the recovery of all groups. It should also be noted that there was no control or comparison group within the study. It seems premature for Minuchin to state, “without any doubt, when AN patients are treated within a year of the beginning with a systems approach in the context of the family, they can be cured in a short period of time” (p138).

The fundamental theoretical stance in relation to the early work of the Milan systems group, based on the formulations of Selvini Palazzoli et al. (1978), was that the family has become a “rigidly organised interactional system in which the symptoms of the illness play an important role as a powerful homeostatic mechanism” (Dare & Eisler, 1997, p312). The aim of therapy is to elicit information concerning the family system whilst also introducing alternative perspectives on the interconnectedness of a variety of aspects of the family. This is believed to enable the therapist to develop hypotheses concerning the family’s organisation as well as the function of the symptom with this organisation.

Rather than the therapist being an observer of the family, who takes a somewhat directive stance as to what the family should be implementing in order to alter its dysfunctional ways of communicating, the systemic therapist takes a more neutral stance. Within systemic therapy, rather than pressurising the family to alter what is deemed to be dysfunctional, as in structural approaches, the systemic therapist will question interactions. The therapist becomes part of the family system, encouraging the family to observe their own beliefs and meanings attached to certain behaviours, and modify their behaviour as and when they deem it to be necessary.

On the surface, this form of approach seems to be more acceptable as it does not presume that there are dysfunctional aspects within the family systems which necessitate altering by the therapist. For instance, in structural family therapy, the therapist may observe there to be an overly close relationship between the mother and the AN sufferer, which may cause the therapist to directly intervene. For example, the therapist may prevent the
mother from speaking for her daughter and may pressurise the daughter to say for herself what she thinks about a certain situation. In contrast, a Milan therapist would take a stance of purely interested curiosity, providing a tentative hypothesis of what may be happening between mother and daughter, suggesting a number of alternatives that can be considered by both these members of the family unit.

Stierlin & Weber (1989) have completed a detailed follow-up study of 42 AN sufferers using this form of family therapy. There were modest outcomes at the end of treatment and at follow-up (varying between two and nine years), with two thirds of the sufferers having achieved a relatively ‘normal’ weight and were menstruating. However, there are no controlled studies comparing this form of family therapy with other approaches to the treatment of AN.

It is currently not possible to consider which of these two approaches may be most beneficial in the treatment of AN, as there have been no studies comparing the efficacy of them. Further, the types of clients that have tended to be seen by these two groups are very different. Minuchin et al., to a large extent, work with adolescents with a relatively short duration of illness. On the other hand, the Milan group have tended to see more chronically ill patients. Thus, further research is required, to test which elements of these two therapies may be effective in the treatment of AN.

There are reasons to believe that concentrating on a purely family oriented approach may be problematic. It may be argued that, by concentrating on the family as the basis of the problem, the family is pathologised. Family members who will probably already be feeling guilty and to blame for one family member suffering from AN, may then take even greater responsibility for what has happened. Further, if a therapist is stating that certain aspects of family functioning are dysfunctional, there is an implication that there are also interactions that can be said to be functional. Each family unit can be deemed to be a unique construct with each individual component coming together to create a unit. It seems that the Milan systems therapy would be more appropriate than a structural
approach from this perspective, as the therapist intervenes in much more indirect ways, taking a stance of curiosity rather than direct intervention. Further, in terms of structural approaches, the therapist is in a more powerful position, observing family interactions and doing something to alter what is considered abnormal. On the surface the Milan approach seems to be more appropriate, as the therapist is there to empower the family to alter what they deem to be necessary. Within this intervention, the therapist will not necessarily expect any level of change, rather patterns being altered if the family believe these changes are necessary.

Many authors have commented on the multifactoral nature of AN and therefore propose the view that interventions should tackle various of the individual’s psychological structures. For instance, Andersen (1987) stated “the approach to self-induced starvation requires a simultaneous or sequential attention to the actual behaviour of starvation, to the irrational thoughts prompting this behaviour, to the meaning of the behaviour in the patient’s life, and to any aspect of mood disorder that is present” (p529). It could be argued that the symptom of anorexia has arisen from a complex interaction of aetiological factors, which then have an influence on individual and family psychology.

Finally, it is possible that the ‘dysfunctional’ aspects of the family could have arisen as a result of the development of a life-threatening illness in one of the children, rather than the illness being a consequence of dysfunctional patterns of the family (Dare and Eisler, 1997). It seems perfectly feasible to hypothesise that any family with a child who has a life-threatening illness would become more overprotective towards that child; for example, because of the fear of the consequences of the illness. However, even if family ‘dysfunction’ was a consequence of the illness, it may still be acting as a maintaining factor.

It is only relatively recently that family therapy has been subjected to rigorous empirical study, with some interesting findings. Russell et al. (1987) compared individual and family therapy following inpatient weight restoration in 80 clients with eating disorders of
varying degrees of severity. It was discovered that, for restricting AN sufferers, family therapy was more effective in producing weight gain, menstrual functioning and global psychosocial adjustment, for those whose illness began before the age of 19 and had a short-term duration of less than three years. Robin et al. (1994) also confirmed the effectiveness of family interventions in adolescents, but their control treatment (ego-oriented individual therapy) was reported as being just as effective. On the other hand, Russell et al. (1992) compared individual supportive therapy, individual psychodynamic therapy and family therapy. The results from this study suggested that family therapy was more effective than the other two treatment approaches.

One problem with these studies, and others similar to them, is that the they have concentrated on adolescent sufferers with the AN being of short duration. This population of sufferers have been found to have a good prognosis anyway; it would be useful to develop more controlled studies to consider whether family therapy is indeed more effective than other forms of therapeutic interventions with this population of clients. It also seems necessary to consider those clients with a longer duration of illness, as the empirical evidence supporting particular treatment approaches with the adult population is much less clear.

SELF-PSYCHOLOGICAL APPROACHES TO ANOREXIA NERVOSA

Cognitive-behavioural therapy and family interventions have their merits but tend to concentrate on the ‘here and now’ in relation to the treatment of AN, in terms of considering current ways of functioning in the individual or the family, and working towards altering these. On the other hand, self-psychological approaches consider past experience to be particularly important in terms of understanding the difficulties the person is experiencing in the present.

Literally hundreds of different approaches to psychotherapy are currently being practised. It is not possible to review all of the approaches that are being implemented in the
treatment of AN, and therefore this section will concentrate on the self-psychological approach developed by Kohut (1971). As outlined in the introduction, this approach contains many similarities to the ideas developed by Bruch in terms of the perceived importance of the centrality of deficits in the sense of self, identity, autonomy and personal effectiveness. Further, this approach provides a feasible and largely comprehensive theoretical conceptualisation and explanation of the psychological processes of the individual sufferer’s intrapsychic world.

Psychoanalytic self-psychology places subjective experience at the centre of its clinical and theoretical concerns. One way self-psychology can be distinguished from other psychoanalytic approaches is by its method of data-gathering. The analyst becomes involved in sustained empathic immersion in the subjective experiences of his/her client (especially in his/her transference experiences). Furthermore, understanding and explanation (the two steps involved in the interpretation process) are also considered from the client’s perspective. Kohut placed empathy at the centre of his clinical method, whereas other analytic approaches tend not to regard empathy as fundamental to the analytic process. Within this clinical approach Kohut formulated a new developmental theory; a novel conceptualisation of the nature of psychopathology as well as a new perspective on the process of ‘cure’.

It could be argued that self-psychology departs significantly from Freudian theory by recognising the importance of people’s needs for relationships, which provide certain types of experiences during growth and maturation. These are termed self-object experiences and include the need to be mirrored, the need to idealise and the need to be like others. Kohut proposed that having sufficient of these ‘self-object’ experiences when the infant and child develop assist in the formation of a strong, cohesive self, which is considered the core of the individual’s personality and character.

Kohut argued (1971) that, if care giving by parents is not traumatically frustrated and the child’s needs are sufficiently responded to, a healthy and mature organisation of the self
results, leading to internal regulation of tension, self-esteem and self-cohesion. However, if the parent is not sufficiently responsive to the developmental needs of the child, these internal capacities will not develop adequately and a disorder of the self will occur.

From a self-psychological perspective it is believed that the failure of meeting the child’s self-object needs may occur because parents are, for instance, overly self-absorbed, psychotic, or anxious. This will lead to the child deciding that it is not possible to rely on others for the provision of self-object needs, and therefore she will develop a façade of pseudo-self-sufficiency (Modell, 1975). On the other hand, the child may believe she is the cause of her parents’ condition, and therefore makes the decision that she does not want to be a burden on others. Thus, she will become a person who turns off her own needs and functions as a self-object for others, while rejecting her own needs. However, although this seems a plausible explanation for the development of disorders of the self, it is not clear from the theory which disorder the person will develop. It does not provide a specific explanation of the reasons for the development of AN in particular, as opposed to other psychological disorders resulting from troubled childhoods.

The onset of the symptoms of AN are considered to occur when unconscious needs and wishes come to the surface. The person’s emaciated body is a highly exhibitionistic statement that others should take notice of her, for her to gain attention and responses from others even if these are negative. Due to the fact that self-object needs have not been fulfilled and internalised in childhood, the AN sufferer lacks reliable self-soothing, tension regulation and mood regulation (Goodsitt, 1997). When the outside world becomes chaotic and confusing, turning inwards, which is observed as the person being isolated and withdrawn, helps her feel a sense of predictability and control, thereby narrowing the world down to something manageable. When the disorder becomes more chronic, it provides the sufferer with some form of identity and selfhood which enables her to feel significant; the illness has to be defended, from her perspective, because it is all that prevents her from a feeling of nothingness or insignificance.
Another particularly important aspect in the development and maintenance of AN, from a self-psychological perspective, is that of self-guilt. The sufferer is believed to feel an intense guilt, resulting from a wish to be separate from her parents, and for acts of separation and individuation. Self-guilt has been described as a sense of discomfort for simply being or existing (Goodsitt, 1997). As the sufferer is extremely concerned about burdening others, she will be determined to make sure she does not make any demands or express her wishes, desires or needs. She will come to feel an extreme sense of guilt if she is given presents or compliments, for instance, and will tend to turn these away, as if she is too undeserving for them. Instead, she will direct her attention to pleasing and accommodating others. However, it seems that, although the AN sufferer does want to please others and satisfy their needs, she is unable to do the one thing that those closest to her need most, namely for her to eat. Self psychology does not appear to explain this apparent paradox.

Separation guilt is also considered important; the AN sufferer will experience a guilt of growing up and therefore separating from those close to her, which she feels will be destructive for them. The sufferer will feel guilt for wanting to, or having, a separate identity from her parents.

Although it does seem feasible that the AN sufferer does not want to burden others, suffers intense guilt, attempts to ignore her own needs, has difficulty in separation and individuation, and has a problem with developing her own sense of identity, which are a result of not having her self-object needs met in childhood, there is no evidence to either support or refute these claims. It seems vital that research into these areas is implemented, to discover whether these aspects are central to the development and maintenance of AN. Perhaps a useful way to consider this approach and its theoretical underpinnings would be to interview people who are recovering or have recovered from AN, to discover whether they believe that, for example, self-guilt is/was an important aspect of their illness, or whether showing these symptoms was the only way they felt able to show others that they needed help.
Once weight has been stabilised at the beginning of therapy, the most important issue, as in all therapeutic approaches, will be to address the client’s reluctance of coming to therapy. The AN sufferer will often be distrusting, withdrawn, terrified of closeness and intimacy, as well as being ashamed of their self-object needs (Goodsitt, 1997). Thus, the therapist will attempt to reach out to the client and allay her misperceptions and anxieties about the process of therapy. The most vital aspect of the early therapeutic interventions will be to develop a strong therapeutic alliance, which is considered vital to the therapeutic process. This can help the anorexia sufferer become aware that she does have a problem as well as assist in the development of a trusting relationship.

During the course of therapy, the establishment of self-object transference will need to be developed, within which self-object needs are identified, experienced and fulfilled. This enables the client to feel that she is important and that her feelings and experiences do matter. The work will involve consideration of those self-object needs that have not been realised in previous relationships and will include needs for validation, mirroring, idealisation, twinship, self-esteem regulation, tension regulation and so on. This aspect is considered central to the therapeutic process and will be the main component responsible for change and healing.

The fundamental roles of the therapist are parent, teacher, guide and coach (Levenkron, 1983). He or she will be actively involved in the therapeutic process, relating to, encouraging and sometimes cajoling the individual, whilst simultaneously providing expert knowledge and experience. The most important aspect is profound empathic immersion, to show that he or she truly cares about the sufferer’s subjective experience, welfare and well-being. Empathy is not unique to self-psychology although, within this approach, the important aspect is for the therapist to show that he/she accepts the person completely for who she is. In cognitive-behavioural therapy, for instance, the therapist will also show acceptance but, simultaneously, is not accepting the person’s current beliefs and attitudes. It would be extremely interesting to consider this aspect of therapy
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further, and attempt to discover which of these approaches to empathy is more helpful to
the client, if either.

A second important element is for the therapist to provide the time and space for the
client to take risks, as well as providing a safe place where she can feel helped,
understood, accepted and encouraged to be. Another important role of the therapist is to
build up and develop the sufferer’s sense of self, which is considered to be lacking. This
is achieved by listening to and taking seriously her thoughts and feelings. It is considered
important, for the AN sufferer, to be able to get in touch with her inner experience so as
to centre herself. It is also considered vital that the client works towards discovering and
accepting her true self, and her goals and values, so as to attain fulfilment.

Unfortunately, there are no outcome or empirical studies that have considered a self-
psychological approach to the treatment of AN and, therefore, any arguments for and
against this approach can, at best, be tentative. What may be useful in the attempt to
validate and evaluate the approach could be series of case studies which aim to elicit
which of the various elements involved in this form of therapy are the most beneficial to
the individual client. It may also be beneficial to embark on follow-up studies, which
would consider the long-term effectiveness of this treatment approach. If relapse rates are
high after a certain period of time, then the approach should be reviewed. Alternatively, if
relapse rates are very low, this approach could be deemed particularly beneficial,
especially with clients who have been chronically ill at the onset of therapy. This would
elicit whether this type of treatment approach would be beneficial in the long term.
Further, comparative studies may be useful, which would consider the efficacy of various
approaches to the treatment of AN, to discover whether this approach is superior to
others.

The most important aspect of this therapeutic approach can be considered a strong
relationship between therapist and client. Without a good therapeutic alliance, it would
not be possible to establish a transferential relationship, which is considered necessary for
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change to occur. Thus, it may be interesting to consider this relationship in more detail to see whether it is this rather than the therapy that is most beneficial in terms of recovery. This could not be considered objectively, but qualitative research may provide useful information concerning this aspect of the therapeutic approach. At present, it does not seem that any research has been done in the attempt to elicit what it was that assisted in the process of recovery.

These are suggestions of ways in which this therapeutic approach could be evaluated. However, at present it is only possible to remain speculative about the effectiveness of this type of approach. A self-psychological approach has been included here as this type of approach does consider the inner conflicts that have and are occurring in the individual, which family and cognitive-behaviour therapies appear to ignore to a large extent.

CONCLUSION

AN is an extremely complex disorder, which is affecting a number of people, and yet there is still very limited evaluative research into the area of treatment approaches.

Attitudes towards the disorder and the AN sufferers need to change. Therapeutic pessimism and therapeutic failure are not uncommon, as well as the labelling of clients in negative terms.

In terms of the three major approaches to the treatment of AN as discussed in this paper, there are a number of potentially positive aspects. However, no specific conclusions can be drawn either pertaining to their effectiveness or as to whether one approach is superior to another, due to a lack of empirical evidence.

Cognitive-behaviour therapy has been proved to be highly effective in the treatment of another of the eating disorders, namely bulimia nervosa. Although there are a number of
similarities between this disorder and AN, it cannot be presumed that this approach will be an effective treatment for anorexia simply because it is effective in bulimia. It is surprising that, despite the apparent importance of empirical evidence in cognitive-behaviour therapy, there is still a dearth of research into the efficacy of cognitive-behaviour therapy for the treatment of AN.

There is some evidence to show that family therapy is a positive approach, at least for a specific client population. Generally speaking, family therapy is currently the treatment of choice if the illness is of short duration (the anorexia sufferer entering therapy within a year of the onset of symptoms), if she is less than nineteen years old, and she is still living at home. However, it seems that more research is required, perhaps comparing this approach to other forms of therapy, to discover whether this form of therapy is superior to, for instance, individual psychotherapy for this group of clients. This approach also assumes that the family is dysfunctional and, surely, this is not always the case. Moreover, this approach is less appropriate for older clients and therefore other approaches need to be evaluated with this group.

Self-psychological approaches seem valuable as they consider past experiences to be especially important in understanding the difficulties the person is experiencing in the present. This may be important as it is concerned with the underlying causes and early conflicts and/or traumas that the person has suffered, which may have an important role in maintaining the symptoms. Unfortunately, there is little or no evidence to indicate whether self-psychological approaches to the treatment of AN are effective. There have been no empirical studies carried out utilising this approach. Again, theoretically, it seems as though the techniques employed in this treatment approach are useful, particularly in terms of the development of a strong and trusting relationship between therapist and client. This seems particularly important in the treatment of AN as the sufferer will tend to be withdrawn, distrusting and fearful of closeness and intimacy.
What does seem clear from the discussions in this paper is the fact that a great deal more empirical, evidence based research needs to be carried out to discover the effectiveness of various treatment approaches as well as the effectiveness of the various techniques employed within these therapeutic interventions. Most research is based on case study material, and tends to be concerned with only one aspect of the disorder, which seems to be inadequate. For instance, concentrating on weight restoration as the key element in recovery is erroneous as it has only short-term implications for the individual’s actual recovery. Perhaps research should begin by considering the overall effectiveness of various therapeutic approaches and, if they are evidently beneficial, then consider which techniques are primary in aiding recovery.

Currently, one of the fundamental problems seems to be the apparent acceptance, by clinicians, that there will be a certain proportion of sufferers who will die from AN. The fact that between 5 and 15% of those suffering from the illness will die from it is rarely disputed in the literature, and there is now the suggestion that the mortality rate is as high as 20%. From this perspective, is it perfectly acceptable for therapists to consider a ‘success’ rate of 80 or 85%? It seems more appropriate to ask why this group of sufferers are dying from the illness, and what is lacking in the current therapeutic interventions, that is leading to this very high mortality rate.
References


MATERIAL REDACTED AT REQUEST OF UNIVERSITY
AN EXPLORATORY INVESTIGATION INTO
THERAPIST'S EXPERIENCES AND PERCEPTIONS
OF WORKING WITH ANOREXIA NERVOSA
SUFFERERS

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Short Title: Therapists’ experiences/perceptions of working with
anorexia nervosa sufferers
Abstract

The aim of the present research was to investigate how therapists represent anorexia nervosa (AN) sufferers from both their clinical experiences and associated theoretical understanding and utilisation of research, as well as to consider how these experiences and perceptions were integrated into their clinical practice. Nine participants specialising in eating disorders were recruited. The participants were all interviewed and the data were subjected to interpretative phenomenological analysis. The analysis highlighted a multi-dimensional theoretical perspective leading to an understood necessity of a flexible therapeutic approach incorporating multi-professional input. There were a number of difficulties encountered when working with this client population including: problems for therapists associated with resistance to treatment; difficulties concerning the overriding physicality of AN; lack of research preventing the utilisation of evidence-based practice and service development; and perceived insufficient funding to provide the most appropriate treatment for this client group.

Key words: anorexia nervosa; therapists; experience; therapeutic intervention; interpretative phenomenological analysis
Introduction
Anorexia nervosa (AN) is a complex psychological illness, which appears to be complicated further by the fact that there are no clear guidelines for treatment or agreement as to the most effective treatment approach for those suffering from the condition (Herzog et al., 1992). In terms of psychiatric disorders, AN has the highest mortality rate (including suicide) with estimates made between 5% to just over 8% of sufferers dying from the condition (Herzog et al., 2000; Steinhausen et al., 2000). A long-term follow-up study also suggested a mortality rate as high as 20% over a twenty year period (Crisp et al., 1992). This high mortality rate suggests that current medical and therapeutic interventions are not as effective as they should be, and yet there is still limited research and understanding of this serious psychological condition.

AN sufferers have gained a reputation of being difficult to ‘treat’. There are many examples of professionals finding work with this client group both difficult and wearing, perhaps because anorexia follows such an unremitting course or because of its ego-syntonic nature (ie the person cannot see that they have a problem because the sufferer perceives her beliefs, behaviours and goals to be desirable). The ‘anorexic attitude’ has been written about for many years. Anorexia sufferers have gained a reputation for being ‘manipulative, devious and deceitful’ (Lemma, 1996, p144). Garner et al. (1997) continue that AN sufferers can generate strong feelings of aggression in the therapist and, further, that these somewhat intense emotional reactions are the greatest encountered in the therapeutic relationship. ‘Perhaps these reactions have been responsible for the malevolent and punitive forms of treatment occasionally reported’ (Garner et al., 1997, p100). From a slightly different perspective, Kaplan and Garfinkel (1999) argue that the perception of AN sufferers as difficult to treat may be because therapists find it frustrating and time-consuming to negotiate with the resistant individual to accept care when it is made available, and also document a general reluctance to work with individuals who are likely to require inpatient care during the course of therapy.
A review of literature on therapeutic approaches to AN by Fleming (1998) concluded that there is a dearth of evidence-based empirical research into the effectiveness of various treatments. From a consideration of cognitive-behavioural therapy, family therapy and self-psychology it was discovered that the majority of the research has been outcome based, looking at the overall effectiveness of specific therapeutic approaches. This has been beneficial for comparative studies and it has been found that family-based treatment approaches are superior when working with adolescents who have had anorexia for a short period of time (Eisler et al., 1997; Robin et al., 1999). However, there are no proven effective therapeutic approaches for adults suffering from AN (Fairburn, 2005). As Tozzi et al. (2003, p144) state: 'the ability to treat the disorder effectively and efficiently remains elusive, with the mean duration of treatment being approximately five years'.

In terms of the process of therapy and specific techniques utilised, there is again limited research. One study investigated the emotional reactions of therapists to working with anorexic and bulimic clients. Their results suggested that working with anorexia sufferers evoked more intense negative feelings than working with bulimic clients. The therapists reported feelings of frustration, helplessness, anger, tension and fear, as well as less success with these clients (Franko and Rolfe, 1996).

There has been some research concerned with clients' experiences of different therapeutic approaches. For instance, within a study by Channon et al. (1989) comparing behaviour therapy, cognitive-behaviour therapy and an unspecified treatment as usual, although there was no significant difference in level of recovery of the sufferers, cognitive-behaviour therapy was viewed as the most acceptable treatment modality. However, in a preliminary study of clients' perspectives on their treatment carried out by Grange and Gelman (1998), although participants described finding a cognitive-behavioural approach beneficial, a significant minority felt that causes of their eating disorder were inadequately explored leading to a level of dissatisfaction with the treatment approach. However, there has also been limited research into therapists' perspectives on working with AN sufferers and, as Goldberg (1986) has commented, research 'has ignored an extremely significant part of the process – the practitioner' (p25).
Jarman et al. (1997) have also recognised this apparent lack of research into the difficulties faced by health-care professionals. They concerned themselves with exploring a multi-disciplinary team of clinicians’ subjective understandings and experiences of treatment of AN sufferers, highlighting the importance of their subjective experiences of working with this client group.

They recognised the difficulties faced by inexperienced therapists working with this client group, which may be caused by the significant lack of clear treatment guidance. Herzog et al. (1992, p217) in research into the treatment approaches commented that ‘clinicians did not believe there was a consensus regarding how to treat eating disordered patients’. It would seem as though clear guidelines for treatment are becoming increasingly important due to the increase in incidence of AN, especially within Western populations (Gordon, 1990). This means that an increasing number of therapists inexperienced in working with AN are coming into contact with this client group, as there is an insufficient number of places in specialist eating disorders units.

Thus, there remain significant gaps in knowledge pertaining to effective treatment approaches to working with AN sufferers. Although treatment guidance would be particularly useful, the literature instead reflects wide-ranging and varied opinions concerning working with AN sufferers. As Jarman et al. (1997) argue ‘it is the understandings and opinions of health-care professionals, working in localised treatment contexts, that is of direct relevance to the clients’ and clinicians’ experiences of the treatment process’ (p139). Currently the research literature fails to examine how therapists working with this client population define and give meaning to AN. Further, there is extremely limited research regarding how they negotiate decisions concerning working therapeutically with AN sufferers, given the lack of research evidence available.
Research Aims
This study aims to investigate the ways in which a diverse group of psychologists and psychotherapists experience working with AN sufferers. Firstly, there will be an attempt to elucidate the ways in which these therapists represent and explain AN. Secondly, the study aims to determine the ways in which therapists define and give meaning to AN. Thirdly, this study will explore the experiences and understandings of AN these therapists have developed as a result of working with this client group. Fourthly, consideration will be given to how their ideas, beliefs and attitudes about AN have developed. Finally, there will be exploration of how these understandings and experiences are integrated into their therapeutic practice.

Method
Participants
The selection procedure for participants was initiated by writing to psychologists and psychotherapists describing themselves as specialists in eating disorders, and who worked from a variety of theoretical perspectives. A list of specialist units was provided by the Eating Disorders Association and a further list of individual therapists specialising in eating disorders was provided by the Eating Disorders Specialist Interest Group at the British Psychological Society. For geographical reasons, only those therapists working in SE England were contacted. Of 56 individuals contacted, nine therapists (16.1%) agreed to take part in the research.

Each participant was sent a covering letter outlining the purpose of the research as well as consideration being given to issues of confidentiality (see Appendix I). Along with the invitation a self-completion demographic questionnaire was sent which included information regarding participants’ theoretical orientations, training, years of experience working with AN sufferers and professional qualifications (see Appendix II).

The nine participants were all female, with a mean age of 45 years (range 30-67; SD 12.38). All held postgraduate qualifications, with 6 trained as clinical psychologists and 3 holding qualifications in psychotherapy. In terms of theoretical orientation, one (11.1%) described herself as systemically oriented, 4 (44.5%) were integratively
oriented, 2 (22.2%) described themselves as eclectic, and 2 (22.2%) as psychodynamic psychotherapists. Finally, with regards to number of years specialising in the field of eating disorders and particularly AN, the mean length of time was 9.3 years (range 1-20 years; SD 6.08). All were still working in the field of eating disorders when interviewed, with one (11.1%) working in a child and adolescent service, 5 (55.6%) were working in specialist eating disorder services, and 3 (33.3%) described themselves as working in private practice.

As mentioned, 9 out of 56 individuals invited to participate in the research agreed to be interviewed, which does raise questions regarding their motivation to take part, and whether they may be atypical. Each interviewee was asked about their motivation to participate during interview and the responses ranged from empathy for myself regarding attempting to recruit participants for doctoral research, to being genuinely interested in any research that is currently being conducted in the field. One participant commented that she was interested in the possibility of reflecting on her own practice and this seemed an ideal opportunity to do so. Further, the interviewees were asked whether they believed their responses to be individual or reflective of others' working with AN sufferers. All perceived their understanding to be similar to those working in the same service, despite professional orientation, and perhaps reflective of psychologists and psychotherapists working with AN sufferers more specifically.

**Procedure**
After the research was agreed and the nine participants had consented to be interviewed, each was telephoned to arrange a convenient time and place for the interviews to take place. Prior to interview, each participant signed a consent form regarding being interviewed (see Appendix III). In terms of data collection, each participant was interviewed face-to-face at their place of work. Each of the interviews lasted between 1-2 hours, were audio-taped and fully transcribed.
Analytic Process

As this research was concerned with personal process issues with the aim of elucidating as full an account of individuals' experiences and perceptions (owing to a lack of available literature concerning an overview of therapists' understandings and therapeutic approach to working with AN, and how these opinions have been reached), an approach was required that would enable complex and diverse personal accounts to be captured and recorded. Thus, a semi-structured interview schedule (see Appendix IV) was utilised for the purposes of eliciting information and developing discussion concerning the areas under investigation. Open-ended questions allowed flexibility and enabled participants to develop the discussion to address aspects that were deemed important to them, which had not directly been probed during the interview. The following areas were covered in each interview: individuals' past experiences and current conceptualisations of AN; an in-depth exploration of participants' experiences of working with AN sufferers (considering their ideas, beliefs and attitudes about AN); and questions exploring the ways in which these understanding and experiences of working with AN sufferers are integrated into their practice. As a result of the first interview, that acted as a pilot, exploration of what participants' professional roles involve as well as issues pertaining to the development of services for AN sufferers were incorporated.

Analytic Procedure

Although there are several available qualitative approaches for examining individuals' accounts of different phenomena, interpretative phenomenological analytic (IPA) techniques were employed for the purposes of analysis of interview transcripts (eg Smith, 1996, Smith et al., 1997; Smith et al., 1999) in this instance predominantly because it has been used to analyse qualitative data on other health related issues (eg Jarman et al., 1997). IPA places its emphasis on participants' perspectives whilst simultaneously identifying research as a dynamic and interactive process, with the researcher's interests guiding this process to a certain extent.

The analysis began with the transcript that was deemed to provide the richest and most elaborate account (see Appendix V for an example). The process involved reading and re-reading the transcript to become as intimate with the data as possible whilst
making notes of any statements or comments that seemed particularly interesting or relevant, regarding issues of importance to the individual's understanding and experience of working with adults with AN. This enabled the investigator to start making links and connections between various aspects of the data, which were then noted in the right-hand margin. Once this process had been continued until there seemed no further associations to be made, the emergent themes (i.e., key words that were felt to encapsulate the fundamental quality of what was represented by the text) were written on a separate sheet of paper so as to consider any connections between them. Themes that clustered together were then grouped together and considered as higher order themes. This process was then repeated with a further two transcripts and these were attended to at the same depth as the first. The themes from these three transcripts were then grouped together. The final six transcripts were analysed in light of the list of themes already developed, although when new themes emerged these were included and previous transcripts were then re-examined to discover whether these had been missed in previous analysis. Thus, the analytic process was cyclical and continued until no new themes emerged.

In order to ensure as far as possible that the interpretations made were consistent with and grounded in the data, all higher order themes and their relevant quotations were checked by a male social psychologist who is highly experienced in qualitative research, as well as another male colleague who had a particular interest in eating disorders. For the purposes of further evaluation, Elliott et al., (1999) emphasise, in guidelines for qualitative research, that the focus of evaluation should be concerned with the persuasiveness of interpretations of the data by thorough grounding of these interpretations within the data. Thus, throughout the analysis, direct quotations have also been provided as far as possible to permit transparency and evaluation by others. Further, it is hoped that there will be a high level of coherence with regard to the narrative provided, so that the underlying structure of the analysis is clear to the reader. It should be noted that any identifying information, including names, have been altered to ensure confidentiality. Information that has been added for clarification has been placed in brackets. Two full stops marks a pause in the interviewee's speech, and three full stops indicates that information has been omitted.
Results

The participants involved in this study provided complex, in-depth accounts pertaining to the process of developing knowledge and understanding of what it means to have AN, through consideration of the therapeutic process and ongoing difficulties associated with working with this client group. Through the analytic process it has been possible to develop a narrative account of these participants’ professional development in working with anorexia sufferers, as well as developing significant insight into problems currently inherent in working within this field.

During the initial process of beginning to work with anorexia sufferers, the participants described a sense of feeling de-skilled, despite having worked therapeutically with various other client groups. They explained that their early experiences were predominantly concerned with lack of understanding of how to work with AN sufferers, leading to difficulties in the therapeutic endeavour. Further, their overriding concern with appearing professionally credible and competent seemed to create, in some instances, overwhelming anxiety, fear and a sense of helplessness, as well as frustration at the supposed ‘irrationality’ and ‘distorted sense of reality’ associated with those suffering from AN. This theme reiterates previous research pertaining to difficulties initially encountered by therapists in working with this client group and will therefore not be elaborated (eg Orbach, 1986; Hamburg and Herzog, 1990).

Through comprehensive deliberation concerning the underlying causal factors that may contribute to the onset of AN, it became apparent that all participants represented conceptualisations of AN based on a multi-dimensional model. Through consideration of their professional development, it was evident that there has been progress from a representation of unitary conceptualisations to a more multi-determined level of understanding with various dimensions perceived as interrelated and interdependent. Through discussion of theoretical developments within the field, all participants were in agreement that there is, in fact, a complex interplay of underlying factors which may contribute to an individual developing AN. These may be at the level of the family; as a result of transitional or maturational difficulties; concerning the issue of low self-esteem with AN as a means of coping with and
developing a sense of self-worth; societal and gender issues; as well as AN as a means of taking control of a life that has become too confusing and chaotic to cope with. Again, this representation of a multi-dimensional perspective regarding understanding AN has been espoused by a variety of theorists and will therefore not be enlarged upon further in this instance (eg Polivy and Herman (2002) provide and excellent summary of findings pertaining to underlying causal mechanisms).

\textit{The therapeutic endeavour: the importance attributed to multi-disciplinary input, flexibility, boundaries and the therapeutic relationship}

\textbf{The importance of multi-disciplinary input}

All participants expressed the belief that there is an overarching requirement of multi-disciplinary input when working with AN sufferers. This was attributed to the concept that there is a multiplicity of disturbance in AN and so an array of input is necessary to manage these various difficulties. As Dr Clement described:

\begin{quote}
I suppose you could say that all patients could do with more input and would benefit if they were seen twice weekly or whatever but certainly, in eating disorders, you have to give a lot more input because they’re not just disturbed in one area, in one field.
\end{quote}

However, ideas about the form that this multi-professional input should take seemed to depend on the clinical setting in which the individual was working. The data suggested that, for most of those working within a multi-disciplinary team, the focus was predominantly concerned with drawing on the expertise of other professionals within the team, having immediate physical access to their expertise, so as to provide a coherent approach, working at the various levels deemed necessary to assist the process of recovery. Dr Green explained that to work in isolation was inappropriate owing to the complexity of difficulties:

\begin{quote}
It’s quite difficult to work with anorexics in isolation … so to be part of a team is probably better … They need a lot of stimulation, you need to input a lot to them over the weeks. You couldn’t do it as an individual.
\end{quote}
On the other hand, although also recognising the overriding importance of multi-disciplinary input Ms Newark, a psychotherapist working in private practice, focused more on understanding her own personal limitations with regards expertise, thereby drawing on others' expertise to manage areas in which she felt unskilled:

There are two sides to it (AN) I think. There is the medical side about which I'm not expert, which is why I prefer to work in conjunction with the GP and a specialist involved ... If your body chemistry's gone to pot, somebody’s got to do something about that. I'm not the person to do that. The area I deal with is to try to find the emotional causes of why somebody is behaving this way.

However, from the data, it seems that multi-disciplinary input is not a necessarily straightforward process. Some participants observed that difficulties can arise when miscommunication occurs and Dr Brown focused on the manipulation of the team that can occur when this happens. Others focused on difficulties arising when professionals do not work together in a coherent manner. From Ms Newark’s experience it seems that, perhaps owing to differing conceptualisations of the requirements of working with AN, this can lead to difficulties in developing a coherent approach to treatment. To expand on this, it may be that different professions’ representations of AN cause miscommunication or different messages which could be construed as confusing for the AN sufferer:

One thing I’ve noticed is that there’s a good deal of adverse discussion between the various ways of tackling anorexia, so that the medics tend to discount the psychoanalytic and cognitive work ... So an awful lot gets lost, because my feeling is you need a very broad understanding with different ways of actually dealing with the individual patient.

*Importance attributed to flexibility within the therapeutic endeavour*

Within the therapeutic endeavour itself, all participants expressed the belief that there is a need to remain open and flexible within the therapeutic approach. Owing to the apparently complex nature of the underlying predisposing picture, there are going to be numerous potential factors requiring attention within therapy. All participants
represented effective therapy as comprising insight-oriented approaches alongside consideration of symptoms, explaining that adhering to one treatment focus/level (some cited a purely cognitive-behavioural approach as an example of a limited focus) would prove ineffective for the creation of longer term dynamic change. For instance, Ms Newark represented cognitive-behavioural therapy (CBT) as providing superficial recovery but, for meaningful change to take place, she argued that attention to the underlying causes of the individuals’ ‘punishment’ of themselves needs to be the focus of therapy:

It’s (CBT) very practical (so) it’s often very effective in the short term. But it doesn’t last ... It helps them to feel that they’re cured but as soon as anything in their life comes up, they haven’t understood the unconscious content that’s driving it ... of why somebody is behaving this way, why they’re punishing themselves.

Thus, the participants highlighted the importance of remaining open and flexible, with consideration given to both symptomatology and potential underlying causal mechanisms. Many highlighted awareness of various underlying factors, such as sexual abuse, being potentially important to work through within therapy. However, there appears to be a lack of consensus as to what may constitute the most beneficial approach when working with this client group. For instance Dr Andrews advocated ‘flexibility’ on account of the ever-changing nature of AN, stating that ‘I’ve also seen such a variety of things make a change that I don’t think I could honestly say that there was one thing that works’. Considering flexibility of approach, she also commented, ‘I think that, if the disorder is evolving, our treatment has to be evolving all the time’. Moreover, seemingly as a result of lack of guidance as to an effective therapeutic stance, some participants focused on the importance of accommodating and altering one’s approach to meet the needs of the individual, rather than adhering to a particular therapeutic framework. As Dr Green stated, ‘(therapy is about) flexibility and ability to see the differences between patients, and not just applying techniques I think’.
The importance of, and difficulties surrounding, the 'boundaried' therapeutic relationship

Although the participants’ experiences seem to highlight a lack of guidance as to specific aspects of the therapeutic process that may prove effective, most highlighted the importance attributed to the process of ‘engagement’ and the development and maintenance of a strong and boundaried therapeutic relationship as essential for effectiveness within the therapeutic endeavour. As Ms French explained, ‘I think that’s (the therapeutic relationship) where I would say the real and enduring cure perhaps might occur’. Dr Andrews comment is representative of a number of participants’ understanding:

I think one of the things that shifts anorexia is establishing a therapeutic alliance with someone. I think actually sometimes the model starts to become a little irrelevant ... The patients who establish an alliance with the team are the ones who seem to make the best progress.

However, again, the processes of engagement and development of the therapeutic relationship were not represented as straightforward by most participants. The predominant difficulty concerned a representation of the ‘reluctant client’ who is resistant to change and enters therapy on the insistence of ‘a caring other’ which evidently has implications for the level of motivation of an individual being essentially coerced into therapy. As Dr Law observed, ‘We often have very reluctant clients. They’re here because their GP insisted or their parents insisted or their partner insisted they come and so that then makes it immediately harder to work on their motivation’.

Some of the participants explained that this reluctance to engage can lead to frustration and even exhaustion on the part of therapists. As Ms Manson stated:

A total diet of eating disorders is totally exhausting and very draining because there’s no let up ... Interesting also is their capacity to make another relationship at all, and certainly a transference relationship ... It’s more of a gobble you up relationship.
This ‘gobble you up’ stance seemed reflective of a number of participants’ narrative accounts of the importance of the therapeutic relationship. From a psychodynamic perspective, Ms Newark represented the relationship as one in which the requirement is to develop and maintain a separateness or objectivity. She seemed to elucidate that the therapist needs to develop a new type of relationship in which the clinician can be perceived as a strong, aware and available other:

If you’re overloaded as a therapist, emotionally, you can’t do good work because you’re not available, you’re too threatened ... You’re repeating the situation that perhaps the parent, or whoever, of ‘Oh my goodness, I’m so frightened, I don’t know if this person’s going to die’ ... if that happens it proves to the patient that they are ultimately dangerous to the world ... You’ve got to keep yourself separate, you’ve got to be able to be objective.

Dr Green, on the other hand, accounted for the importance of the therapeutic relationship by a representation of the AN sufferer as an individual terrified of rejection because of their ‘disgusting’ symptoms that nobody else in their life can cope with. Thus, she represented the job of the therapist as to provide a secure environment into which they are able to bring their ‘awfulness’ and not be judged for this.

Within this ‘secure relationship’, most participants emphasised the apparent importance attributed to the setting of limits and boundaries – that, in fact, it could be considered deleterious to the therapeutic endeavour not to adhere to this component. However, Ms French, Dr Clement and Ms Newark described the process of setting limits as particularly complex, explaining that it was difficult to manage an individual showing suicidal ideation, for instance, towards the end of the session and how easy, but problematic, it can be to continue for even a few minutes after the allocated session time as this can be manipulated by the individual. On the other hand, Dr Andrews centred her representation of this issue around the difficulties associated with referring an individual to inpatient services and how desperately upsetting but essential it can be to confront this. As she disclosed:
People constantly losing weight and then pleading with you not to refer them … And then getting to the point where they end up having a fit or having physical consequences of that. It’s very, very hard. I mean it’s quite heartbreaking when somebody’s sitting in front of you begging you not to force them to gain weight or to go to an inpatient setting.

This could be further interpreted as the individual needing to maintain a level of professional objectivity concerned with remaining empathic but not becoming too enmeshed with the AN sufferer. It seems as though it might be exceptionally difficult to maintain clear boundaries as to when to refer on, especially considering that there are no clear weight criteria to indicate when this should occur. The difficulties associated with referral, particularly to inpatient units, was represented by Dr Green as there being ‘a move away now from inpatient units because of the fear that they lead to revolving door patients’.

Thus, from the representation of various issues considered imperative for the therapeutic endeavour, it seems necessary to maintain a high level of awareness of potential issues. Moreover, it could be argued that not working flexibly and, as Dr Law commented, ‘clinging to a particular model’ could be detrimental to an individual’s progress in therapy. Engagement, also represented as essential from the perspective of the majority of participants, can be complicated by not adhering to boundaries and therefore becoming overly enmeshed with the client which, in turn, could be detrimental and even ‘damaging’ (as Ms Newark commented). Finally, many of the participants stressed the need for a high level of understanding of the processes involved in AN, which perhaps implies the need for specialist input when working with this client group. As Dr Law succinctly stated:

It’s difficult because that (seeing numerous professionals) brings a lot of hostile and angry feelings towards professionals. Certainly I’ve heard ‘Well, if she could just have a good meal, she’d be right’.
Within the therapeutic relationship and, more generally, the therapeutic endeavour, participants emphasised the importance of accepting the ‘reality’ of AN, seemingly as an important coping mechanism for the therapist. Dr Clement described this in terms of available research, commenting that ‘if you can do anything to help the person either change or adjust or adapt to live some sort of reasonable life you’re doing well’. She continued that evidence reveals that only 45% of those who have received therapeutic input will show ‘some form of major recovery’ with the remainder either staying symptomatic or deteriorating. Others described how this knowledge and awareness can assist in preventing some of the frustration and irritation often experienced within the therapeutic relationship, associated with lack of motivation to change, and developing an appreciation for less dramatic changes than one may expect when working with other client groups. As Dr Green concluded:

You know, it can be very exhausting at first but, if you have goals – very small goals – you just work towards those goals. You shouldn’t really get too frustrated. You’re not trying to achieve a miracle in a short space of time. As long as you don’t go in with the illusion that you’re going to do wonders overnight, you should be ok.

**Ongoing Difficulties**

*Working with resistance*

Despite the wealth of information, understanding and experience presented by the participants, most reported a variety of challenging issues in working with AN sufferers. Many represented the process of recognising and managing ‘resistance’ as particularly perplexing, describing an important attribute of therapists as having ‘an ability to tolerate denial’ as Dr Law commented. The view expressed by Dr Brown highlighted the difficulties associated with this issue when she stated:

I think it can be exhausting and I think it can be very frustrating … But the sort of feeling you’re hitting your head against a brick wall and that they haven’t told you the whole truth.
As a result of discussion regarding the apparently related processes of resistance to therapeutic support and denial of the anorexic condition, a number of participants represented AN sufferers as exceptionally ‘difficult to treat’. Two of the participants discussed this in relation to the process of engagement, considering lack of motivation to work in therapy as especially challenging, causing a degree of frustration for the therapist, especially in the initial stages of therapy. As Dr Brown discussed:

The experience of sitting in a room with someone who doesn’t want to talk to you … for weeks on end is exhausting … Just feeling like I can’t really be doing with it, there’s a lot of other people who want to come and need to talk, and it’s such a slow process. Perhaps that’s my inability to sit there patiently waiting for somebody to turn around and say they want some help.

On the other hand, Dr Clement focused on recognition and acceptance of these processes as especially helpful for the therapist, so that the therapeutic process will be slower than with other client groups but that appreciation for this will lead to a reduction in levels of frustration, summarising that it is ‘a very, very, very hard disorder to shift’. Dr Green represented this resistance at a deeper level of appreciation of underlying issues, with a sense that the AN sufferer is, instead, ‘stuck’ behaviourally and psychologically, thereby lacking thinking space to consider alternatives:

The process (of therapy) is much slower, there’s often more resistance, which is often with the physiology because they are so stuck in what they’re doing, and control. And because they focus so much on not eating, a lot of their thinking time is spent on that subject, so they’re not going to practise or think about what you’ve been doing in the session.

In relation to this issue, others focused on the representation of AN being ‘difficult to treat’ as associated with problems surrounding the ‘powerful position’ held by the anorexia sufferer. Dr Clement stated that ‘they (anorexies) put themselves in a very powerful, omnipotent, narcissistic, egocentric position’ which evidently makes them more difficult to reach.
However, from a different perspective, Dr Howarth explained that, although she had entertained the prior impression that working with this client group was going to be difficult, this had not been her experience. She clarified her comments by suggesting that she may have been fortunate with the clients she had worked with to date rather than altering her preconception of the client group as ‘difficult to treat’:

I went into it being incredibly anxious and thinking I was going to be working with kind of no change clients and having to tolerate that kind of process for a long time. And that hasn’t been my experience to date. And whether that’s about me being fortunate … but my experience has been one of an ability to change and move forward.

*The physical manifestation of AN*

Within their narrative accounts of difficulties associated with working with AN, all participants identified the overarching physical manifestation of AN as a particular complicating and perplexing factor of therapy. This was predominantly related to the representation of therapy as not purely focused at the psychological level, but also having to adhere to the impact that physical illness has on the individual. Dr Law reported that, ‘one sometimes doesn’t have the luxury, if you can call it that, to kind of just go with the therapeutic context’. Rather, managing the level of physical illness of many suffering from AN was regarded as particularly challenging for some participants, seemingly because therapists are not necessarily accustomed to working with those who are extremely physically ill. For instance Dr Andrews illustrated:

I think also that you have to be able to tolerate that people are so physically unwell, that (it’s) quite a horrific physical condition, which I suppose as a psychologist, is not something you’d usually have to deal with, with patients. So you’re sometimes watching somebody die.

In considering the physical manifestation further, most participants emphasised the continual dilemma between focusing on the physiological and psychological within therapy. For some this representation was concerned with being more directive in
therapy than they would be with other clients, which seems to place a greater demand on the therapist to be effective in alleviating physical symptoms. Dr Andrews summarised:

\[\text{I think that (the physical) places a very particular pressure on you. You know, you've got to get this person to gain weight or they will die or have a fit – they're doing themselves such physical damage.}\]

For others, there was the representation of the need for therapy to focus on the physiological and psychological as the two were considered highly interrelated. As Dr Clement reported, ‘you can’t have recovery ... if they’re four stone in weight. What does that mean? You know, it’s got to have the physical parallel’. Dr Brown also focused on this representation of the physical and psychological as parallel processes within therapy, in that it seems imperative that an individual’s weight is known so as to understand any changes at the psychological level. She commented:

\[\text{Unless you know how much somebody actually weighs, and how much they're actually eating, then you're just working in a vacuum ... They may be feeling better but you don't know whether that's because their weight is going down.}\]

Finally, Dr Andrews and Dr Clement expressed the opinion that the overarching physical manifestation of AN was one of the fundamental reasons why there is seemingly a professional reluctance to work with AN. Moreover, they extended this by consideration of the representation of it being clearly evident whether a therapist was being ineffective in terms of the measurability of weight gain. Dr Clement explained:

\[\text{(Helplessness and fear) is something which accounts for one of the reasons why mental health professionals are so reluctant to get involved in eating disorders ... Everybody can see if you're not helping an anorectic, because they get thinner and thinner ... It's (on) a daily basis that everybody is seeing what that person looks like.}\]
**Service development issues**

Taking a step back from issues associated directly with the therapeutic endeavour, those participants working within eating disorders services discussed difficulties concerned with the development of services, although this was not directly probed within the interview schedule. Ms French, working as a psychotherapist in private practice, alluded to the concept that service issues were less of a constraint for her compared with health service provision regarding availability of resources.

However, most initiated discussion of therapy as complicated by the conceptualisation that there was no proven method of working with AN sufferers. As Dr Clement commented, 'there are no fixed magical cures'. In an exploration of evidence-based practice as an issue, all presented discussion of the available research, but it was noticeable that this related to adolescent AN sufferers or BN sufferers, not the older AN group. Dr Law commented:

> With bulimia there are very clear guidelines that would indicate that cognitive-behavioural therapy and interpersonal therapy are the kind of evidence-based approaches, but in anorexia there is some research that shows that family work with the younger group is effective, but otherwise it's open for interpretation. At the moment it's not clear what is the most effective method.

This lack of evidence-base was further encountered in the setting up of services as, for those involved in this endeavour, there was both a sense of confusion and lack of cohesion in the development of an appropriate service for this client group. Dr Law explained:

> Part of the difficulty (developing the service) was trying to get together what sort of team and, therefore, what sort of method of working ... There was also disagreement from the medical director ... and that I think was part based on then having to think about what model of working they wanted to follow because they were thinking if we have a service, what kind of service would that be.
Further, Dr Clement and Dr Law in particular discussed their personal experiences of difficulties in securing sufficient funding for the creation of specialist services. Dr Clement considered this resource issue in greater depth, arguing that AN sufferers require a great deal of resources which was, in turn, perceived as problematic for health authorities:

There are some forms of therapy like art therapy and so forth that might be helpful ... So, you know, it's very resource hungry. And that's why it's so expensive, and that's why Trust and Health Authorities have a problem with the amount of expenditure.

For others, the issue of funding was further explored by consideration of there not being specific criteria concerning the amount of expenditure required for each individual and, rather, this being a subjective decision of the professional involved. For instance Dr Brown commented that 'if your GP decided you should be paid to go to Rhodes Farm (a private inpatient community for adolescents suffering from AN) or something, then there's a huge amount of resources put into you. So it's a discrepancy between what you get in the community and what you get in an inpatient setting'. From Dr Green's perspective, the financial criteria seemed to override the individual needs, with resources being provided in certain geographical areas but not others:

Most services couldn't afford a five or seven day unit. The best is supposed to be 8am to 8pm seven days a week. And that's costly ... So unless you, say, have the Oxford unit like Fairburn ... they've got the money and they've got the name.

Most participants commenting on the issue of service development agreed that there should be appropriate day service treatment and associated funding available within the community with inpatient-based care reserved for those at serious medical risk. For instance Dr Brown argued:
If you compared our treatments we provide to the, say, Maudsley, we’re very badly resourced. It’s the amount of treatment you can have on an inpatient unit … is a million times away from what you get here … I think more resources should be put into the community, before people get to the Maudsley or something like that, because the problem of that is they go away from their families … and then they come back and the problems seem to re-emerge.

However, from discussion with participants it seems that, without the relevant research pertaining to how these services should be set up, it has been a process of ‘trial and error’ in creating the most effective, multi-professional approach to treatment within the resources available. Moreover, Dr Andrews suggested that the research endeavour is further complicated by the representation of AN as continually evolving and, as such, treatment approaches need to continue progressing to accommodate the changing way in which the nature of AN is understood:

I think there are a lot of gung ho approaches to eating disorders and experimental things. And I think these are great, and it’s important to be constantly creative … It (AN) evolves over time and is responding to society and, for example, our outpatient programme that was developed not very long ago, probably six or seven years ago, is already slightly redundant.

Overview
This study has attempted to elucidate the experiences and understandings of a small group of professionals involved in the often demanding task of working therapeutically with those suffering from AN. Although this study does not provide a complete picture of work with AN sufferers, it does seem to reveal that the experiences and meanings developed by the therapists themselves (a research orientation often neglected) may be exceptionally important in developing understanding of the therapeutic process from their unique perspectives. It is possible that this research does not provide the potential breadth of therapists’ experiences because the number of professionals working in the field of eating disorders is relatively small and, therefore, there may be a networking of ideas through discussion groups and conferences that lead to a focus on particular experiences (according to
Vandereycken, as of 2003, there were only 39 specialist NHS services in the UK. It may have been beneficial to the study to have recruited non-specialist professionals who had contact with AN sufferers to ascertain whether and how representations of this complex disorder may have differed.

The current study does provide tentative insights into therapists’ experiences of working with this client group, as well as possible implications for therapeutic practice. Furthermore, knowledge from qualitative research tends to be cumulative through a succession of projects which focus on a variety of issues. Future research may advance this process through consideration of the conceptualisations and experiences of various professional groups working from a variety of perspectives.

For these participants, it was evident that developing competence in working with AN sufferers was especially difficult and all described a sense of feeling de-skilled when starting to work with this client group. This theme reflected previous research in the field; for instance, Orbach (1986) found that clinicians described the work involved as anxiety-provoking and demanding, and Hamburg and Herzog (1990) described how young therapists found work with this client group difficult with negative affects associated with fear, incompetence and anger. It could be postulated that these responses may contribute to therapeutic difficulties on at least two levels. Firstly, these reactions may be portrayed or alluded to within therapy which may, in turn, lead to countertransferrential issues perhaps with the therapist not being perceived as a trustworthy and dependable other. At this stage the impact of these negative affects is unknown and it would be highly worthwhile to explore this sense of therapists feeling de-skilled at greater depth, which could provide insight into training requirements for working with AN sufferers. Secondly, it is perhaps this fear of professional incompetence that may prevent mental health professionals from working in this field, which was alluded to by some of the therapists interviewed.

A consistent finding within the study was that all participants, irrelevant of theoretical background, represented a complex and perplexing picture of underlying causal mechanisms which may contribute both to the onset and maintenance of AN. This multidimensional model is generally accepted in the literature although, as some
participants reported, the weight each of these mechanisms should be given has not been identified. Polivy and Herman (2002) provide a comprehensive overview of findings related to various casual mechanisms and it may be necessary to accept, as these authors conclude, that the combination of factors contributing to any individual’s experience of AN will be almost unique. What may be important is knowledge of these characteristics and how they may influence the individual sufferer that is necessary for the development of appropriate therapeutic input. As Polivy and Herman (2002, p206) comment, ‘we can treat headaches with aspirin without understanding either where the headache came from or how the aspirin works’.

From discussion of this complex underlying picture of AN, all participants expressed the belief that the therapeutic approach employed requires a level of flexibility and openness to accommodate various difficulties that the AN sufferer presents, as well as being attentive to the evolving nature of AN. As a result of this, it may be that an integratively oriented therapeutic approach may be most appropriate, both to accommodate to the individual and to enable input at the various levels of the multidimensional theoretical understanding. However, this does have quite serious implications for the research endeavour because, according to these therapists’ representations of the therapeutic process, it is not possible to develop randomised controlled trials testing specific treatment modalities as it is necessary to develop one’s therapeutic approach in relation to the unique needs of the individual in question. From this perspective, psychotherapy process research (Elliott and Shapiro, 1992) may be particularly beneficial, in which both therapists’ and clients’ perceptions of the therapeutic process could be taken into consideration, in the attempt to discover what aspects of the therapeutic endeavour are deemed useful and assist in the process of change.

The analysis also illustrated the importance of the development and maintenance of a strong and boundaried therapeutic relationship as imperative to the therapeutic endeavour but that ‘resistance’ is a particular obstacle, apparently owing to the ego-syntonic nature of AN. Some participants considered lack of motivation to change as especially difficult to manage, leading to slow progress and lack of discernable movement within therapy. This seems to highlight an important aspect of therapeutic
work for those not familiar with working with AN – that to prevent the negative affects often associated with issues of ‘denial’ and ‘resistance’, maintaining awareness of and adhering to motivational issues may be an important part of the work. This was highlighted in a study by Geller (2002), who argued the importance of an accurate assessment of ‘readiness to change’ in AN sufferers, and providing a range of services dependent on the individual’s level of motivation and stage of readiness for therapeutic input.

Finally, working as part of a multi-disciplinary team was highlighted as imperative from these therapists’ perspectives owing to the complications associated with the overriding physicality of AN. However, there is currently a dearth of research into service development (Fariburn, 2005), with there being no empirical evidence to support the utilisation of any one treatment setting over another. Thus, there appears to be a distinct lack of guidelines for the development of services or routes to referral that can be drawn on by clinicians to assist in the decision making process. This seems to create an additional difficulty for therapists who are already attempting to work with a ‘difficult to treat’ client group without any empirical evidence to support one therapeutic approach over another.

In conclusion, this research highlights a compelling need for further research into AN. From discussion, it seems that therapists are currently being guided by clinical experience rather than evidence-based practice when attempting to develop an appropriate therapeutic approach for working with AN sufferers. These therapists highlighted various aspects as important to the therapeutic endeavour, such as understanding potential causal mechanisms that may arise in therapy, the importance of the development of a strong therapeutic relationship, the utilisation of a coherent multi-disciplinary approach, and flexibility and adaptability of therapeutic approach. However, lack of empirical support for various approaches, or even which treatment setting would be most appropriate for an individual leads to difficulties, particularly given the seriousness of this condition. It seems that specialist therapeutic provision may be a necessity but what form this should take is still in question. To conclude with a quotation from Woodside (2005, S41):
The usual argument that the condition is rare and that most treatment centres do not have an adequate volume of patients (to carry out research) does not seem compelling, as these problems exist for many other conditions. What is it about our field that has made it so difficult to organise collaborative multicentre studies in AN, when we have been so successful in doing so for bulimia nervosa?
Reflections on Use of Self

My interest in eating disorders has developed over many years. I attended an all girls boarding school, during which time a number of friends succumbed to eating disorders. During this time, my closest friend became extremely ill with anorexia. It proved distressing for me personally to witness her physical and psychological deterioration, and she eventually had to leave school for six months owing to hospitalisation. Her experiences and descriptions of the treatment she received heightened my emotional interest in wanting to understand why she had become afflicted by and committed to starvation. The therapeutic approach in the mid-eighties seemed to be predominantly behavioural and she described experiences of nasogastric tube feeding, electroconvulsive therapy, and forced bed rest to name but a few. I felt quite horrified at this seemingly harsh treatment and this led to an interest in reading about the development of and treatment for eating disorders.

Through training I developed a more intellectual curiosity concerning the causes of and treatment for eating disorders, and anorexia in particular. Throughout this time I have been quite astonished by the lack of research into this extremely serious, life-threatening condition. There seems to have developed greater theoretical insight into the potential causes of the condition, with conceptualisations moving towards more profound explanations of potential underlying difficulties a sufferer may present with. However, research endeavours into treatment approaches based on these theoretical assumptions are few and far between, with no guidelines for or consensus on what may constitute effective therapeutic practice. I became especially curious about how therapists in the field were actually working with this client population, and perceived a potential starting point in this endeavour to discuss with therapists their personal experiences and perceptions of working with anorexia sufferers.

Throughout the interviews and analytic process I kept finding myself baffled by a seeming paradox – these individuals had chosen to specialise in working with AN sufferers yet described their experience as often tortuously difficult and frustrating. I would have been fascinated to debate this but felt, not only may this appear too intrusive, but also may have taken us too far away from the research questions. Further, this may have alienated the participants and prevented honest and in-depth
discussion. I was tempted not to report these seemingly negative reactions to this client work because I was quite concerned regarding the impact this may have on clients. To expand, not only do they (as a group) find it hard to trust another sufficiently to work through their difficulties, but what kind of impact would it have if they perceive the therapist to find them difficult, frustrating and not expected to recover?

I also reflected on my own experience in working with AN sufferers to consider whether my perceptions were similar to those of the participants. I found myself disagreeing. Yes, it has been difficult to engage clients on occasion but my interpretation was that something traumatic must have happened to prevent them from being able to openly discuss their problems. For some individuals, the therapy was not concerned with 'recovery' at that stage, but providing a holding environment in which they did not become a danger to themselves. For others, the expectation was that they would make a full recovery and a number of them appeared to achieve this.

Perhaps my experience differed both because of the service in which I was working and the nature of the supervision I received. My supervisor assisted me in the process of recognising the level of change that an individual may be capable of. Further, the service was appropriately tiered so that, at assessment, each individual was provided a seemingly appropriate treatment package at a pace they were ready for. Thus, there seemed less pressure on both therapist and client as a result.

I found the process of analysis an exciting but daunting prospect. There seemed such an abundance of potentially interesting material that could be the focus for interpretation that it was difficult to know where to start. During the initial stages of analysis I found it extremely difficult to attain the right interpretational stance, in terms of being sufficiently but not overly interpretative, and continually grounding my analysis in the data. I doubted my abilities as a researcher on numerous occasions but, through persistence and the support of my supervisor, it gradually became possible to strike this balance with the first transcript. I also found IPA a useful analytical stance because it does provide a step-by-step guide through the process of analysis, thereby enabling me to complete the analysis task by task.
During the write-up I wanted to do justice to the breadth and depth of information that had been provided by the participants in this research. Thus, I chose to focus on two themes at a more in-depth level but provided an overview of the themes that had some prior research pertaining to them. I think the end result was quite strongly influenced by both the literature I have read concerning theoretical orientations to AN and therapeutic approaches that have been utilised, as well as my own personal experience of working with eating disorder sufferers.

Prior to this, I have never completed a piece of research of this sort of proportion, nor one which I think could assist in the process of development of continuing research into eating disorders. It has been, at times, frustrating but overall I have found the research process an absolutely fascinating and highly rewarding endeavour.
References


Coady NF, Wolgien CS. 1996. Good therapists’ views of how they are helpful. *Clinical Social Work Journal, 24(3)*, 311-322


APPENDIX I

LETTER TO PARTICIPANTS AND CONSENT TO BE INTERVIEWED

Dear

I am currently training for my practitioner doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. During the course of my training I have developed a particular interest in eating disorders, both through my reading on the subject (I completed a literature review last year concerning various theoretical and therapeutic approaches to working with anorexia nervosa sufferers) and practical experience of working with this client group.

Through both reading and practical experience I have become extremely interested in how specialists in the field of eating disorders view anorexia, both in terms of your experiences and perceptions of this complex disorder. There has been very little research carried out concerning therapists experiences with what has been terms a 'difficult to treat' client group, and I feel this to be particularly lacking. I believe this to be a highly valuable area of research as it could provide highly important information concerning working with this client group and help promote understanding for those who have limited contact with clients suffering from anorexia.

I am aware of how busy you are but I would be extremely grateful if you would consent to take part in this important research. In terms of your participation, it would involve an interview that would last approximately 45 minutes to 1 hour, which would take place at your convenience. The interview would be audio-taped so as to ensure that any quotes used for the purposes of analysis would be accurate and direct quotations.

I would also like to assure you that all information provided would be confidential. Your name and the centre at which you work would be anonymised; you would be provided with a pseudonym in the transcript and all audio-tapes would be destroyed.
after they have been transcribed. Although some of your responses would possibly be reproduced for the final report, it would be ensured that you would be in no way identifiable.

If you are interested in taking part, please could you fill in the form enclosed and return it to me in the stamped addressed envelope provided.

Thank you in anticipation.

Yours sincerely

Caroline Fleming
Counselling Psychologist in Training
Consent to participate in research concerning therapists’ experiences of working with anorexia nervosa sufferers

I ___________________(print name) consent to be interviewed concerning my experiences of working with anorexia nervosa sufferers.

Address: .................................

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

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

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

Telphone no: .................................

Signed: ................................. Date: .................................
APPENDIX II

CONSENT FORM

There are three fundamental aims within this research. The first aim is to investigate the ways that therapists specialising in working with anorexia nervosa sufferers understand and define anorexia. Secondly, the way in which these are integrated into practice with this client group will be explored. Thirdly, this project also aims to explore therapists' experiences and perceptions of anorexia nervosa sufferers.

In terms of your participation in this research, you will be asked to take part in an informal interview concerning your views and perceptions concerning anorexia nervosa. This interview will be audio-taped so as to ensure that any quotes used for the purposes of analysis will be accurate and direct quotations. I would like to ensure you that all information provided will be confidential. Your name and the centre at which you work will be anonymised; you will be provided with a pseudonym in the transcript and all audio-tapes will be destroyed after they have been transcribed.

If you have any questions or you would like any further information about the research before we proceed, please do not hesitate to discuss these with me before consenting to participate.

Please read the following paragraph and, if you are in agreement, sign where I have indicated.
I agree that the purposes of this research and what my participation would entail have been clearly explained to me in a way I understand. I therefore agree to be interviewed concerning my experiences and perceptions about working with anorexia nervosa sufferers. I also consent to the interview being audio-taped and that all of this recording can be transcribed for the purposes of the research only.

Name: __________________ Signature: __________________ Date: __________

On behalf of those involved in the research, I undertake that confidentiality will be ensured throughout the research, and that the audio-tapes and transcripts will be protected and for the purposes of the research only. It will also be ensured that anonymity of the participant and the centre at which he/she works will be protected throughout.

Names: ________________ Signature: ________________ Date: __________
APPENDIX III

DEMOGRAPHIC QUESTIONNAIRE

Therapy with Anorexia Nervosa Sufferers

The research is concerned with considering the ways in which therapists understand and define anorexia nervosa. Further, I am interested in the ways your experiences and understandings inform your practice with this client group.

It would be useful for me to have some basic information about you before the interview. Please could you fill in this form and return it to me in the self-addressed envelope provided.

1. Are you male or female? [ ]

2. How old are you? [ ]

3. Which ethnic group/s listed below would you say you belong to?

White ............
Black – Caribbean ............
Black – African ............
Chinese ............
Indian ............
Pakistani ............
Bangladeshi ............
Other (please specify) ............

4. What is your highest educational qualification?

5. What are your professional qualifications?
6. What is your therapeutic accrediting body?

BPS division of clinical psychology .............
BPS division of counselling psychology .............
UKCP .............
BAC .............

Other (please specify) ______________________

7. What is your theoretical orientation?

8. What is your current job title?

9. How long have you been in your current post? _______ years _______ months

10. How long have you been a specialist in eating disorders? ______ years _____ months

11. How long have you been working as a specialist with anorexia sufferers?

Thank you
INTRODUCTION

anorexia is an extremely complex disorder and, as the incidence rate has increased significantly over the past few years, more health professionals with little experience are working with this client group with very little clear guidance concerning how best to help each individual. My research is concerned with exploring how specialists in the field understand anorexia and how they integrate this understanding into their practice. The main focus of this interview is to explore your experiences and perceptions of anorexia and how they have developed.

SECTION 1

In the first part of the interview I would like to explore with you what your past experiences and current conceptualisations of anorexia are – what anorexia means to you.

1. In terms of anorexia sufferers, what do you understand to be some of the main psychological difficulties associated with the condition?
   What makes you say that?
   Where does this information come from?

2. And now, concerning the ways in which anorexia sufferers may be treated by those around them, such as their family, peers, health professionals ... others that they are in contact with. What kinds of influences do you think these might have on a sufferer's experience of the condition?
   Can you tell me more about that?
   From your experience, can you give me an example of this from your therapeutic work?
3. And can you think of any other social influences that may have an effect on a sufferer's subjective experience of the condition?
What makes you say that?

4. And for you, personally, do you think there is anything that has influenced your understanding of anorexia, such as theoretical orientation, discussion with colleagues, training, the media, or anything else?

5. So you have mentioned your understanding of the main difficulties, wider social issues, and personal influences ... Could you please tell me a little more about how you, personally, might have been influenced by any of these aspects in your work with anorexia?
Are there any specific aspects which stand out as being influential?
Could you tell me more about how these have influenced you?
Can you give me an example?
What was that like for you?

6. During the course of your training, do you remember having studied anorexia specifically as part of the course?

If yes: How important do you think this was?
If anything, did you find any particular aspects or people helpful or unhelpful?
Could you tell me more about that?
If you can remember, what effect did this have on your personal views of anorexia at the time?
Looking back, how influential do you think this was?
Do you think your training helped or hindered you when you began to work with this client group? In what ways?

If no: In retrospect, do you think there is anything that would have been helpful to you?
What makes you say that?
Can you tell me more about that?

7. Were there any other aspects of your training that stand out as being especially influential in shaping your conceptualisation of anorexia?
Can you tell me more about that?
Could you give me an example of these influences?
(Probing questions to explore how training affected/helped develop their view concerning anorexia and how these views have developed as a result)

8. What made you decide to specialise in working with anorexia sufferers?
What were your early experiences like?

9. Thinking about it now, do you think your understanding of anorexia has developed or changed over time?
In what ways?
What do you think has led to these changes?
10. Given your experience, how would you now define anorexia?
   In what ways, if any, have your experiences of working with this client group
   assisted in framing your conceptualisations?
   Are there any other specific aspects that stand out as being influential in
developing your current understanding of anorexia?
   Could you tell me more about that?
   Could you give me an example of that?

SECTION 2
I would now like to look more specifically at your views and experiences of working
with anorexia sufferers.

1. In terms of professional practice, what qualities stand out as being
   especially important for working with this client group?
   What makes you say that? (Where does this opinion stem from?)
   Can you tell me more about that?

2. There appears to be a large variation in the ways therapists work with
   anorexia sufferers. Do you think there are any guidelines that you
   practice by generally?
   Where does this way of working stem from? (eg theory, supervisor, training,
   experience etc)
   Has you method of working changed, developed or evolved?
   (Probes to elicit what specifically has altered)
3. It has been stated that there are as many therapeutic approaches as theoretical orientations when considering working with anorexia sufferers, which can lead to confusion for health professionals beginning to work with this client group. From your experience, do you think that there is an especially appropriate way of working with anorexia sufferers? What makes you say that? Can you tell me more about that? Is it possible for you to give me an example of how you would work with an anorexic client? What have you found influential in your particular way of working?

4. Do you think there is specific information that therapists should know about anorexia, before beginning to work with this client group? What guidance would you give to other health professionals who were beginning to work in the field? What makes you say that?

5. Some people are of the opinion that there is a particular time to work with anorexia sufferers, that if they are of a particularly low weight then psychological input is not going to be particularly useful. And others are of the opinion that you can work with anorexia sufferers at any weight. Where would you position yourself? How have you reached that opinion? (theory, research, clinical practice)

6. In your opinion, do you think there are any practices that are detrimental to the recovery or the process of recovery for anorexia sufferers? What makes you say that? Can you tell me more? (eliciting where this stems from)
7. Some say that working with anorexia sufferers is exhausting and frustrating, leaving the therapist feeling somewhat hopeless and helpless. Others find working with this client group challenging but highly rewarding. Where, if anywhere, would you position yourself along this continuum? What makes you say that? Can you tell me more about that? *(Probing attitudes to working with client group)*

8. If it is possible to say, to you think there are specific ways in which working with anorexia sufferers is different from working with other client groups ... in terms of the therapeutic process?

9. You have described some of the major differences between working with anorexics as compared with other client groups. What would you say are the main similarities? What has influenced this opinion? Could you provide an example?

**CONCLUSION**

1. To what extent do you think your views concerning working with this client group are representative of those of other professionals working in the field?
2. I was also wondering what made you, personally decide to participate in this project?

3. And how has it felt to be an interviewee?

4. Is there anything else you would like to add, or anything that you think has been missed in this interview, that you would like to add?

THANK YOU

GENERAL PROMPTS

Can you tell me more about that?

Why do you say that?

Could you give me an example?

What makes you say that?

What effect has this had on you?
APPENDIX V

EXAMPLE OF INTERVIEW TRANSCRIPT

R1: Anorexia is an extremely complex disorder and, as the incidence rate has increased significantly – or at least the referral rate has increased significantly – over the past few years, more health professionals, sometimes with little experience, are working with this client group with very little clear guidance concerning how best to help each individual. My research is concerned with exploring how specialists in the field understand anorexia and how they integrate this understanding into their practice. The main focus of this interview is to explore your experiences and perceptions of anorexia and how they have developed.

First though, I would like to find out a little about the setting you work in, and your role within that setting.

P1: Yeah, yeah, I'm the clinical services manager and consultant psychologist. So the clinical services manager is the head, or runs the eating disorder service. So I was involved in the development of the service, obtaining the funding, writing proposals and planning and designing the service, recruiting the staff, determining the programmes and so forth. And running it.

R2: So you've had a busy time setting it all up.

P2: That's right.

R3: That's useful, to gain a broad outline of where you're coming from, when we're going into the main interview.

P3: At the moment my prime work is not therapy in an individual sense. Because of the time constraints I do some, but not much at the moment. And basically I'm providing the resources for others to do it and so forth. And this service
itself runs a day unit for patients coming in particularly with anorexia, but sometimes with some forms of bulimia or chaotic behaviour. And they attend during the day. And we have a multi-disciplinary programme for them, as well as for outpatients who we see individually and in groups for therapy. And this service acts, well I act, as the lead clinician for the authority for determining which patients will go off to inpatient care, should they require it. So in a sense we’re a gatekeeper also.

R4: So if you can treat people as outpatients you will do, but then if that’s not working for a particular client then they’ll be referred on.

P4: Yes that’s right, but within financial and clinical constraints. So that basically I suppose I’m responsible for policy and programmes to do with eating disorders in this trust and I also contribute to the health authority who fund this service, in terms of plans for developing the service and funding arrangements, tertiary referral policies and that thing.

R5: And what age groups is it here?

P5: Right, well, our policy is from 16 to 65. But if somebody is in full time education, between the age of 16 and 18 they’re seen by child and adolescent, or as called family consultation services, within the trust. But we liaise with them in terms of carry over or hand over of patients as they reach their 18th birthday. The average is 25, of our referrals, but I’ve got a little distribution of that.

R6: So if we could now go on to the main questions. In the first part of the interview I would like to explore with you what your past experiences and current conceptualisations of anorexia are – what anorexia means to you.

QUESTION 1:
In terms of anorexia sufferers, what do you understand to be some of the main psychological difficulties associated with the illness?
P6: Right. Complex question and depends on which model you adopt. I suppose the model we have found most useful is Arthur Crisp’s model of anorexia, which is the notion that in some way anorexia represents a regression, a psychological regression, to a state of pre-puberty development psychologically and physically. And is reflecting the crystallisation of some sort of fairly deep-seated problems in the family, for which if you like the anorexic the is symptom carrier. And that there may be an organic or genetic component to anorexia, nobody’s terribly clear about that. I think the animal based research is not, the analogy between pigs or sheep and their anorectic behaviours, is not all that relevant at present in terms of drawing conclusions, and that there certainly is a physiological contributor in that some people find it easier to starve. If we’re all on a desert island, some people would be able to lose weight more easily than other people, and some people would give up more quickly than others, in terms of trying to keep themselves alive. Physiologically there’s always a contribution, almost always – some cases not – but a major loss of weight from a higher weight than the individual didn’t want to accept. Some cases you find people who’ve always been a low weight but mostly you find in assessments, and I’ve assessed hundreds of people, that people have been a higher weight than they would’ve liked. And then undergone dieting and that’s moved into anorexia. So you’ve got organic and physiological, you’ve got contribution from the family, you’ve got personal factors, psychological factors, characteristics of the anorectic that we know to be so typical. The tendency toward obsessionality, perfectionism, conformity, compliance, which seems to be there fairly well from the start, and possibly in other family members. And that is … does anorexia attach itself to that, because if they’re good at complying and conforming in other things, they’re probably going to be good at dieting. So there’s that. Other psychological factors, once anorexia starts to take hold, or contribute to it, you always find, without exception in my view, some significant separation in the person who goes on to develop anorexia. Often it’s a separation early in life – adoption is quite significant in my view. I’m trying to do some research on that, or fostering, death of a parent in early life, separation, divorce, living away from
the parent in early life, significant major illness early in life, hospitalisation. But all these things can contribute to other disorders, so they're not unique for anorexia. But they certainly add to the predisposing picture if you like. It seems to me that bulimia is contributed more to by trauma that occurs later in life, either in later adolescence, 16 to 18 or something like that, around puberty, like marital break ups and so forth, also seem to affect anorexia. We can't avoid the fact that sexual abuse seems to play a role. Some estimates are around 58% of people with eating disorders, and we certainly find it here, and certainly in running our bulimia groups. We find that they get very difficult because many of the patients do disclose sexual abuse as things go on, and then they don't want to participate with others in the group. But overall, I guess I'd focus on, if you were going to ask my understanding of anorexia, it is a regression to a more dependent state, it's about the individual not being able to face, to put it bluntly, sort of growing up. And they're retreating to a more immature state, where in some way they can control the environment around them, because it's a very controlling illness, but not through adult behaviour where you influence events. In a sense it's emotional blackmail. And I think the, I wouldn't want that explanation misquoted, but there is no doubt that patients with anorexia exert a tyranny over all those around them. That they put themselves in a very powerful, omnipotent, narcissistic, egocentric position. And role the universe into a ball, and saying the whole world is interested, or my life depends on whether I put on one or two ounces, which is absurd. So it's a very narrowing focus. I don't know whether that's helpful.

R7: Yes it is. And where does that information come from? You mentioned that you follow quite closely Arthur Crisp's model, does it also come from you experience or ...?

P7: Oh yes, all that stuff. I mean that's not Crisp's model that I've presented here. I've presented little bits of it. But basically that's my accumulation of understanding.

R8: Yes, as you say, you've done hundreds of assessments ...
P8: Yes, and there are a lot of other factors I haven't mentioned. Anger seems to be very important in bulimia, more so than anorexia. You often find that a bulimic is much more angry about parental sort of issues. But in both of them there's a pivotal thing about not being able to maturely separate off from the family of origin and develop an independent life. And I think if you want to sort of move into the wider picture, if you like, the sociocultural, because these factors certainly also influence anorexia, if you like it's the modern neurosis. It's involved in a way that young women express their distress about moving into adult life. You know, moving into adult life. In earlier times, for example late 19th century, it might have been that women expressed it through hysteria, hysterical paralysis, fainting fits, smelling salts. Where women seemed to be, you know, collapsing and fainting an awful lot, and so forth. I think, nowadays, because of the huge emphasis on weight and shape, and the fact that people's weights and shapes are so much more evident than they've ever been in history before. If you think about it, never has the body been so exposed. Last century and up to then, I'm not sure what the Romans did, but if you take Western or sort of English society, if you looked after your face and your hair and your top part, who was to know if you were overweight under your huge dress or whatever? As we understand it, people had sex without looking at one another's bodies. I don't know whether that's true but it's what we understand, so people weren't exposed in the way they are now, down to every inch of flesh on their body. And I think, I don't know why that is, why we've gone towards this exposure. It sort of seems to fit in with the whole relaxation of formality and so forth in society possibly, but it means that there's a focus on the body that people never had to put up with in the past.

R9: And that's perhaps why the incidence rate has ...

P9: And feeds into it ... and also in the past, there are other venues if you like, other vehicles that people could use to ... not hide their anorexia because they probably didn't know they had it, but to channel it for example. Being a nun, living in a convent, many girls were nuns, eating a minimal diet. Who know
what you looked like under your habit? In fact frugality and low rations and so forth were a good thing.

R10: Yes. You have to suffer …

P10: Yes. There’s the whole thing about the fasting saints, and the girls who were regarded as miracles because they could refrain themselves from eating. And people travelled miles to see these fasting saints. But there was the girl, the sort of model of the family, whereby if the girl wasn’t going to get married, wasn’t going to develop her own life, she was not outgoing, she was quiet, she stayed at home and looked after the father. Or she was the daughter who just stayed at home or went to the convent or was the maiden aunt, hanging around the family. Didn’t have to address emotional, sexual or social issues probably. I think it was easier. People weren’t so exposed.

R11: And it sounds like role were so much easier …

P11: Roles were more structured.

R12: And now there’s so much more pressure …

P12: I think the fact that we don’t have set paths that we go down, as limiting as it was in some ways, also means that people have to ask questions about what they’re going to do with their life early on. And if you ask an anorexic to think about their life, what they’re going to do with it, even if they’re a student and ostensibly have a career ahead, one of the chief things is they don’t know what they’re going to do with their life. They can’t come to a decision about what they’re going to do. They may have fantasies, but they may for example have had to pull out of university. I means, we’ve got at least 4 or 5 university students among our 10 here, day patients, whose anorexia has stopped them from going to university. Now you have to ask what that’s about.

R13: Yeah. And when you were talking about the regression, and becoming more
dependent, perhaps that was the first time they'd become more independent.

P13: It is. Separation triggers anorexia. Quite a frequent precursor to anorexia is the first separation from home. Going to university or leaving home.

R14: QUESTION 2:
And with thinking about the family and social issues and other issues that there are for anorexia, that we've been talking about. Do you think there are specific ways that that affects their experience of the illness?

P14: I ... Right. Once it starts getting sway, it's very hard to work out you know, it's chicken and egg, what contributes to the illness, isn't it, because the parents and the daughter can get into fights and so forth about food. So, did the conflict arise from the anorexia or was it always there? Is it easier to fight about food, as painful as it is, than it is to fight about something else that's going on in the family? Abuse or the fact that the parents have got difficulties. I mean I think that probably isn't very popular to say because it looks as though it's somehow victimising the mother, and mothers have a difficult role, but there is often a strong collusion between the mother and the daughter so that the mother couldn't face, although she'd never admit it, the daughter leaving home. And that in some way, keeping the daughter as a child, even though she's anorectic and that's painful for everyone, it's somehow easier to cope with than letter her grow up.

R15: And again, where does that information come from? Is it your experience or research or anything else?

P15: Yes. I think so, a mixture of that.

R16: QUESTION 4:
Do you think that you personally might have been influenced by any of these aspects that you've been talking about, such as the understanding of the family and psychological issues and difficulties? Do you think that any of these
P16: Of course they must.

R17: In what ways?

P17: Well by determining the issues you’ll deal with the patients so, you know, that separation issues are bound to come up and that’s an area that you need to work with the patient and design the service around. For example in a day service you must pay a great deal of attention to the ending of the person’s stay here, because as you probably know as a psychologist, symptoms often worsen at the end of treatment. So you can get a reversion back, basically because the person can’t handle leaving. So you mustn’t enable the person to become too dependent on the service. So it’s a difficult balance because you want to give them trust, you want them to develop trust, suppose, and the only way you can do that is being there for them. But if you are there for them too much, you will end up them seeing this as their home, their family. So you have to plan discharge many months in advance and keep talking about it, and working out arrangements with the patients, and getting them to be independent. And that can be seen as very tough.

R18: It seems like there’s a really fine balance there.

P18: Oh it is. But one of the technical ways we do that is by reducing the person’s amount of time spent on the unit so that most of the time, when they’re in full treatment, they’re here 4 days of the week, 9 through to 6. So as they start to put on weight, and when we talk about discharge, we cut that down so that there’s an agreement with them and get them to work out the programme. They say 3 days then 2 days then 1 day, and then they continue on an outpatient basis.

R19: It sounds like you’re really pushing towards their independence, so they’re making the decisions to cut back on their time here. You’re helping them
move towards that …

P19: Absolutely. Sometimes it doesn’t work, some people use it as an excuse, attendance, but we’ve only had one case of that so far. Most people comply fairly well with that and … because you find as patients get better anyway, they become more emotionally mature, as well as physically, and you can see that. And that means their interest in the outside world develops. So that they way to be doing things and having appointments with other people and activities, and that naturally evolves in the same way as with a child growing up. First of all they’re with their family and then they start to have outside interests and that process is mirrored in the therapy with the anorectic. They suddenly start talking about ‘Oh I think I’ll go out and join that dancing group’ or something, whereas 6 months previously, when they’re in the throws of anorexia, the grip, they will not be remotely interested in other people or what they’re doing.

R20: It sounds very daunting. From what I’ve read about it, it’s a very isolating condition. They isolate themselves from social life.

P20: Partially because they don’t want to eat with others, and for others to observe their eating behaviour. And a lot of socialising around food. Most of our socialising is around food isn’t it? A party, or meet for lunch or dinner, or have a drink or whatever.

R21: And they just can’t cope with that so therefore…

P21: They get isolated.

R22: And where do these ideas come from?

P22: Oh definitely from my experience.

R23: It does seem like a vicious circle they get into.
P23: Absolutely. So how that influenced my personal practice … obviously you’re aware of sort of pivotal issues. It informs your assessment, the sort of questions you ask. And when you’re dealing with patients you are on the look out for certain things and you try to focus treatment, both individual and group or day on that basis – on things that are likely to come up.

R24: So do you tend to follow what the person brings into the room or do you help them move towards the issues that are already there?

P24: That’s a loaded question.

R25: I’m not trying to be, I’m just trying to understand your practice.

P25: No no. that would be different. Answering as an individual therapist, um, it depends on what model you are working in. So that say you’re working in schema focused therapy, you’d be helping them to elicit patterns that are already there. So I mean I think it’s naïve for any therapist to say that it all comes from the patient. I mean, unless you’re a complete … I don’t know whether even Rogerians do that … just amplify what the patient says. That’s naïve isn’t it? To think that’s all you do. No, well … certainly in analytic therapy, psychodynamic type therapy, of the analytic type, you have the issues around and take the opportunity to offer an interpretation when the issue turns up. I mean, if you’re working with the transference, people bring the issues that are really important for them, right from the first time you see them. Not … they may not articulate them but they’re there in some sort of way, the way they present themselves to you. And in CBT you work on it more overtly, by identifying the thoughts, and in interpersonal therapy the same. So I guess the second part of your answer, you don’t just sit there and wait for the patient to do everything, because clearly they haven’t been able to, otherwise they wouldn’t be seeking help.

R26: So your practice appears to be related to both underlying theoretical
understanding, which is translated into your experience with the client group.
Is that right?

P26: Yes.

R27: QUESTION 6:
And in your training, do you remember having studied anorexia specifically as part of your course?

P27: There's no, to my knowledge, any specific training for working with eating disorders as a psychologist in any academic course, except for some seminars that contribute to clinical courses. Just a few seminars. But there's no recognised training course. No, it's all through workshops, conferences, reading, meeting people. Especially when I started out 9 years ago, and I started (nb why specialised qu 8) simply because the Dutch psychologist in our team who had been dealing with the anorexia left and somebody had to look after them. And I didn't know a thing about anorexia so I had to start learning.

R28: And quickly – that sounds quite daunting.

P28: That's right.

R29: What were your early experiences like?

P29: Helplessness. A total feeling of helplessness. And being controlled and tyrannised and frightened – because the patient could die you see. And that is something which accounts for one of the reasons why mental health professionals are so reluctant to get involved in eating disorders. If you're treating somebody and they're mildly depressed, in a sense if you're not particularly helpful to them the implications aren't that great. But everybody can see if you're not helping an anorectic, because they get thinner and thinner. Now I'm not belittling other areas of mental health because if you don't work properly with a schizophrenic for example, the person might act out in some
terrible way or whatever, or a person might commit suicide. But it’s not a
daily basis that everybody is seeing what that person looks like.

R30: It’s a real physical manifestation.

P30: Yes, it is a real physical manifestation and it’s very measurable, what you
achieve. Patients put on weight or they don’t in anorexia. And that’s got to be
part of the therapy. You can’t have recovery – it’s meaningful to say a person
has recovered but meaningless psychological for anorexia if they’re 4 stone in
weight. What does that mean? You know, it’s got to have a physical parallel.

R31: Yeah. It sounds terribly daunting, and thinking about it from the perspective
of other health professionals that are starting to work with it, or see 1 or 2
clients with anorexia, it must be incredibly daunting for them. If they don’t
have a great understanding and haven’t had a lot of experience.

P31: Exactly. But that’s the same with any field you go into. As I say, working
with your first schizophrenic patient must be pretty daunting, if you’re in that
field.

R32: SECTION 2 QUESTION 8:
And is that one of the main difficulties working with an anorexic patient, as
compared with say a depressed patient, one of the major differences in the
therapy is this physical manifestation?

P32: Obviously the physical manifestation, and the way you have to focus on
weight. And be directive in a way that in other forms of therapy you can go
along with the patient perhaps to a greater extent, getting them to guide things.
But if you do that in terms of weight, they won’t want to put any weight on
and will want to continue losing. So there’s a little bit of a conflict there,
between being directive and less directive. So that’s in a sense why you have
to have a tier, a range of services for people with anorexia, ranging from
inpatient care where they go and it’s weight and the psychologist might do
some work with them as they start to put on weight. Day care where there’s ongoing psychological work, even group skills, social skills, assertion training, as well as individual therapy. Through to your outpatient person who’s probably going to have more psychological work but, nevertheless, there’s still the focus on weight and eating patterns. And that’s why it has to be multi-disciplinary, so that the dietician can focus more on their food intake than the therapist.

R33: It does sound incredibly important to have a variety of perspectives coming in to help that person …

P33: It’s difficult to do it yourself because it’s quite difficult to flip from say doing baseline food activities and intake and charts and things, and then flipping to what’s going on for you now.

R34: Yeah, it would be very difficult to work out your relationship with that person, because at one moment you’d be very directive saying what they have to eat, and then going into a more therapeutic role.

P34: And for them to work out their relationship with you too.

R35: I imagine that would be very confusing, so it does sound incredibly important to have that multi-disciplinary input.

P35: And that’s why it’s quite resource dependent and resource heavy and expensive.

R36: Yeah, because there does seem to be such incredible individual attention.

P36: That’s right. And if you want to enlarge upon that, there are forms of therapy like art therapy and so forth that might be helpful. We have some art therapy here, for the patients who can’t verbalise very well. It helps to open them up. So, you know, it’s very resource hungry. And that’s why it’s so expensive,
and that’s why Trust and Health Authorities have a problem with the amount of expenditure.

R37: Yeah, much more difficult. And you were mentioning earlier about training and how – having none, and there isn’t anything out there. Do you think there is anything that would be useful for people who are thinking about going in to working with eating disorders? Something that would be particularly beneficial to them?

P37: Yes. I think now we know enough … we don’t know all the answers and so on, but we know enough now that I think there could be a module for eating disorders. Easily enough information to run a 24 week module or whatever it is, within a psychology course, or nursing. In fact I set up a nursing module for the English National Board at a university. And there is a huge amount of information that could be given. It’s just about setting it up. Personally I don’t think a couple of seminars in a course – they’re a taster.

R38: Yes. I mean on our course I remember as an undergraduate we had one session. Then we’ve had one day that would be over three years, and it seems so minimal.

P38: I think it’s postgraduate work. As an undergraduate you talk about it at the same level as depression, or in your abnormal psychology or whatever it’s called these day, but in that sort of area.

R39: So in postgraduate training it would be extremely useful for people thinking about going into the field, to be able to have a more specialised module.

P39: I think if you were going into general adult and mental health or child, nowadays, you have no excuse for not knowing about eating disorders, because it’s a very common presentation. And the profession should acknowledge that the ways of receiving further training and contributing is the British Psychological Society has a special interest group for eating disorders.
And I'm a committee member on that. And we have four meetings a year and
the various services meet up and psychologists in eating disorders and have
seminars and so forth.

R40: So once you're able to get into the field, there's a lot of input?

P40: Endless conferences and workshops and things to go to – endless.

R41: SECTION 2 – QUESTION 4:
So that's really useful. But there seems to be a gap there, about a person who
wants to go into the field gaining the training, experience and knowledge
necessary … in terms of specific information that someone must know before
working in the field, like you mentioned how important it is to know about the
physical aspects and the physiological problems …

P41: You need to know everything. You need to devise a curriculum and I can’t
devise one off the top of my head. But clearly it would … discuss aetiology,
diagnosis, classification, because whatever view one has of classification
systems the fact is an anorectic is diagnosable, they conform to criteria and
they're so evident that you can't sort of pretend that it's just the myth of
mental illness, you know the Szasz view. You know, it's a reality. There's a
constellation of symptoms that go together that are a syndrome. So those sort s
of things, and models of treatment and so forth. And then supervision.

R42: So it does seem as though there's no excuse for someone not being able to
diagnose anorexia.

P42: The information is there. It's not like we haven't got the information …
nobody's got really fixed magical cures. We know some things are useful and
some things aren't.

R43: I'm recognising time. So I'll move onto the second part of the interview if
that's ok.

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R44: QUESTION 1:
I'd like to look a little more specifically about your views and experiences of working with anorexia sufferers. In terms of professional practice, what qualities stand out as being particularly important for working with this client group?

P44: Patience and perseverance. Ability to tolerate denial. Ability to tolerate everything that the patient throws at you really, without responding. And capacity to deal with feelings that automatically develop in you – of anger, hostility, frustration, helplessness. All those things that patients experience in dealing with a family member who's got anorexia, because a therapist gets all those feelings too. At base, why won't you eat? But you must obviously not use that as a basis for relating to the patients, because it's your job to understand why they can’t eat. And after a while that's not hard. You just, you know that you don’t try and make them change their views of feelings by telling them that they shouldn’t feel like that, or giving them advice. I mean you realise it has to come through some dynamic psychological change.

R45: Which, as you mentioned, takes a lot of patience and a lot of waiting.

P45: And input.

R46: Yeah. And it sounds like you have a lot more input generally, like when you’re working here specifically, you have a lot more input than you would with somebody coming to an adult mental health team.

P46: Yes, well, I suppose you could say that all patients could do with more input and would benefit if they were seen twice weekly or whatever, but certainly in eating disorders you have to give a lot more input because they’re not just disturbed in one field – in one area.
R47: QUESTION 2:
And there appears to be a large variation, as you mentioned, in the number of models there are that people use to work with anorexia sufferers. Do you think that there are any guidelines that you work by generally?

P47: I've sort of answered that. The guidelines about being aware that the patient is generally speaking in denial. That, you know, you can't just use rational argument with them. And being aware of the issues that they're likely to bring up and use as an opportunity to work through any issues, as they come up repeatedly, repeatedly. And not expecting too much and being very reinforcing of any small changes. And not being surprised by anything. And not regarding yourself – not projecting a patient's failure onto yourself, but acknowledging. I think that's one of the most healthy, life saving things a therapist can really hold on to in working with patients with eating disorders – that it is a very, very, very hard disorder to shift. That it is an illness that is almost at the level of a psychotic delusion. And I think one day it will be classified as a psychosis. And that if you can do anything to help the person either change or adjust or adapt or live some sort of reasonable life, you're doing well. And that you're only going to get a 40% or so show some form of major recovery, 40% partial recovery and the rest get worse or deteriorate. The middle 40% that show some partial recovery, that may be just that they don't die ... that they manage to keep themselves at a low body weight. So not to set too high, unachievable goals, for yourself or your patient, because you hit your head against a brick wall. And that is very difficult for the young psychologist, who comes out fired up with CBT models and so forth. That if you do this or that and so forth, the symptoms will remit. Because the reality isn't like that.

R48: So it's very important to have that awareness and, as you mentioned, to lower the expectations that you have. And looking for the small changes being so important.
P48: Yep. Or the person showing some concern for the other, rather than just for yourselves.

R49: Yeah, because you were mentioning about the omnipotence and narcissistic quality of it.

P49: I mean, I do have to say those are not cognitive-behavioural terms. I find the psychodynamic concepts essential in understanding eating disorders. People, for example, Fairburn gave a talk a the recent London conference on eating disorders, on a cognitive-behavioural model of anorexia nervosa. And it was about how weight reduction behaviour is maintained by cognitions that the person develops from culture and the family and so forth. And every clinician there who has worked with patients with eating disorders said ‘sorry it’s inadequate’. You can’t just understand it in terms of cognitions. There’s something else going on – it’s more complex. It’s not just about the person reading their weight and overvaluing ideas of weight and shape. Why do they overvalue ideas of weight and shape? What’s that to do with? It’s not just ... you know, I haven’t given you a very good description of Fairburn’s latest theory, but everybody there basically said ‘what you’re telling us is inadequate’. So I think psychodynamic concepts of individuation and narcissism and omnipotence and things like that are very helpful.

R50: And from my reading, when I was doing the literature review last year, those kinds of ideas were really making sense. Looking at the early history and how important that seems to be. As you were mentioning earlier, about the very early separation being so important. From my reading that made a huge amount of sense.

P50: Yes, that’s right, it doesn’t just come out of nowhere.

R51: I realise we’ve gone through quite a lot.

P51: Don’t worry, you’re doing well.
R52: QUESTION 5
Some people are of the opinion that there’s a particular time to work with anorexia sufferers, that if they are of a particularly low weight then psychological input isn’t going to be particularly useful. And others are of the opinion that you can work with anorexia sufferers at any weight. Where would you position yourself?

P52: Right, well, because the question is up for grabs, nobody really knows the answer. We accept patients here with a BMI as low as 13 and we’ve had BMIs lower than that, between 12 and 13. And we ... insist, not insist but it’s part our programme, that patients join in with group therapies and the individual therapies right from day one. And that doesn’t seem to have been a problem. I guess, in the individualised therapy, you focus more on thoughts and feelings about food and what the patient brings, rather than focusing on the bigger question. But I would say that we haven’t had any negative responses yet. In fact, the only negative responses we’ve had is with patients who don’t think we’ve organised the individual therapy quickly enough for them. And that could be due to availability of therapists, of you know...

R53: So what’s the most important is getting the person here first and then input for them.

P53: Yeah. Yeah.

R54: QUESTION 6
In your opinion, do you think there are any practices that are detrimental to the recovery or the process of recovery for anorexia sufferers?

P54: Yes, I think not focusing on boundaries. Anorexics have this problem, and bulimics even more so I suppose, with boundaries. Again that’s a very useful concept in terms of informing one’s practice, thinking about your earlier question. And that if you don’t look after the boundaries, then you’re not
helping the patient. For example, if you don’t have a definite cut off time in therapy, if you don’t actually bring things to a point where we say ‘are we moving on now or not’, where if you’re being too available for the patient, you’re like a mother who’s constantly available. That’s not a good lesson. Life isn’t like that. You’re not going to learn that mother has her own things to do. The therapist has her own world. That’s what adults do. So I think not paying significant attention to the boundaries which can sometimes be very difficult – for example where the patient who routinely tries to … act out on Friday afternoon, possibly ends up when she’s not on this unit, in order to get into this unit she would suicide attempt and so forth. Friday afternoon of course, just when staff are leaving, all this sort of thing. So we just have to hand over to the crisis team. You might say that’s cruel, she wanted the person she was seeing here, but you have to set limits and that can be deleterious if you don’t set boundaries, because then the person – in a sense it reinforces behaviour. I think providing too much structure is wrong, because that feeds into the whole obsessionality and perfectionism of the anorectic. So we have set meal times and set routines at meals, but it’s not like an army camp where food is dolloped onto your plate. And the focus is, at meal times for example, conversation amongst the nursing staff and the patients, rather than the food. But at the same time they also have to pick up on whether somebody’s not eating, and nudge them and reinforce them. So that’s very difficult. I mean, I would say that those people who have the hardest job in dealing with patients with eating disorders are the nursing staff, who sit with the patients when they eat. That to me is the hardest role, because they’re the people who are seeing the phobia at its height. The phobic object is the food.

R55: Because that’s where, as you were saying about families, conflict is in the food and therefore that can become a real battle ground, and sort of who’s got the stronger willpower here.

P55: That’s right, exactly. So I think that giving the structure, giving too much structure, not adhering to issues around boundaries, can be deleterious, allowing yourself to be manipulated and tyrannised by patients simply
because, in anorexia, ultimately they have to make choices about their life. And I think, in a sense, taking over the omnipotence that the patient wants to project onto you, and not realising you know, that you’ve fallen into the trap. Imagine that you’re more powerful because the patient wants you to be powerful while, at the same time, they want you to be helpless. But in a sense the therapist who doesn’t receive supervision, who doesn’t talk about their work, can start to feel they have too big a role in the person’s life, and therefore they’re taking away from the patient their capacity for independent action. So you’ve got to guard against omnipotence, boundary breaking, giving too much structure. And I guess the other side of that is allowing the patient to become too dependent on you. Those things would all be deleterious. I wouldn’t, by any stretch of the imagination, say that’s a complete list.

R56: But those are the real solid basics that you’ve got to be so careful to guard against.

P56: Yeah.

R57: QUESTION 3:
And you mentioned earlier about levels of frustration and helplessness, and anxiety and anger that can build up in a therapist. Some people concentrate on that when they’re talking about therapists feelings when working with this client group, and others are saying it’s challenging but highly rewarding. And it seems like quite a broad spectrum. Where would you position yourself?

P57: You’re aware of the concept of countertransference?

R58: Yeah.

P58: Right. For me ... in my role, the rewarding bit of seeing a service set up, that provides appropriate treatment for patients and providing somewhere for them to go. And providing them with a programme, giving that there was nothing
here previously. So that, for me, is terribly rewarding. But with the individual patient, oh it’s terribly rewarding when somebody gets up to a normal body weight. And we’ve got two patients who are just about to do that, and be discharged and go back to university. Well that is very, very rewarding. But on the other hand, where can I put myself on the continuum, the day to day individual work with patients, it’s more frustration than the reward.

P59: And you mentioned having to tolerate that constant frustration.

P59: Yeah.

R60: CONCLUSION
I think I’ve nearly come to the end of my questions. You provided a very honest and in depth account and I appreciate that. A lot of what you’ve said is very individual to you as a personal therapist. Do you think some aspects though are similar to other professionals?

P60: Oh I’d say I’m reflecting the experience of the team.

R61: Yeah, because you’ve mentioned the nurses and how difficult their role is as well. And again, them having to tolerate the frustration especially around meal times and how difficult that can be.

P61: On the other hand they have the personal relationship with the patient which, once you’re involved with a patient on a day to day basis, there’s something about the nature of the interpersonal interaction, which provides its own reinforcement, isn’t there, and its own interest. And it’s ongoing motivation. Whereas if you’re not seeing patients all the time, you know, you’re not as interested in it if you’re not pivotal in what’s going on for them. And so you don’t have that motivator. You just see the crises. You just see the problems or the achievements.

R62: Yeah, I had that last year with a client. I was only seeing her one hour a week.
And it just seemed so minimal. And it was just seeing the crises every week. And when you're talking about the boundaries, there was often the floods of tears at the end and 'I don't want to leave'. And then having to break away to keep those strict boundaries. But her having nothing else outside. And that was very difficult.

P62: That's right, but the ... I mean on your personal life, I don't know whether that's one of your questions. But it's about ... I would never engage in conversation with anybody about their weight, shape or appearance. I mean, even with family members you become very wary because people pay far too much attention to what you say, because they think you're an expert and you have the knowledge. Wherever I go, if people know who I am, they immediately make a comment about what's on their plate, what they're eating. 'Oh I bet you're watching what I'm eating now', as though you're monitoring the whole world's eating behaviour. People project this onto you. Of course you're not remotely interested, and you couldn't care less. I mean what's on their plate or what they do about their weight, that's their business. It's nothing to do with me. So if ... but if a colleague or family member or friend or something started to talk to me about eating disorders, you would give a little bit of information, but you'd direct them to a professional service. No way would you get involved in giving advice unless you were a very silly person. But that goes the same for any professional. You just operate on the basis of what a friend would normally do. But people will project an amazing amount of expertise onto you, and knowledge, and interest. So that they think you were judging and having opinions about their weight, shape and what they were eating, simply because of your role. And I suppose it's the usual joke about the psychiatrist - well now you're analysing me. So you just deal with it in that sort of way. Of course you're not analysing everybody you see because you don't know anything about them. So just on a personal level that's interesting and you need to consider that and adjust your behaviour, and not naively get involved. If somebody says to you, and they know you're an eating disorder specialist 'I think my daughter's a bit thin', what they're asking is 'Do you think she's anorectic, and please give me some advice'. So you
have to see that for what it is, and not pretend to yourself that it isn’t.

R63: And then against that’s boundaries isn’t it? You’re creating your personal boundaries and professional boundaries, which seems vitally important from what you’ve been saying.

P63: Absolutely. You have to realise there’s no such thing as an unloaded question, about everything to do with eating disorders. Also with professionals, with students, with people who visit the unit, you often find at some level there’s some concern themselves. I mean about either being overweight or underweight and, at some level, they want you to give them advice. I had some ladies visiting from an external organisation who, at the end, they both sort of said ‘You haven’t got any advice about overweight have you, and how we can go on diets’. And you know these were professional people. I think that every individual who works in the field of eating disorders is there for an unconscious reason other than to do with their intellectual interest. So there’s something about them, around weight and shape isn’t there? Even the fact that you’re doing your thesis on it. Why has the topic attracted you more than working with schizophrenics? Somebody’s had somebody in their family, or somebody’s had a concern about themselves, or they’ve had a battle themselves with their weight ... I don’t ...

R64: For me it was being in boarding school for years. I mean it was rife there. And you want to understand.

P64: It’s a mystery, an intrigue, a question. There’s a question in your mind that you’re trying to solve.

R65: Yeah. And that keeps you motivated and interested. It does for me anyway. Just before we finish I’d like to ask how it felt to be an interviewee?

P65: Oh I think you’re an excellent interviewer. And you make it very easy for somebody to speak and be forthcoming. You’re intelligent, you know your
subject, and one doesn’t feel one’s having to be at all patronising because you
don’t know what the topic’s about. You’re very widely read in the area, it
seems to me. You’re on top of your topic and it makes the interviewee feel it’s
worthwhile doing the interview, because they’re not being asked questions that
are not serious or not well thought about – not sensible. And that the
information could actually be useful, that they’re giving, so it’s worth their
time to contribute. And it’s also interesting to reflect on one’s field.

R66: I’m finding this whole research absolutely fascinating.

P66: And I can imagine it would be very rewarding for you.

R67: Yes it is. Just before we end, do you think there’s anything I’ve missed in the
interview that you think is important to discuss?

P67: I suppose probably with individual therapists you might be able to get a little
bit more down to the nitty gritty, but I don’t think you can do that in an hour.
Like you could take a model and ask what are the cognitive distortions in
anorexia, how useful do you find that when you feed it back to patients. Break
down some of the models into more detail, but you couldn’t do that in an hour,
that would have to be a separate thing.
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
An Evaluative Study to Investigate Whether Outpatient Therapy is Beneficial in the Treatment of Anorexia Nervosa and Bulimia Nervosa

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Short Title: Evaluation of outpatient treatment for anorexia nervosa and bulimia nervosa
An Evaluative Study to Investigate Whether Outpatient Therapy is Beneficial in the Treatment of Anorexia Nervosa and Bulimia Nervosa

Abstract

The aims of the current study were to evaluate whether an integratively oriented therapeutic approach to working with eating disorder sufferers was effective, and to explore an individual's experiences of the therapy provided. Fifty-six clients completed the Stirling Eating Disorders Scales (SEDS), the Beck Depression Inventory (BDI), and the Beck Anxiety Inventory (BAI) pre- and post therapy. One individual was interviewed concerning experiences of therapy. Analysis revealed statistically significant improvement on all subscales of the SEDS. Both comorbid depression and anxiety were targeted effectively. Qualitative analysis revealed that, for this client, resistance and difficulties initially trusting the therapist proved problematic. When this was overcome, the development towards recovery was possible. The study provided interim support for this therapeutic approach but follow-up is required to discover whether improvement was maintained or whether clients relapsed. Further exploration of clients' experiences of therapeutic support is required.

Key words: eating disorders; service evaluation; outcome; patient participation
Introduction

Eating disorders are highly complex with multi-dimensional causal mechanisms as well as potentially serious psychological and physical consequences (see Appendix I for DSM-IV definitions); anorexia nervosa (AN) has the highest mortality rate for any psychiatric disorder, with some studies reporting mortality rates as high as 20% in chronically ill adults with AN (Ratrasuriya et al., 1991; Sullivan, 1995).

Bulimia nervosa (BN) has received most research attention in relation to controlled outcome studies concerning the efficacy of various treatment modalities. From this body of studies, the results suggest the superiority of cognitive-behavioural therapy (CBT) when compared with anti-depressant treatment (eg Agras et al., 1992; Mitchell et al., 1990) as well as other psychological therapies. For instance, CBT has been shown to be more effective than supportive-expressive therapy (Garner et al., 1993) and short-term focal psychotherapy (Fairburn et al., 1986) among others. To date, it is only interpersonal psychotherapy (IPT) that has shown equivalent outcomes to CBT, although the effects of this form of therapy were slower to materialise; post-therapy, CBT was deemed more effective but the two treatment modalities demonstrated equivalent outcome at follow-up (eg Agras et al., 2000).

In contrast, research into outcomes of therapy for AN sufferers is noticeable by its absence. There is currently a dearth of studies into efficacious treatments for this serious and, sometimes, life-threatening disorder. According to Grange and Lock (2005), there are only seven published controlled trials of outpatient psychotherapy and thus a “compelling need for further systematic investigation into treatments for AN” (Grange and Lock, 2005, p80). These studies suggest that, not only do adult clients with AN fare comparatively poorly after exposure to therapy, but that no specific psychotherapy has been demonstrated to be particularly helpful with this age group “leaving clinicians and researchers alike stranded without any clear indication as to which treatment is likely to be effective” (Grange and Lock, 2005, p89) (emphasis in original).
Furthermore, despite evidence suggesting CBT as the most efficacious of treatment approaches for BN to date, 50-60% of clients within this treatment modality remained symptomatic after therapeutic input (eg Agras et al., 2000; Fairburn et al., 1995). Also, the majority of treatment trials have utilised behavioural change as the prominent measure of outcome, and there is the suggestion that other, psychological, aspects also require attention in outcome studies for this client group (Openshaw et al., 2004). Finally, there is current debate concerning whether psychologists in clinical practice are utilising the empirically validated treatments and, if not, why this may be the case. For instance, Mussell et al. (2000) indicated that, although clinicians used some of the techniques of these treatment approaches, they did not follow the manualised form owing to both lack of training in their use and poor dissemination of results of treatment outcome studies. Haas and Clopton (2003) also discussed similar findings. Their study indicated that treatment for eating disorders in clinical settings differs substantially from treatment in research settings for a number of reasons. Firstly, comorbidity is rarely discussed in research studies although this is an issue for clinical practice with this client group, especially anxiety and depression (Margolis et al., 1994). Secondly, research studies tend to focus on symptomatology whereas, in the clinical setting, underlying issues such as sexual abuse, personality disorders, suicide risk require attention. Thirdly, the clinicians in this study suggested that manualised treatments were not adequately flexible to meet the individual needs of clients; in short, that therapists are required to attend to a multiplicity of difficulties when working with eating disorder sufferers (Kazdin et al., 1990), the complexity of which are apparently not the focus of outcome studies.

Again, there has also been limited research into clients’ experiences of therapy, and the processes through which individuals are able to overcome their eating disorders. For instance, Kaplan and Garfinkel (1999) reviewed client and clinician variables that may impact on and contribute to treatment resistance, concluding that some difficulties relate to the complex biopsychosocial mechanisms associated with AN and BN, issues of trust and the difficulties of comorbidity. In terms of clinicians’ variables, difficulties were considered to pertain to lack of understanding of the complex underlying causal mechanisms and a lack of appreciation for their own countertransference reactions. However, research is evidently lacking concerning the
subjective experiences of therapy and processes involved in the development towards recovery from AN and BN. Weaver et al. (2005) highlighted this issue and provide interesting insights into women’s journey towards recovery from AN, culminating in an explanatory framework of the development away from AN towards the informed self-care of healthy eating and the development of problem-solving practices. However, these authors do not look at the therapeutic process per se, instead considering the process of recovery in the context of the family, community and/or society.

The current study is concerned with evaluation of one aspect of a specialist multi-disciplinary eating disorders service based in the south east of England, that offers outpatient and day services to adults suffering from AN and BN. The service is exceptionally busy, with a full day service offered to those with more severe eating disorder symptoms, a variety of group programmes for both day patients and outpatients, dietetic, nursing and psychiatric support, as well as weekly individual therapy for both individuals attending the day service and outpatients attending the eating disorders service. Through an in-depth multi-professional assessment, the clinicians will make an informed decision regarding which programme will be most suitable for a particular individual as, currently, there is no empirical evidence to support the utilisation of any one treatment setting over another (Fairburn, 2005). However, outpatient therapy is of particular interest as it is the mainstay of treatment of eating disorders. As Fairburn (2005) comments, it is the only treatment modality provided for many and, even if individuals have received treatment in other settings, this will usually be preceded and/or followed by outpatient therapy. Further, there are concurrently other research studies being carried out at the eating disorders service pertaining to other programmes offered.

The integrative theoretical approach of the service is based on a multi-dimensional model of understanding of the development and maintenance of eating disorders. Fundamentally, the theoretical stance argues that there is no single conceptualisation of AN or BN and, rather, that there are a variety of underlying difficulties that may be encountered by the individual entering therapy. Thus, causal mechanisms underlying the eating disorder symptoms may include sociocultural aspects and family
difficulties, as well as individual psychological difficulties. As a result of a thorough assessment of these potential underlying factors, the therapeutic endeavour will be tailored to meet the individual needs of the client, remaining aware of potential issues that may be encountered but not assuming dominance of any of these. These may include difficulties pertaining to self-assertion, self-esteem and locus of control. Within this approach, symptomatology is also given precedence, to assist in the alleviation of overt difficulties surrounding restrictive eating and bingeing as well as compensatory behaviours.

To change focus at this juncture, it seems important to acknowledge that, in terms of the evaluation of services, there has been a substantial increase in the recognition of the importance of developing and evaluating the effectiveness, cost and quality of health care within mental health services (Clarke, 1999). Donabedian (1980) has identified three fundamental questions that provide the focus for evaluation of services: the structure of services, for instance the distribution and number of buildings, personnel and so on; outcome, which is primarily concerned with measuring the impact of services on the health status of patients for example; and the process of health care provision, ie what occurs between therapist and client during the course of therapy.

Within evaluation research there are a number of difficulties that need to be considered, not least of which is the type of methodology and analysis utilised in the process. As Patton (1986) comments, the evaluator needs to be both situationally responsive and methodologically flexible so as to consider the individual context in which the research is taking place. Thus, within evaluative research it can be beneficial to utilise both quantitative and qualitative elements, thereby taking into consideration the outcome and process of the health care provision in question. Within the current evaluation it seemed appropriate to measure both the outcomes objectively so as to address whether there was improvement or deterioration regarding both psychological and eating disorder variables after exposure to therapy, as well as to describe the perceptions and experiences of the general processes involved in the therapeutic endeavour from the individual client's perspective.
Although it is not possible to do justice to the literature concerning evaluating psychotherapy services and related evidence-based practice in the limited space available, it seems imperative to provide some commentary regarding the suggestion that 'empirically validated' treatments should be the ultimate aim of the research endeavour. There is argument to suggest that the 'gold standard' randomised controlled trial (RCT) does have associated problems and limitations (Roth and Fonagy, 1996; Parry, 1999). For instance, it is suggested that the RCT includes homogenisation of cases (i.e., treating clients as though they have standard, defined problems), and limitations pertaining to only 'pure' cases being included in trials, leading to questions concerning the generalisability of results to routine clinical practice. Further, as Ryle and Kerr (2002) argue, the RCT is largely a quantitatively based model, leading to questions concerning its relevance to the complexity of difficulties presented by individuals coming for therapy. It is recognised (e.g., Parry, 2000) that alternatives to RCTs require serious consideration, such as series of studies of uncontrolled treatments and a focus towards the relation of process to outcome in various therapies, which is the focus of the current study. It would have proved unfeasible to utilise an RCT due to the complexity of difficulties of people referred to the service, with individuals requiring therapeutic intervention as quickly as possible. Further, with the ethos of the service being to provide therapeutic intervention based on the idiosyncratic needs of the client in question, the development of a manualised treatment approach would have run counter to this more flexible and adaptable approach to therapeutic input.

The fundamental aim of the current study was to examine the effects of an integrative therapeutic approach for AN and BN. Specifically, it evaluated the impact of therapy on core eating disorder symptomatology and associated psychological difficulties, as well as an evaluation of the impact of treatment on comorbid difficulties of anxiety and depression often associated with eating disorders (Margolis et al., 1994). It was hypothesised that, at the end of therapeutic input, there would be a significant reduction in eating disorder cognitions and behaviour, as well as significantly more positive self-evaluation, self-assertion, self-esteem and more internal locus of control. It was hypothesised that there would also be significantly reduced levels of anxiety and depression. Further, it was hypothesised that the impact of treatment would be
significantly greater for BN owing to the current research suggesting that therapeutic input is more effective for BN than AN sufferers.

For the purpose of attempting to gain some initial insight into the general processes involved in therapy, it was deemed important to also consider a client’s account of the therapeutic encounter. Specifically, this addressed aspects of therapy that were felt to have been beneficial for therapeutic outcome, as well as those aspects that were deemed ineffective or even detrimental to the therapeutic process. Further, this qualitative data explored the experiences and understanding developed about difficulties associated with having an eating disorder as a result of therapeutic input.

Method

Participants

One hundred and twenty one clients at the eating disorders service were approached. These were individuals who had agreed by written consent prior to therapy that case material could be utilised anonymously for the purposes of evaluation, and who had engaged in and completed an episode of outpatient individual therapy (those who had dropped out or been deemed inappropriate after assessment by the clinical team were not included). Please note there was no assumption regarding the number or form of previous episodes of treatment received. Of these, 56 (46.3%) individuals completed both pre and post-therapy self-report measures and could therefore be included within the present study (see Appendix II). Of these 20 (35.7%) were diagnosed with AN and 36 (64.3%) were diagnosed with BN.

Of those included, 23 individuals, who had completed therapy within the previous year, were contacted by letter and invited to be interviewed regarding their experiences of therapy (see Appendix III). Within the letter, assurances were given regarding confidentiality of all material provided. Further, it was clearly stated that, if any participants wished to withdraw from the project at any time, this would be respected; as such, all material pertaining to their previous participation would be destroyed. As a result, one individual agreed to be interviewed. After two telephone conversations regarding the various potential ways of interviewing (face to face, recorded telephone interview, email), the individual in question decided that she
would prefer to be interviewed via email and thus we ‘met’ online a total of four times to discuss her experiences.

Measures
The participants completed three self-report questionnaires prior to therapy and again on completion of therapeutic input. The Stirling Eating Disorders Scales (SEDS) (William and Power, 1995) was the main measure utilised. This is an 80-item questionnaire, comprising 8 subscales (10 items in each). Four of these subscales relate to eating disorder pathology (both bulimic and anorexic dietary cognitions and behaviour), and four subscales tap into psychological difficulties found to be associated with individuals with eating disorders, namely Perceived External Control, Low Assertiveness, Low Self-esteem and Self-directed Hostility.

With regard to comorbid conditions, the Beck Depression Inventory (BDI) (Beck, 1978) and the Beck Anxiety Inventory (BAI) (Beck et al., 1988) were utilised, both of which have good psychometric properties and good levels of internal and external validity.

In terms of the qualitative measure regarding one individual’s experiences of therapy, a semi-structured interview format was developed following extensive review of the relevant literature (see Appendix IV). This enabled an in-depth exploration of individual meanings in relation to therapeutic experience. Further, this approach allowed scope for the participant to influence the direction of the interview and cover areas that might not have been probed, whilst also directly addressing the topics under investigation. The schedule was designed with the aim of exploring overall experiences of therapy as well as more specific aspects pertaining to the understood quality of the therapeutic relationship, aspects perceived as particularly helpful in assisting the change process, as well as those that were deemed unhelpful or detrimental to the therapeutic process.

Data Analysis
For the purposes of quantitative analysis, non-parametric measures were deemed most appropriate owing to the ordinal nature of the scales utilised as well as the fact that
some of the subscales were not normally distributed. Thus, the Wilcoxon Signed-Rank Test was utilised for repeated-measures analysis across the participants, and Mann-Whitney U Test was used for between group comparisons.

To expand, the mean scores for each of the SEDS subscales (separately and total scores) were calculated, as well as mean scores on the BDI and BAI. The data were then examined to check for assumptions of normality through inspection of the distribution of data (skewness and kurtosis) and comparing this to a normal distribution. Through this examination there were a number of subscales that did not meet normal distributional assumptions and, therefore, it was decided that non-parametric analyses be employed throughout.

Prior to being interviewed, the individual who had agreed to be consulted regarding her experiences of therapy was e-mailed a consent form outlining details of confidentiality regarding the material that she would provide (see Appendix V). This was signed and returned by post. There were six preliminary questions regarding demographic information. The main questionnaire consisted of fourteen open-ended questions focusing on: an exploration of this individual’s understanding of the therapy she had received; specific aspects associated with experiences of therapy including the therapeutic relationship, and particular areas of the therapeutic experience that may have been helpful and/or detrimental to the change process; and potential factors that may have been associated with maintaining changes and continuing progress once therapy had ended. The final question provided the opportunity to write about anything else that she felt to be important to discuss, which she felt had not been covered in the questionnaire. The questionnaire was initially e-mailed to the participant to provide time to consider the questions prior to our e-mail discussions. We ‘met’ on line a total of four times to discuss her experiences; this also provided the opportunity to probe issues further, and thus provided a greater depth of understanding of her experiences.

The interview data were analysed utilising interpretative phenomenological analysis (IPA) (Smith, 1996; Smith et al., 1997, 1999). IPA’s focus is two-fold; it stresses the individual’s perceptions of their subjective experiences whilst simultaneously
recognising the interactive nature of the investigator’s involvement in the data. IPA also recognises that research is a dynamic and interactive process and that access to the individual’s personal world is affected by the researcher’s own perceptions thus the importance of interpretation is made explicit. Finally IPA also lends itself particularly well to a case study approach to research (for example, see Osborne and Coyle, 2002; Riggs and Coyle, 2002).

The analysis began with a thorough reading and re-reading of the transcript of the e-mail discussions so as to become as intimate with the data as possible. With each reading points of interest, responses, summary statements and phrases were noted in the left-hand margin, regarding the individual’s experiences and understandings of therapy and the nature of her eating disorder. Through continued re-reading, emerging themes (i.e., key words that captured the fundamental quality of what was represented in the transcript) were noted in the right-hand margin. These were then produced on a separate sheet of paper to detect any connections between them. Some themes seemed to naturally cluster together and, through this process, a list of superordinate themes and subthemes was produced, and the connections between them checked again. Direct quotations from the interviewee’s responses were utilised where practicable so as to attempt to make the analysis as transparent and open to others’ evaluation as possible (see Appendix VI). The individual interviewed has been provided with a pseudonym to ensure confidentiality. In terms of quotations, information that has been added for clarification has been placed in brackets; three full stops indicate that information has been omitted; any words in italics were provided by the participant for emphasis and have been quoted as written.

**Results**

*Demographic information*

Of the 20 AN sufferers, the mean age of onset of eating disorder symptoms was 18.1 years (range = 12-43 years, $SD = 6.52$). The mean age at receiving therapy at the eating disorders service was 28.6 years (range = 18-51 years, $SD = 8.26$). The mean length of time between onset of eating disorder symptoms and therapeutic input from the eating disorders service was 10.5 years (range = 1-26 years, $SD = 7.61$). The mean number of sessions of therapy received was 21.65 (range = 12-35, $SD = 6.67$).
Of the 36 BN sufferers, the mean age of onset of eating disorder symptoms was 17.2 years (range = 9-34 years, $SD = 4.80$). The mean age at receiving therapy at the eating disorders service was 27.4 years (range = 18-39 years, $SD = 6.65$). The mean length of time between onset of eating disorder symptoms and therapeutic input from the eating disorder service was 10.2 years (range = 1-21 years, $SD = 6.37$). The mean number of sessions of therapy received was 17.3 (range = 11-34, $SD = 4.79$).

The individual interviewed regarding her experiences of the process of therapy was a 25 year old female, who explained that she had suffered from both AN and BN but believed that she had suffered AN more severely and thus focussed on her experiences of anorexia in greater depth. The onset of her eating disorder symptoms occurred at approximately the age of 14 when she became bulimic, after which she described herself as developing AN at the age of 17. She was diagnosed with AN at the age of 19. When asked the extent to which she had 'recovered' from eating disorder, she ticked ‘partially recovered’.

The quantitative results are divided into three parts to correspond with the research questions. Part 1 presents analysis of pre-post therapy outcome scores. Part 2 presents analysis of between group comparisons, considering whether there was any significant difference between the degree of change for AN versus BN. Part 3 considers post therapy scores to discover whether scores on the SEDS, BDI and BAI were not within the ‘normal’ population.

**Part 1 – Analysis of Outcome for both AN and BN**

Results of each of the subscales and total of SEDS as well as the BDI and BAI were analysed using Wilcoxon Signed-Rank Test to ascertain whether there was a significant difference between pre-post therapy scores across the 56 participants. It should be noted that all analyses have been subjected to a bonferroni correction (significant level <0.0045).

Table 1 shows the mean SEDS, BDI and BAI scores for the 56 participants at the two time points. Between the onset and end of treatment, there was significant
improvement in all subscales on the SEDS scales (both relating to eating disorders cognitions and behaviours and psychological characteristics associated with eating disorders), as well as significant improvement in both BDI and BAI scores ($p<.001$). Please be referred to Table 1 for all relevant $p$ and $z$ scores. Thus, the hypothesis can be accepted and null hypothesis rejected in that there was significant reduction on all subscales pre-post therapy.

Part 2 – Between Group Comparisons of Whether there was a Significantly Greater Degree of Change for AN or BN

For the purposes of this aspect of the analysis, the post-therapy scores were subtracted from the pre-therapy scores to create a new variable of ‘change’ so as to ascertain whether a significantly greater degree of change had occurred for AN or BN, or whether there was in fact no significant difference in level of change between the two groups. The Mann-Whitney U Test was utilised for all scales and subscales.

Table 2 shows the mean SEDS, BDI and BAI scores for 20 AN sufferers and 36 BN sufferers. The analysis revealed no significant differences between the level of improvement between the two groups on any of the SEDS subscales or on the BDI or BAI. Thus, the hypothesis can be rejected and null hypothesis accepted in that there was not significantly greater improvement for BN pre-post therapy.
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Table 1. Changes in eating disorder behaviors and cognitions, related characteristics, depression and anxiety across participants (N=56)
Part 3 – Bar Charts Showing Percentages of Participants Above Cutoff for Eating Disorder and Levels of Depression and Anxiety Post-Therapy

Figure 1 reveals a trend towards a greater improvement in eating disorder behaviour over cognitions (although not necessarily significantly greater). Further, although there was a general improvement for the group on three of the associated psychological subscales, there was a trend towards greater self-directed hostility.

Figure 2 reveals that the BN group, as a whole, had shown improvement on all subscales post-therapy. However, a high percentage remained above cut-off for both eating disorder and associated psychological difficulties.
Figure 2: Percentage of BN Sufferers Above Cutoff for Eating Disorder Pre-Post Therapy

Figure 3 and 4 reveal that, with regard to depression, many from both the AN and BN group reported ‘normal’ levels of depression on the BDI post-therapy. 50% of the AN group and 77.8% of the BN group reported moderate to severe depression pre-therapy which decreased to 25% for AN and 27.7% for BN post-therapy.

Figure 3: Percentage of AN Sufferers with Varying Degrees of Depression Pre-Post Therapy
Figures 5 and 6 also reveal lower levels of anxiety both within the AN and BN group when contrasting pre- and post therapy scores. 55% of the AN group reported moderate to severe levels of anxiety pre-therapy, which had reduced to 35% post-therapy. 72.2% of the BN group reported moderate to severe anxiety pre-therapy, which reduced to 25% post-therapy.
Figure 6: Percentages of BN Sufferers with Varying Degrees of Anxiety Pre-Post Therapy
**Case Study Analysis**

The case study analysis provided useful insights into one individual’s experience of the therapeutic process towards change, thereby highly some key aspects of the therapeutic endeavour for Abigail personally. Thus, the quantitative analysis provided some useful information regarding the general effectiveness of therapy as provided by this eating disorders service, whereas the qualitative analysis provided a more in-depth exploration of one individual’s experience of the process of change.

**The anorexic experience – towards understanding the inner turmoil of the anorexic world**

Through consideration of general processes and experiences that may have contributed to the onset of AN, Abigail identified physical and emotional abuse as fundamental factors that affected her significantly during her formative years. These traumatic experiences were exacerbated further by perceived lack of parental support in alleviating these distressing circumstances:

> Things that happened in my childhood, that’s where my hatred for myself came from. I had been badly bullied when I was in (boarding) school … It was alright for other kids, they could go home at the end of the day, but I was being bullied all day every day … I can’t describe how awful it was. I’d go to the toilet and cry every night. I went home for holidays and begged not to be sent back but they sent me back anyway. I didn’t understand. And then my housemistress started to hit me as well and that went on until I left school.

She continued by describing AN as a double-edged sword. Firstly, AN seemed a means of gaining control over one aspect of life when all else was perceived as chaotic and confusing. Secondly, she described AN as a form of self-punishment in the sense of not deserving of the fulfilment basic human needs, ie to eat to sustain one’s life. She reported:

> I suppose my anorexia was my escape from all that (abuse). It was the one thing in my life I could control when everything else was so awful. But as well I think it was about punishing myself for being such a horrible and hateful
person who didn’t deserve to eat ... I didn’t deserve to live, I didn’t deserve to eat, and I didn’t really deserve anything.

In addition, Abigail described AN as an expression of her intrapsychic conflict and psychological distress. It could be interpreted that she had been ineffectual in eliciting external support and, consequently, AN proved a way of expressing with her body what she was ineffective in expressing in words:

For me it (AN) was the only way I could express for myself the pain I was going through in my life. It was the only way I could get some control over everything that was going wrong in my life ... Anorexia gave me a way of getting rid of that pain. I could feel numb because I had to spend all my time thinking about not eating.

Retrospectively, Abigail provided insight into how terrifying an experience it was when in the throes of AN. She described feeling overwhelmed and consumed by self-hatred and self-destruction. This highly negative self-evaluation seemed to be one reason for rejecting professional help, as she appeared to be fearful of others judging her as negatively as she judged herself. As a result, she seemed to need to conceal her ‘awful’ true self from others:

I was frightened of anyone getting inside my head and knowing what a horrendously awful person I really was. I used to put on this pretence for the outside world that I was really ok, that I didn’t have any problems, but inside I felt I was dying and I was really terrified of myself.

When in the throes of AN, Abigail seemed to be dissociated from the negative effects of starvation. She seemed to be deceiving herself by physically managing, by ‘working hard and not getting bad grades’ at university. Thus, although she complied with her mother’s request to see the GP on return home, she described being shocked and surprised at her mother’s distress regarding her physical deterioration, explaining:
She burst into floods of tears and told me I was so skinny she didn’t know how I was standing upright. She was so upset and I couldn’t understand why.

Anyway, I agreed to go to a doctor, I suppose to please her.

The process of denial and negative associations with enforced treatment

The data suggested that Abigail was consumed with self-hatred and unable to express her fears. It seems that her eating disorder symptoms were positively self-reinforcing by ‘numbing’ unwanted affects. She experienced a sense of confusion at the disparity between her conceptualisation of her self-management and that of others. When confronted, she explained:

I didn’t think there was a problem and I certainly didn’t think I had a problem with eating ... When we got home (from GP) my mum made me a huge meal and said we were sitting at the table until I had finished it. It ended in a blazing row ... I couldn’t understand it. I didn’t know where to turn.

The data suggested that she was unable to appreciate the threat of starvation to her health, and was ultimately referred for inpatient treatment. She described an intense anger at being coerced into treatment, explaining this experience as ‘pure and utter hell ... I’ll always be angry that I was forced to go there ... I felt as though I was being punished’. This perception of treatment as ‘punishment’ seemed related to denial of personal choice, leading to a loss of the desperately needed ‘control’ she had attained through the process of starvation. She reported:

I felt so completely out of control. Everything felt so confusing and mad. I just didn’t understand what was happening to me. I hadn’t agreed to all this and all of a sudden there I am on what they called forced bed rest.

The account Abigail provided of her inpatient experience was one of isolation and fear, perceiving herself to have been unfairly treated. She described the treatment as one of weight restoration without exploration of the meaning of eating disorder symptoms. However, as she remained in denial of AN, it could be interpreted that she was resistant to professional support during hospitalisation which may have prevented
her from accessing the support she ultimately required. She commented that ‘they had all these groups and things but I felt too exposed and couldn’t talk. I just sat there silently and wanted to crawl into a corner’.

Abigail described the process of eating and associated weight gain as one of a means of ‘escape’. When reflecting on her inpatient experience she utilised the simile of feeling akin to a ‘prisoner’, that ‘it’s kind of like a prison sentence but there’s no justice because you’ve done nothing wrong – you’re innocent’. Once discharged it seemed that further professional support was rejected because of her negative associations with treatment and because she remained firmly embedded in AN. She commented:

I don’t think I was in a place (after hospitalisation) where I could accept any help – I didn’t think I had a problem. It was only later on that I started recognising things were getting difficult, and that’s when I made the decision to get some help.

The process of therapy – from recognition to the development towards change

The data suggested that the process of change was initiated by identification of the negative health consequences of prolonged starvation. The account Abigail provided suggested that she began to recognise the severity of her symptomatology through realisation of the extent to which AN was interfering with her life:

I was tired, my bones ached, I felt ill all the time, my hair was falling out, I had no friends, I wasn’t doing anything with my life except for exercising and not eating. When I was taking laxatives I couldn’t leave the house in case I needed the toilet.

It seemed necessary for her to hit rock bottom to develop a conceptualisation of AN as a problem rather than a solution to her difficulties. It seemed that this dawning realisation enabled her to elicit the support she needed to start battling the AN. She represented this by stating:
I think (after recognition of not coping) that’s when I was at my lowest and I realised I needed help. There’s no way I could do it (fight AN) on my own. I just couldn’t eat and didn’t know how to start. It was really scary.

Overall, Abigail described a multi-dimensional therapeutic approach (at the centre under study in this paper), that took into consideration current symptomatology, but also paid attention to the onset of her eating disorder, as well as underlying psychological factors that were maintaining her current behaviours. She explained:

We did look at what I was doing, like whether I was being sick or taking laxatives or whatever, but most the time we talked about how I was coping and how things that had happened in the past might have caused me to feel the way I was feeling about myself and the world I guess.

Abigail was clearly initially ambivalent about committing to therapy saying that ‘I didn’t know whether I wanted to get better or not’. A useful strategy pertaining to entertaining change seemed concerned with experimentation with change, of risking experiencing taking control of the AN through personal responsibility rather than being coerced to take this risk:

I thought I have to give this a go (changing eating behaviours) because I haven’t got anything to lose by at least trying. She (therapist) said that I could always have the choice to lose weight again afterwards, but that it was worth giving it a try.

The therapeutic process was described as a difficult and often frustrating endeavour. Through the development of self-awareness of the difficulties associated with suffering from AN, it seemed possible to work through the underlying meaning of her symptoms in that ‘anorexia and the laxatives stopped me from feeling and thinking, they stopped me from feeling the total messed up chaos I felt before I started starving myself’. Abigail described the importance to her of addressing the injustices of the abuse she had experience and, instead of blaming herself for others’ behaviour towards her, she learned to place responsibility externally. Furthermore, rather than
expecting miraculous changes overnight, it seemed that the therapist was effective in assisting the process of appreciation of small changes, thereby enabling gradual incremental progress:

I think it helped me to realise that she understood what I was going through and for me not to expect miracles. I think I was and still am a bit of a perfectionist and once I set my mind to something I’m going to go hell for leather to get there. I wasn’t allowed to be a perfectionist in this. I had to take things slowly step by step.

Therapy also adhered closely to the practical aspects of re-learning how to eat. From Abigail’s account, it seemed that the practicalities of eating ‘normally’ had become alien to her. Dietetic input seemed to assist in developing understanding about concepts such as portion size and calories required to maintain and increase weight, which was then utilised in therapy for working against the anorexic symptoms:

I had no idea what a plate of food looked like … I had no idea what it should consist of. I know exactly the calorie content of everything and I still do, but I couldn’t turn that around to be useful for fighting the anorexia.

The frustration associated with the process of re-learning to eat seemed associated with the concept that she was armed with knowledge regarding the importance of regular food intake but unable to utilise this in practice. The frustration and associated anger towards herself for her lack of ability to change was described as leading to self-harming behaviours as a means of managing these unwanted affects. Thus an important aspect of therapy, for Abigail, was to learn alternative means of releasing overwhelming tension:

Sometimes I was so angry with myself and didn’t know what to do with myself and started cutting myself. She told me it was something to do with my ways of coping and taught me other ways I could let out my aggression at myself, my anorexia and the whole world.
A final difficulty identified by Abigail as preventing recovery was associated with battling the ‘anorexic voice’. It seemed that she cognitively understood what was required for change to occur but, on an experiential level, the experience of an intensely critical inner voice proved especially difficult to contend with:

I was arguing in my head 24/7. I couldn’t sleep for the arguments – you must eat, you mustn’t eat, but you want to get better, but you mustn’t eat, you don’t need it, you don’t deserve it, you’re useless and a waste of space. I thought I was going really crazy.

The importance attributed to the development of supportive relationships
The analysis reflected Abigail’s perception that support both in therapy and the external environment were imperative in terms of her process of recovery. She gradually came to appreciate that she needed to let another into her chaotic inner world if she was going to make the changes necessary to recover from her eating disorder.

However, it seemed to prove difficult for her to accept this support initially. She described an inability to trust her therapist which seemed implicitly related to irrational beliefs concerning her therapist’s motivations – that she would be re-referred to an inpatient unit if she spoke candidly about her psychological distress: She reported:

I really thought I was going mad and that she would lock me up in a mental hospital if she knew what was really going on in my head. She saw the frustrated tears but it took ages for me to let her in.

However, the data suggested that, despite Abigail’s initial resistance, the therapist remained empathic and understanding, patiently waiting for Abigail to embrace therapy. This supportive and non-confrontational approach seemed to assist the process of developing trust:
I think she understood me much earlier than I gave her credit for. As I said, I wouldn’t even talk at the beginning, let alone let her help me. She stayed with me through all this and didn’t get frustrated or angry with me, and I think I gradually got to the point of trusting her enough to let her in.

Through interpretation, it seems that the therapist also appreciated the reality of the change process and imparted this knowledge to Abigail, thereby setting realistic goals and accepting that the process of change would be cyclical with relapse being a natural part of the process. This also seemed to assist in the development of trust in the therapeutic relationship – that there were realistic expectations of what could be achieved whilst not expecting immediate or long-lasting alterations in eating disorder behaviour:

She told me it was going to be a struggle and some days it would be easier to fight than others. She explained that I would have hiccups and would perhaps go back to my old ways but that she would be there to help me. I started to believe her that I might be able to change ... I wanted to change but I didn’t know whether I could.

Abigail provided an overview of insight into her experience of anorexia and the supported process of change. It seemed a terrifying place to be when in the throes of AN but, through the process of enabling others’ to understand her inner torment, they were then able to assist her through the arduous task of working towards recovery. As she described:

It was like I was at the bottom of a huge pit with snakes and spiders all crawling through my body, wanting to poison and kill me. The sides of the hole were smooth and however much I tried I couldn’t get a hand hold or a foot hold to start levering myself up and every time I did I got bitten by the spiders or strangled by the snakes. So eventually I gave up. My therapist and my mum came to understand this hold and started to try and find ways of getting down to me, to find me in this place and work on ways of helping me to get back up again.
Abigail described using the strength of trusted others’ in assisting her to break free from AN. It seemed that recognition of their support assisted in helping her believe she could escape from the ‘strangling hole’ (as she described her AN):

They were stronger than the spiders and snakes and they had pick axes to start making holes in the walls. Sometimes I’d fall right back down into the pit, sometimes I’d fall only a few notches. Every time I did they fell back down with me and pushed me up again from behind. I know it sounds rubbish but they saved my life.

The process of recovery – ongoing and never ending?
For Abigail, the anorexic identity had become so entrenched, reporting that ‘anorexia was so much part of who I was’ that it proved immensely difficult to contemplate who she might be without AN. Thus a useful strategy for her was the perception of AN as a separate object, enabling her to distance herself from AN sufficiently to struggle against a perceived entity rather than against herself:

She (therapist) said it was like I had a gargoyle on my shoulder with its claws stuck into my head and it was gripping on for dear life … She said that that was the anorexia, that it was something separate to me, and the arguments in my head were actually the battles between me and this gargoyle.

However, she reported that, although helpful, she perceived AN as too much a part of her identity to ever be entirely free of it. Instead, the objectification of AN as a separate being seems to have enabled her to remain in control of eating disorder symptoms:

I am better but I don’t think I’ll ever be fully recovered, whatever that means. I think I had it for too long. It’s in a way too much part of me. I think the gargoyle will always be sitting on my shoulder waiting for an opportunity to pounce, but I’ll try not to let his claws dig in again.
As a means of remaining on the road to recovery, it seems that self-monitoring has been useful for Abigail, to remain on track and not relapse. As a result she does appear to feel more in control of the anorexia despite the fact that it does retain a level of hold over her. This seems to be assisted by having a greater degree of self-awareness concerning potential relapse whilst simultaneously recognising AN as an Achilles heel:

I don’t think you ever really recover from anorexia completely. I think it’s always there in the back of your mind. I don’t hate myself so much anymore but sometimes I wake up and look in the mirror and see that fat person looking back at me and I can’t bear myself for the day.

Finally, through deliberation of her level of recovery, it seemed that she was still struggling to cope with a sense of uncertainty concerning becoming a potent adult in terms of being unsure about what role she may develop. She described a process of an attempt to make up for ‘lost time’ when in the throes of anorexia but there still remains a sense of lack of clarity about clear direction in her life. Thus, in a sense, her life remains on hold whilst attempting to make these existential decisions, which appears to cause her a degree of distress:

There’s still so much I haven’t achieved … I know I want a family. I know I want a career. But I don’t know quite what I want … Mum says that I have plenty of time, but I’ve wasted so much time already. I’ve spent so long anorexic and wasted so much of my life that I don’t want to waste anymore, but I just don’t know what I want to do. It makes me so stressed thinking about it too much so I’m kind of ticking along at the moment.
Discussion
The results of the current investigation suggest that people with both anorexia nervosa and bulimia nervosa can respond well to an integratively oriented outpatient based treatment. Overall, statistical analysis suggested a significant improvement in both anorexic and bulimic cognitions and behaviours, as explored through analysis of these subscales on the SEDS. Further, there appeared to be associated statistically significant improvements in psychological functioning, pertaining to greater levels of assertiveness, self-esteem, perceived external control and less self-directed hostility. From the analysis, it seemed that associated depression and anxiety were also effectively targeted, with statistically significant improvement across the group of fifty-six participants.

Although it was hypothesised that those suffering from bulimia nervosa would fare better than those suffering from anorexia nervosa owing to research suggesting that bulimia sufferers tend to respond better to treatment (Grange and Lock 2005), this did not appear to be the case among these participants. The results (in Table 2) suggest that both client groups responded equally well to this integratively oriented approach.

The data suggest that therapy has proved more effective in alleviating eating disorder behaviours than associated cognitive processes, with 75% of the AN group and 47.2% of the BN group scoring within the ‘normal population’ after exposure to therapy. For BN, these scores are comparative with those of other studies (as reported by Chen et al 2003). Interpretation of the data also suggests that associated psychological functioning was more effectively targeted with the AN than the BN group. This was highlighted in the account provided by Abigail in that she believed that, although she was now able to manage her eating disorder symptoms/behaviours more effectively, she believed that the AN was too much part of her identity and thus, psychologically, she could be said to remain having difficulties associated with anorexic cognitions.

Thus, although the data suggest that there has been statistically significant improvement in symptoms and associated psychological functioning for this group of eating disorder sufferers, a significant percentage remain in the eating disorder range after therapeutic input. Further, the results need to be considered cautiously as there
were no follow-up data available. It is currently not known whether improvements would continue between the end of therapy and follow-up, as is suggested to be the case with interpersonal psychotherapy (eg Agras et al 2000), or whether these participants would relapse and thus require further therapeutic input at a later stage. There would be concern for Abigail in relation to this, as she did not believe she had entirely overcome her eating disorder and could therefore be said to be at risk of relapse.

As a result, this should be regarded as an interim study with a view to extension to both one and five year follow-ups. Finally, consideration needs to be given to the fact that only 56 of those who received this form of outpatient treatment provided follow-up data at the end of therapy. It is unknown whether those who responded to treatment most favourably returned post-therapy questionnaires or whether these individuals were reflective of the general level of therapeutic effectiveness. Currently these questionnaires are posted to individuals on completion of therapy and, for the purposes of service development, it may prove beneficial to ask clients to fill out these forms prior to ending treatment, and incorporate them into the therapy itself, so that they are able to see for themselves their overall level of improvement. This would also provide the possibility of analysis of clinically significant change, through discussion as to whether the individuals themselves perceive the results to be reflective of their level of change. Further, the significant improvement but not complete recovery from psychological difficulties associated with eating disorders requires further consideration. Research is required to determine the optimum treatment length, in that is it effective to focus more extensively on these issues, once remittance of symptoms has been attained and maintained and, further, does this have an effect on longer-term recovery?

To expand further on the qualitative data, the case study analysis highlighted some important issues for this particular individual with regard to the effectiveness of therapeutic input for her personally, but that is also reflected in the available literature regarding individuals’ experiences of treatment for anorexia nervosa in particular. Her experiences reflected the often discussed ego-syntonic nature of anorexia and associated resistance to treatment. This ‘resistance’ has been described by therapists as
especially problematic and difficult to overcome (eg Fleming, 2005). It appeared that, for Abigail, she only entered the health care system at the instigation of others, owing to lack of recognition of the physical and psychological effects of starvation. Weaver et al. (2005) highlighted this as problematic in their research into attempting to understand the process of recovery from AN. This resistance to change and lack of recognition of AN as a problem may be an underlying cause of Abigail’s negative account of her experiences of inpatient treatment. Further, in Abigail’s case, it seems that the therapist both recognised and accepted her ambivalence to change, providing sufficient time to work through this before focusing more intensively on her eating disorder pathology. This seemed to assist her in developing the therapeutic relationship with regard to an experience of a therapist who was perceived as understanding, caring and knowledgeable. This understanding and supportive stance has been highlighted as an important facet of therapy by previous researchers (Keski-Rahkonen and Tozzi, 2005).

Despite the fact that Abigail became motivated to change and overcome her eating disorder, this was not a straightforward process and was described as an often difficult and frustrating endeavour. In Keski-Rahkonen and Tozzi’s (2005) study, they also found that the journey towards recovery incited strong emotions. For Abigail, it seemed that these difficulties were primarily related to the strength of the developed anorexic identity, in terms of not knowing who she was or could potentially be without anorexia. This was highlighted in Weaver et al.’s, (2005) study as an important aspect of the recovery process, in terms of the development of a non-anorexic identity and was described as ‘encountering the self’. In terms of the theory of self-development elaborated as a result of that research, Abigail would be described as being within the stage of ‘informed self-care’, managing the AN symptoms through the processes of ‘normalising eating’ and ‘self-monitoring’. However, the assumption of this model is that true recovery is only possible when individuals reach the stage of ‘celebrating myself’ in which they have truly ‘moved on’ from anorexia in terms of becoming ‘happy with herself and knowledgeable about how best to meet her needs in situations and relationships’ (p199).
In terms of future directions for treatment research, it seems that the present study has highlighted a number of issues that require further development. It seems that there is a substantial divide between research into treatments and the therapy provided in the clinical setting. It seems that the development of manualised treatments needs to be extended to incorporate co-morbidity factors and needs to be more flexible so as to incorporate underlying issues that may be the focus of therapy. Additionally, it seems important to develop research concerning the process of therapy from the perspectives of both clinicians and clients, so as to attempt to discover what factors may be indicative of change. Finally, the study by Weaver et al. (2005) provides a coherent theoretical perspective on the journey towards recovery, and further research into individuals’ subjective experiences of the therapeutic process could be used to examine this theory further, both with AN and BN sufferers.

Reflections on the use of self

For many years I have found myself frustrated and angered by the apparent lack of serious attention being given to eating disorders, especially anorexia nervosa considering the seriousness of the condition. Not only have I found myself wondering why professionals are apparently so loathe to work with these client groups but, more importantly, why there is such limited research pertaining to what may be effective in assisting individuals in overcoming these conditions. When scouring the literature after deciding to undertake this particular piece of research I was again, in turn, astounded and then outraged concerning the apparent lack of available information. My interest in these conditions stems back twenty years, when ‘treatment’ seemed primarily concerned with strict inpatient behavioural programmes. Although there have been developments in theoretical understanding, I found myself wondering how much progress had actually been made in terms of treatment approaches.

Once I started working at a specialist eating disorders unit, I felt it was an ideal opportunity to turn this frustration into action – there is so little published research pertaining to health service provision for these client groups, this seemed an even more worthwhile endeavour. Further, although the eating disorders service has a strong research commitment, it was proving exceptionally difficult to get these projects under way. All the therapists are under pressure to reduce the waiting lists as
quickly as possible, and to work therapeutically with the individuals referred. I know that I often felt exhausted because of working with individual clients, arranging for referrals when necessary, setting up and running groups (without guidance from the literature as to what may be most useful), attending meetings regarding care plans, and conducting assessments. Not only was the manager continually battling with the health authority to maintain funding, outcome research was also supposed to be on the agenda.

Personally this research endeavour did prove to be a daunting prospect, because I was ultimately analysing the effectiveness of therapists’ work in treating those with eating disorders. On occasion I found it difficult to remain objective both because I had worked at the service and I knew everyone who worked there personally. I found myself wanting to show the service in a good light and did not want to criticise the hard work of the therapists who work there. In this respect, supervision proved particularly important in the process of writing up, so as to develop as honest and accurate interpretation of the data as possible.

I had additional doubts concerning my abilities to develop a quantitative piece of research at doctoral level. I had not utilised SPSS in a research project prior to this as, at undergraduate level, we were required to learn Minitab, and thus many of us completed research and examinations in statistics with the use of a calculator and tables instead. As a result, although I had completed a quantitative research methods course and practised using SPSS within this, I found a significant divide between utilising the programme at a theoretical as compared with practical level. However, getting to grips with this and utilising SPSS within this research proved a personal achievement.

I found the case study to be especially challenging and I grappled with the paradox of being a therapist, on the one hand, and carrying out an interview for research on the other. As a therapist, the relationship between myself and my client is paramount, within which we will work together to make developments towards change. Having worked with eating disorder sufferers, I have learned the overarching importance of
developing a trusting therapeutic relationship, and how relapse can be part of the therapeutic process.

Conducting an interview for research was far removed from my experience of conducting therapy. Not only was it necessary for me to be more directive than I would normally, I was also conducting the interview via email, which reminded me just how much we rely on body language and the minutiae of communication in interaction with others'. I found myself continually wondering how ‘Abigail’ was responding to my questions, and whether any of the interview was causing her distress. I found myself amazed at the open and in-depth narrative she provided regarding some extremely sensitive issues. Throughout the analytic process, I wanted to do justice to her account. Initially, I was unsure as to whether to incorporate her experience of inpatient treatment, as this research was concerned with outpatient therapy. However, within my own therapeutic experience, I often encountered individuals struggling to manage their negative affects associated with this enforced treatment. I decided to include it both because ‘Abigail’ had chosen to disclose sensitive information regarding this experience, and because it seemed to reflect others’ experience of this form of treatment.

At the end of the interview, I found it exceptionally difficult to simply walk away, especially because ‘Abigail’ seemed to still be struggling to manage her eating disorder. I was unable to intervene in an explicitly therapeutic manner and could not provide any intervention to assist her toward further recovery. I did end by pointing her in the direction of some potentially useful literature, in a way to give her something back.

Thus, although challenging, this study was particularly regarding both on a personal and professional level. The results of the statistical analysis in particular will hopefully be useful to this eating disorders service and will assist the manager in retaining the funding necessary to develop the service further. However, as with the majority of the available published research, this study also points to the need for further clarification, with the ultimate question still to be answered – what constitutes an effective therapeutic approach to working with eating disorders sufferers?
REFERENCES


Orbach S. 1982. *Fat is a Feminist Issue.* Arrow Books: London


Striegel-Moore RH. 2005. Health services research in anorexia nervosa. *International Journal of Eating Disorders* 37, S31-S34


18 October 2000

Ms Caroline Fleming
Tallinn, Estonia
Surrey GU2 7XH, UK
Telephone +44 (0)1483 300800
Facsimile +44 (0)1483 873811

Dear Ms Fleming

An evaluative study to discover whether the use of cognitive-behaviour therapy is beneficial in the outpatient treatment of anorexia nervosa and bulimia nervosa sufferers (ACE/2000/64/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and the subsequent information supplied and has approved it on the understanding that the Ethics Guidelines are observed.

The letter of approval relates only to the study specified in your research protocol (ACE/2000/64/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected (with reasons). I enclose a copy of the Ethics Guidelines for your information.

Date of approval by the Advisory Committee on Ethics: 18 October 2000
Date of expiry of Advisory Committee on Ethics approval: 17 October 2005

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Professor L J King, Chairman, ACE
    Dr Adrian Coyle, Co-Investigator, Dept of Psychology
Diagnostic Criteria for F50.0 Anorexia Nervosa

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

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

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

D. In postmenarcheal females, amenorrhea, ie, the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, eg oestrogen, administration.)

Specify type:

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

Binge-eating/Purging type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour (ie self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Relationship to ICD-10 Diagnostic Criteria for Research

The ICD-10 Diagnostic Criteria for Research and the DSM-IV criteria for Anorexia Nervosa differ in several ways. ICD-10 specifically requires that the weight loss be self-induced by the avoidance of ‘fattening foods’ and that in men there be a loss of sexual interest and potency (corresponding to amenorrhea in women). Finally, in
contrast to DSM-IV, which gives Anorexia Nervosa precedence over Bulimia Nervosa, ICD-10 excludes a diagnosis of Anorexia Nervosa if regular binge eating has been present.

**Diagnostic Criteria for F50.2 Bulimia Nervosa**

A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
   (1) eating, in a discrete period of time (eg within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
   (2) a sense of lack of control over eating during the episode (eg a feeling that one cannot stop eating or control what or how much one is eating)

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

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

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

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

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

**Non-purging type:** during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas

**Relationship to ICD-10 Diagnostic Criteria for Research**

The ICD-10 Diagnostic Criteria for Research and the DSM-IV criteria are almost the same except for the relationship between Anorexia Nervosa and Bulimia Nervosa. In contrast the DSM-IV, which excludes a diagnosis of Bulimia Nervosa if the behaviour occurs exclusively during the course of Anorexia Nervosa, ICD-10 excludes a diagnosis of Anorexia Nervosa if regular binge eating has been present.
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
APPENDIX III

LETTER OF INVITATION

Date

Name
Address

Dear

I am currently in the final year of training for my practitioner doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. During the course of my training I have developed a particular interest in eating disorders and worked for the Eating Disorders Service.

Through my reading and experience in this field it has become increasingly evident that more research into eating disorders is needed, especially with regard to individuals’ experiences and perceptions of the therapy they have received. I believe this to be an exceptionally important area of research as it could help promote understanding of the benefits and problems associated with therapy for individuals with eating disorders. Through discussion with (service manager), we thought that it would be very beneficial to evaluate the individual therapy offered at the Eating Disorders Service. The purpose of this will be to consider your experiences of therapy, as well as taking a more general look at the effectiveness of the outpatient therapy programme.

I recognise that you have little or no contact with the service now, but I would be extremely grateful if you would consent to take part in this important research. In terms of your participation, it would involve an interview that would last approximately an hour, which would take place at your convenience.
The interview would be audio-taped so as to ensure that all the information and insights you provide can be included in the analysis.

I would also like to assure you that all information provided would be confidential. In other words, all personal information including your name, the names of anyone you mention in the interview, specific dates and addresses of places you may talk about, all would be changed so that there is no way you could be identified. Also, all audio-tapes would be destroyed after they have been transcribed by me personally and you are welcome to look through the transcript after the interview, to ensure that all the information you have provided is a true record of what you have said. Although some of your responses would possibly be reproduced in the final report, it would be ensured that you would be in no way identifiable.

If you are interested in taking part please could you fill in the form provided and return it to me in the stamped addressed envelope provided. Alternatively, if you would like more information or would like to discuss any aspects of the research before agreeing to participate, you would contact me via the address at the top of this letter. Finally, summaries of the research findings will be compiled at the end of the project and these will be sent to you when they are available.

Thanking you in anticipation.

Yours sincerely

Caroline Fleming
Counselling Psychologist in Training
I would/would not like to be interviewed concerning my experiences of therapy at the Eating Disorders Service.

Name: .......................

Address: ......................

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

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

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

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

Telephone Number: ............................

Thank you
APPENDIX IV

E-MAIL INTERVIEW SCHEDULE

Introduction

My research is concerned with exploring how individuals who suffer, or have suffered, from eating disorders feel about the treatment they have received. The main focus of this questionnaire is to explore your experiences of the therapy you have received and a little about whether you think this has helped you in overcoming your eating disorder.

The preliminary questions only require fairly brief answers. These answers will allow me to describe the range of people who took part in my study, which is important in this type of research. However, I will not report your answers to these or any other questions in ways which might infringe your confidentiality. The questions in Sections 1, 2 and 3 call for longer answers so you might decide to write your answers over several sessions rather than trying to respond to all the questions at one sitting. Remember that what you write will be very important: people with eating disorders are seldom asked to reflect on their treatment in this way so it would be great if you could answer as fully as you can.

If you have any questions or queries about any areas of the questionnaire, please do not hesitate to contact me by email on cpbryants@aol.com.

Preliminary questions

1. How old are you now?

2. Do you/did you suffer from anorexia, bulimia or both anorexia and bulimia?

3. How old were you when your eating disorder symptoms started?
4. How old were you when you were diagnosed with an eating disorder?

5. To what extent do you think you have recovered from your eating disorder?
   (please tick one of the following)
   - completely recovered
   - partially recovered
   - about the same as before therapy
   - worse than before therapy

6. Please could you provide a short outline of the overall ‘treatment’ you have received for your eating disorder.

   

Section 1

In the first part of the questionnaire I would like to explore with you your understanding of the therapy you received.

1. Before starting therapy, did you read anything about your eating disorder?

   (If so) Did you find any of this information useful to you?
   (If not) Looking back, do you think that any information would have been useful to you at this stage?
2a. Looking more specifically at your therapy, could you please tell me a little about what it involved?

2b. Some people start working in the present and consider eating difficulties first, whereas other look at more general issues before moving onto working on their eating disorder symptoms, whereas others work on both symptoms and underlying difficulties at the same time. Can you say a little about how you worked through your difficulties?

3. Now looking at your individual sessions, could you describe what generally happened during appointments with your therapist?

(Were there specific aspects or problems you worked on? Who decided (you or your therapist) what you were going to be working on?)

4. Were there any specific factors that you worked through with your therapists, that were especially helpful in overcoming your eating difficulties, such as working on issues related to anxiety, depression, your symptoms, problems in relationships, difficulties from childhood, or any others?
5. On the other hand, when working through your difficulties, were there certain areas that were concentrated on, that you found were unhelpful or even detrimental to you working through and overcoming your problems?

6. Do you think there were any factors or people, outside of therapy, that helped you in working through your difficulties?
   (If so) Can you tell me how influential these factors/people were?
   (If not) Looking back, do you think that any support or help outside of therapy would have been beneficial for you?

Section 2

We have looked in some depth at your therapy in general, both in terms of the individual sessions and the overall process of therapy. I would now like to explore with you specific aspects of your experiences of therapy.

1. If you can think of any, were there any specific moments in therapy that you found especially helpful in working through your difficulties?
2. On the other hand, did any particular events happen in your therapy that were especially unhelpful or detrimental, and you feel prevented you from making progress?
(If so) were you able to talk to your therapist about how this/these were unhelpful? What do you think may have been more helpful?

3. And now, looking at your relationship with your therapist. Could you say a little about what that was like?

4. How would you describe your therapist?
   Do you think he/she understood your problems?
   And do you think he/she was understanding of you as a person?
   What effect, if any, did this have on your therapy?

5. And now, looking back at your therapy as a whole. What would you say helped you most in terms of your level of recovery from anorexia/bulimia?
   For example: was it to do with certain techniques or strategies? Was it learning specific skills about how to cope? Was it something to do with your therapist? Something else?
6. Again, looking back at your therapy as a whole, were there any aspects that you think prevented you from recovering more quickly?

Section 3

Finally, I would like to ask a couple of questions about how you have coped since your therapy ended.

1. Do you think you have maintained any changes made during therapy, or have you had difficulty staying on track?
   (If so) What or who has helped you maintain your recovery?
   (If not) What do you think would be most useful to you, in terms of staying on track with your eating?

2. And finally, looking back at when you completed therapy and how you are now, could you tell me a little about how you have been coping?
   Is there anything else you think you have needed during this time?
Conclusion

Thank you very much for taking the time to fill in these questions.

Is there anything else you would like to add or anything you think has been missed in this questionnaire, that you think it is important to discuss?

[Blank space]

Thank you.

These questions provided the basis for discussion and were based on a semi-structured interview schedule for an alternative face-to-face discussion. Each of the questions were probed more fully through interview via e-mail and the full transcript can be viewed in appendix VI.
APPENDIX 5

CONSENT FORM

The aims of this research are to explore your experiences of therapy and to attempt to discover, with you, the impact that both your therapy and possible other support (from family, friends, social networks) may have had in assisting you in the process of battling against your eating disorder. This research also aims to consider your experiences and perceptions of the development of your eating disorder and the process of battling against your condition.

In terms of your participation in this research, you will be asked to take part in an informal interview concerning your views and perceptions of therapy. This interview will take place at your convenience, and you can choose whether we meet for a face-to-face discussion, whether we have a telephone interview (which will be audio-taped), or whether we discuss your experiences via an e-mailed questionnaire. I would like to assure you that all information provided would be confidential. In other words, all personal information including your name, specific dates and addresses of places you may talk about, all would be changed so that there is no way that you could be identified. If you choose to be interviewed face-to-face or by telephone, the audio-tape would be destroyed after if has been transcribed by me personally and you are welcome to look through the transcript after the interview, to ensure that all the information you have provided is a true record of what you have said.

If you have any questions or would like any further information about the research before we proceed, please do not hesitate to discuss these with me before consenting to participate.

Please read the following paragraph and, if you are in agreement, sign where I have indicated.
I agree that the purposes of this research and what my participation would entail have been clearly explained to me in a way I understand. I therefore agree to be interviewed concerning my experiences of eating disorder and the therapy I have received. I also consent to the interview being audio-taped and that all of this recording can be transcribed for the purposes of the research only.

Name: ____________________ Signature: ____________________ Date: ________

On behalf of those involved in this research, I undertake that confidentiality will be ensured throughout the research, and that the audio-tapes and transcripts will be protected and for the purposes of the research only. It will also be ensured that anonymity of the participant will be protected throughout.

Name: ____________________ Signature: ____________________ Date: ________
APPENDIX VI

INTERVIEW TRANSCRIPT

Introduction

My research is concerned with exploring how individuals who suffer, or have suffered, from eating disorders feel about the treatment they have received. The main focus of this questionnaire is to explore your experiences of the therapy you have received and a little about whether you think this has helped you in overcoming your eating disorder.

The preliminary questions only require fairly brief answers. These answers will allow me to describe the range of people who took part in my study, which is important in this type of research. However, I will not report your answers to these or any other questions in ways which might infringe your confidentiality. The questions in Sections 1, 2 and 3 call for longer answers so you might decide to write your answers over several sessions rather than trying to respond to all the questions at one sitting. Remember that what you write will be very important: people with eating disorders are seldom asked to reflect on their treatment in this way so it would be great if you could answer as fully as you can.

If you have any questions or queries about any areas of the questionnaire, please do not hesitate to contact me by email on cpbryants@aol.com.

Preliminary questions

1. How old are you?  25

2. Do you/did you suffer from anorexia, bulimia or both anorexia and bulimia?
I had both anorexia and bulimia, but I had anorexia more severely

3. How old were you when your eating disorder symptoms started?

14ish – I can’t quite remember but that’s when I think I became more bulimic. I then started losing weight when I was about 17ish

4. How old were you when you were diagnosed with an eating disorder? 19

5. To what extent do you think you have recovered from your eating disorder?
(please tick one of the following):

   completely recovered
   partially recovered   XXX
   about the same as before therapy
   worse than before therapy

6. Please could you provide a short outline of the overall ‘treatment’ you have received for your eating disorder

You could say I’ve had 2 ‘treatments’. The first happened when I was 19. I had lost so much weight at the start of university that I was chucked into hospital. They said I had a BMI of 11 but I didn’t understand what that meant. Eventually I gained a load of weight and was let out again.

The second treatment happened when I was 22. After I’d left hospital they did offer me to go and see someone about my eating disorder but I guess I couldn’t accept that I had a problem at the time so went to see someone twice and then just stopped going so they discharged me. When I was 22 I collapsed in the street when I was out with a friend. They were terrified and my mum was really upset so I said I’d go and see my doctor. He referred me to an ‘eating disorders specialist’. At first I didn’t want to go
but my mum was so stressed out and I felt so guilty that I agreed to see a therapist. She said that we would look at what might have happened in my past that caused me to stop eating, but that we would also be looking at my 'symptoms' and try and work on those as well. She weighed me every week which was hard, but I thought I had to accept it.

I'm not sure which you want to concentrate on.

(Interviewer) You mentioned that you had two treatments, firstly as an inpatient and then as an outpatient. It would be useful to get a little bit of an overview of what it was like for you as an inpatient first, if you don't mind, and then we'll concentrate more on your experiences of being an outpatient.

(Abigail) OK. Being in hospital for pure and utter hell. I hated every second of it and I think I'll always be angry that I was forced to go in there. I now know that I was very ill at the time and very underweight, but I felt as though I was being punished. I didn't think I had a problem you see. I didn't think there was anything wrong with me. I was at university, I was away from home, I was working hard and not getting bad grades. I can't really remember what happened that landed me in there. I went home from uni one holiday and my mum told me she was really worried about me – actually she burst into floods of tears and told me I was so skinny she didn't know how I was standing upright. She was so upset and I couldn't understand why. Anyway I agreed to go to the doctor, I suppose to please her, and he weighed me. He said that if I didn't start eating I would end up in hospital. BUT I didn't think there was a problem and I certainly didn't think I had a problem with eating. I was fine. When we got home my mum made me a huge meal and said we were sitting at the table until I had finished it. It ended in a blazing row and I ran out to a friend's house. She also told me I had a problem. I couldn't understand it. I didn't know where to turn. So I went back home again. Anyway, after a month of rows and crying and, I guess, me throwing childish tantrums, the doctor referred me to an inpatient unit as an emergency. They took me in straight away.
I felt so completely out of control. Everything felt confusing and mad. I just didn't understand what was happening to me. I hadn't agreed to all of this and all of a sudden there I am on what they called 'forced bed rest'. I wasn't even allowed to walk around the ward and talk to other people. I just had nurses watching me the whole time – or at least that was how it felt. I can't even remember how long I was there. It was just one long nightmare of being forced to eat really disgusting really fatty food.

At the beginning I couldn't eat at all. I just wanted to get out of there. Eventually I got talking to one of the girls who had been there for ages. She said that they only way you could escape the hell hole was to eat your way out. I can't really explain. I can't really remember. I think I've blocked it all out. BUT after a while I took her advice. They said that they would be prepared to force feed me if I didn't start eating, so I started eating. It was so disgusting, I can't tell you. I was terrified of everything and had no one to talk to. And nobody seemed to care. It felt like you were there to be a fattened calf and whatever happened that's what you were going to be. The weighing as well was just a nightmare. You weren't allowed to see your own weight and so I had no control over gaining the weight. I just had no control. So I ate my way out of there. After a few months I escaped – well I was let out – and my weight was up. But I hadn't spoken about anything. They had all these groups and things but I felt too exposed and couldn't talk. I just sat there silently and wanted to crawl into a corner. I don't remember much about that. But, looking back, it's weird that nobody wanted to know why I didn't want to eat. Isn't that their job? Reading this back, it's kind of like a prison sentence but there's no justice because you've done nothing wrong – you're innocent.

(interviewer) It sounds as though you had a very negative first experience of professional help, and that you felt unsupported and kind of being punished but not knowing why. Perhaps this was why you decided not to continue with a therapist when you came out of hospital?

(Abigail) Yeah, I think so, and also I'd just had enough. I don't think I was in a place where I could accept any help – I didn't think I had a problem. It was only later on
that I started recognising things were getting difficult, and that's when I made the decision to get some help.

(interviewer) Can you tell me a little of what happened?

(Abigail) I hadn't been able to go back to university and so was still living at home. I started taking laxatives and throwing up after eating. I know now that I was trying to please my mum and prevent myself from being sent back to hospital and she was watching me like a hawk with what I was eating when I was eating it. And I started feeling really sick. And then my mum found the laxatives and that caused another blazing row. And then I really started to try and stop taking them. I really did. And I couldn't. And I think that's when I realised there was a problem. I think I started to realise that I wasn't coping at all well. I sat down with my mum and just cried and cried. I couldn't stop crying. I told her everything I had been doing and she told me she already knew but she didn't know what to do. I think I'd got myself really stuck. I couldn't believe my mum was being so nice to me after everything I'd put her through. I didn't deserve it. I think that's when I was at my lowest and I realised I needed help. There's no way I could do it on my own. I just couldn't eat and didn't know how to start. It was really scary.

(interviewer) It sounds terrifying.

Section 1

In the first part of the questionnaire I would like to explore with you your understanding of the therapy you received.

1. Before starting therapy, did you read anything about your eating disorder?
   (if so) Did you find any of this information useful to you?
   (if not) Looking back, do you think that any information would have been useful to you at this stage?
(Abigail) I didn’t read anything to start with. I didn’t know I had an eating disorder. Them my mum and dad were out one night and I was wandering around the house and I found a book called Catherine, I know it was written by her mum but I can’t remember her name. I started reading it and it was awful. She could have been writing about me. It was all about Catherine’s anorexia and all the times she went into hospital and then tried to eat and get on with her life and then couldn’t and lost weight again. In the end she died. I found that book really traumatic.

I don’t think anything would have been helpful at the beginning. As I’ve said, I didn’t think I had a problem so I wouldn’t have read anything anyway. I think my therapist would have said I was ‘avoiding the issue’.

2a.Looking more specifically at your therapy, could you please tell me a little about what it involved?

(Abigail) I was my therapist every week for the first 1½ years and then cut back to every two weeks to I saw her for 2 years in the end. What do you mean, what it involved?

(interviewer) Perhaps a little about whether there was a particular way your sessions were organised, whether you were weighed, perhaps the types of things you spoke about or worked on.

(Abigail) I was weighed every time I saw her, at the start of the session. That was really hard, especially at first because I hadn’t let anyone see my weight for years. She explained that she needed to know my weight to make sure I wasn’t losing any. At the beginning I remember I argued with her about it every time and I have no idea how she always managed to get me on the scales.

She’d always start by asking me how I’d been over the week and if I had any problems I wanted to talk about. She’d always talk about it if my weight had gone down. It’s a bit difficult to remember exactly what happened. We did look at what I was doing, like whether I was being sick or taking laxatives or whatever, but most the
time we talked about how I was coping and how things that had happened in the past might have caused me to feel that way I was feeling about myself and the world I guess. I was so down on myself and hated myself so much I felt guilty all the time. It was really hard to talk and it took a long time before I could really start opening up. I guess I’ve always been a private person and kept things inside and bottled up and hidden. I guess that was part of the problem. And it was really hard to start talking about all the made things that were going on in my head. But she gradually got me talking and I have no idea how.

2b. Some people start working in the present and consider eating difficulties first, whereas others look at more general issues before moving onto working on their eating disorder symptoms, whereas others work on both symptoms and underlying difficulties at the same time. Can you say a little about how your worked through your difficulties?

(Abigail) I think like I’ve said, we worked on both things together. She said that we couldn’t just ignore the fact that I wasn’t eating and doing the other stuff as well. So yeah, I remember she told me that we needed to look at both things together because when I started talking about the mental things in my head my eating could go down and she needed to stop that happening. So yeah. We spent some of the time looking at my symptoms and ways to gradually start increasing the amount I ate so that I would put on weight very gradually. I didn’t believe her at first. I thought I was going to pile on the pounds the second I ate that first biscuit and it made me really scared. I didn’t put on any weight for ages but did just about manage to keep my weight at one level for quite a long time. The rest of the time we talked about the past and how that may affect that way I feel about myself. I know I was better at talking about the eating than talking about the other stuff. I was scared you see.

(interviewer) Do you mind me asking what you were scared of?

(Abigail) OK. I was scared that I was going to fall apart. I was scared that if you took away the eating, well not eating, I would fall to bit. I learnt it was all about control you see. The anorexia and the laxatives and the throwing up stopped me from
thinking and feeling, they stopped me from feeling that total messed up chaos I felt before I started starving myself. She helped me realise that the anorexia was now controlling me and that I could take back that control by controlling the anorexia. I don’t know if it makes sense, but that’s what I kind of understood from it. It did make sense to me but it’s difficult to put into words.

(interviewer) So much of your therapy was concerned with taking back control over the eating disorder and therefore gaining some semblance of control over your life? That, perhaps, through gaining control of your eating disorder, you could gradually start claiming back control over your life?

(Abigail) Yeah I think it was something like that, but it wasn’t smooth. I had loads of ups and downs and kept just wanting to give up but my therapist kept me going. She also brought my mum in a couple of times so that she could help me better with the eating at home. I tried but I couldn’t ask her myself and so my therapist agreed to help me to ask her.

3. Now looking at your individual sessions, could you describe what generally happened during appointments with your therapist?

(Where there specific aspects or problems you worked on? Who decided (you or your therapist) what you were going to be working on?)

(Abigail) Mostly it was about how I felt about myself and how I had got so low in the first place and how the anorexia can be about coping with feeling so bad about yourself. We did a lot of stuff around that. I guess, looking back, but I can’t be sure about this, my therapist suggested problems that I had which she had found out about through talking and then asked if I agreed. If I did agree that’s what we would look at. Sometimes we ended up looking at things that weren’t at all important because I didn’t know how to say she was wrong. That was quite funny really. We’d end up going on these wild tangents because I suppose I didn’t have the belief in myself to say something if someone else had got something wrong. So we’d end up talking about basically nonsense for a couple of weeks. That was more in the first year I
think. I think she eventually called me something like a people pleaser and I'd do anything to make someone else feel better about themselves and it didn’t matter if that had nothing to do with how I was feeling. That’s right – I didn’t feel I deserved the right to have needs and so I had to look after everyone else’s needs instead. It was quite astonishing the number of times she picked that up. She made me face myself for the first time.

(interviewer) So you worked a great deal on your self-esteem and, I imagine related to that, your self-worth, having the right to have your own needs met as well as meeting the needs of others?

(Abigail) Yeah and as I think I’ve said, we worked a lot on my eating. You see I had no idea what a plate of food looked like. I’d spent so many years avoiding plates of food that I had no clue how to start preparing a meal for myself. I had no idea what it should consist of. I knew exactly the calorie content of everything and I still do, but I couldn’t turn that around to be useful for fighting the anorexia.

(interviewer) How did you go about that?

(Abigail) She actually sent me to see a dietician for a couple of sessions and that was really useful. She explained a lot about what our bodies need to keep going, how much to put on weight, how much to maintain weight, what size portions I should be aiming towards, things like that. That was really helpful. It was very frustrating though actually. I knew what I needed to do, I knew what my plates of food should look like, I knew that I had to start eating more, but I just couldn’t do it. It was so frustrating and I got more angry with myself than I’ve ever been in my life. I was arguing in my head 24/7. I couldn’t sleep for the arguments – you must eat, you mustn’t eat, but you want to get better, but you mustn’t eat, you don’t need it, you don’t deserve it, you’re useless and a waste of space. I thought I was going really crazy.

(interviewer) Did you talk about this with your therapist?
(Abigail) Eventually. You see I really thought I was going mad and that she would lock me up in a mental hospital if she knew what was really going on in my head. She saw the frustrated tears but it took ages for me to let her in to what was going on in my head. I did let her in there eventually though.

(interviewer) Can you remember her response?

(Abigail) Yeah, it was really quite amazing actually. It's taking me a while to think of it. Yeah, she said it was like I had a gargoyle on my shoulder with it's claws stuck into my head and it was gripping on for dear life. I had to imagine it was the most disgusting and hideous creature imaginable. She told me that that was the anorexia, that it was something separate to me, and the arguments in my head were actually the battles between me and this gargoyle. For the rest of therapy we talked about the anorexia in this way. You know, it really helped to separate it off. At first I couldn't see it as something separate from me because it was so much a part of who I was. I didn't know who I was if I wasn't anorexic anymore. But we worked really hard at looking at what was anorexic thinking and what was my thinking. Yeah that was really huge.

4. Were there any specific factors that you worked through with your therapist, that were especially helpful in overcoming your eating difficulties, such as working on issues related to anxiety, depression, your symptoms, problems in relationships, difficulties from childhood, or any others?

(Abigail) I think I have to say that, at first, I couldn't work on anything. I feel really sorry for my therapist looking back at it. It wasn't really ready to start working on anything, I suppose I was still more in denial about having any problems. She worked really hard on making me see that I had anorexia and what that meant. She gave me a book called Anorexics on Anorexia and I wouldn't read it for ages, it just sat there gathering dust in my room. But I did eventually read it and I think that's when I started opening up more. I could see that I was really quite like them.
I guess then we worked on all those things you’ve mentioned, particularly things that had happened in my childhood, that that’s where my hatred for myself came from. I had been badly bullied when I was in school. I was in boarding school for a few years and I was bullied from day one. It was alright for other kids, they could go home at the end of the day, but I was being bullied all day every day. There were 2 girls in particular, who were of course the most popular in the year. They were both in my room and they decided they wouldn’t talk to me which meant that the rest of the room wouldn’t talk to me either. That went on for a year. I can’t describe how awful it was. I’d go to the toilet and cry every night. I went home for holidays and begged not to be sent back but they sent me back anyway. I didn’t understand. And then my housemistress started to hit me as well and that went on until I left school. My therapist helped me to understand that it wasn’t my fault, that I hadn’t done anything wrong and that I wasn’t the horrendously awful person that I had made myself out to be. Yeah, kids can be cruel. I still don’t understand why my housemistress decided to take her hatred out on me as well. But in therapy I gradually started to stop blaming myself. I think that’s why I find it incredibly hard to trust people. You know how some people are able to talk to anyone about anything. Well I’m pretty much a closed book.

(interviewer) It sounds as though you really began to understand where your difficulties stemmed from and, from that, you were able perhaps to understand your experiences in a different way, from a different perspective, or at least explore how the past had affected you.

(Abigail) Yeah, I suppose anorexia was my escape from all that. It was the one thing in my life I could control when everything else was so awful. But as well I think it was about punishing myself for being such a horrible and hateful person who didn’t deserve to eat. It did make me feel better about myself for a while but I don’t think it lasted very long.
On the other hand, when working through your difficulties, were there certain areas that were concentrated on, that you found were unhelpful or even detrimental to you working through and overcoming your problems?

(Abigail) I don’t know really. I think there were probably. I can’t remember now.

(interviewer) Sometimes therapists can get things wrong. Sometimes they say things that their clients don’t agree with. Sometimes they assume somebody has a difficulty in a certain area of their life and try to guide therapy towards working towards that when that wasn’t the problem in the first place. Sometimes therapists find it hard to understand what a person is going through or what they have been through in their life. Does any of that make sense in your therapy?

(Abigail) There was one occasion I remember quite vividly now actually. After my mum had come in for a couple of sessions my therapist tried to say that she was part of the problem. Well not in those words but, basically, that my mum was in some way responsible for me getting anorexia. I felt so angry at her for that. My mum is brilliant. She supported me all the way through and still supports me now. We are really close and do everything together. She shouldn’t have said that.

(interviewer) Were you able to tell your therapist about how you felt about that?

(Abigail) No, I couldn’t. I just felt really angry inside. I think I thought you really don’t understand at all.

(interviewer) It sounds as though your therapist’s lack of understanding about your relationship with your mum affected the relationship you had with her for a while – that you felt misunderstood and, perhaps, you felt your mum was being judged by her which made you feel so angry. Could you tell me what you did with those angry feelings?

(Abigail) I stopped eating! I guess I gave up for a while.
Can you remember what happened that helped you start to fight against your anorexia again?

(Abigail) Not really. I guess it happened gradually.

Do you think there were any factors or people, outside of therapy, that helped you in working through your difficulties?

(If so) Can you tell me how influential these factors/people were?

(If not) Looking back, do you think that any support or help outside of therapy would have been beneficial for you?

(Abigail) Yeah, my mum. She was so brilliant. We have blazing rows about what I was eating and how much I was eating, but she always stood by me. She never gave up on me. We’ve had some amazing conversations.

(Was there anyone else who helped you, apart from your mum and your therapist?)

(Abigail) Not really. I guess I’d cut myself off from my friends. I didn’t want to go out. I didn’t want to see people. I wasn’t working. I really just stayed at home.

(If you can remember, how did that change?)

(Abigail) It’s difficult to remember. It wasn’t an overnight thing. It took ages before I became confident enough to go to the pub or go out for something to eat. Actually as part of my therapy I had to go and do something for ‘homework’. Like I would have to go and see a film, or go to a café, or see a friend, or something like that. We built up a list of things I had to do, starting with the easiest and going from there.

(Did you do those things on your own or did you go with someone?)

(Abigail) Yeah I went with my mum. At first I was really quite anxious. I thought everyone would be looking at me and talking about me. I think I recognised then that
I was really thin and people would make comments. That was quite horrible. But my mum helped me and sometimes forced me to do these things. I guess it gradually became easier. I don’t have any problems with going out now. I probably go out too much!

**Section 2**

We have looked in some depth at your therapy in general, both in terms of individual sessions and the overall process of therapy. I would now like to explore with you specific aspects of your experiences of therapy.

1. If you can think of any, were there any specific moments in therapy that you found especially helpful in working through your difficulties?

   (Abigail) Not really. I can’t remember anything specific. I think it was really gradual.

2. On the other hand, did any particular events happen in your therapy that were especially unhelpful or detrimental, and you feel prevented you from making progress?

   (If so) were you able to talk to your therapist about how this/these were unhelpful? What do you think may have been more helpful?

   (Abigail) Again I don’t think so. The only thing that stopped me getting better was me. I had to make the decision that I didn’t want to live with anorexia anymore and then I learned to fight against it.

3. And now, looking at your relationship with your therapist. Could you say a little about what that was like.
(Abigail) Mostly it was pretty good I’d say.

(interviewer) If you don’t mind, it would be quite helpful to think about the development of your relationship with your therapist. If you can remember, what was it like being with her at the beginning?

(Abigail) Oh, I was a nightmare. I didn’t really want to be there. I didn’t know really whether I wanted to get better or not. I know I was really angry inside. I hated professionals you see. I guess it was about not wanting to be there because of what had happened to me before. After being in hospital I promised myself that I would never see any ‘professionals’ again. I thought nobody could understand what I was going through and I think I thought she was going to force me to eat and then if I didn’t she would put me back in hospital again. I was horrible to her really and I feel really guilty about that. I didn’t speak about anything and just sat silently hating being there and hating myself for being so awful.

(interviewer) If you can remember, how did she respond to that?

(Abigail) She said she was there to try and understand what was going on. She told me she wasn’t going to force me or pressurise me into saying anything I didn’t want to. She told me what she thought anorexia meant. I guess, looking back, she was trying to say that she could understand what I was going through.

(interviewer) Did you feel she understood you?

(Abigail) Not at the beginning, and I hated being weighed like some prize cow. I did stupid things then so that she couldn’t really see my weight. Like I’d wear really heavy clothes and put on a heavy belt and sometimes I even put weights in my pockets. I didn’t want her to know that.

(interviewer) It sounds as though you weren’t ready for her to know you in a real sense, what was going on in your mind or what was happening with your weight?
(Abigail) Yeah I suppose that’s right. I was frightened of anyone getting inside my head and knowing what a horrendously awful person I really was. I used to put on this pretence for the outside world that I was really ok, that I didn’t have any problems, but inside I felt like I was dying and I was really terrified of myself.

(interviewer) It sounds as though things changed though. From what you’ve said before, you did gradually let her in. How did that come about?

(Abigail) I’m not quite sure. I suppose part of me wanted to get better and that’s why I was there, so I eventually had to let her know what was going on in my head. I was so stuck I didn’t know where to turn and she did really seem to want to understand and help me get better. I remember one session she got out this form and I had to write down a little bit about what it was like living with anorexia. Then I had to write down what it would be like to still be living like this in 6 months and then 5 years. I couldn’t bear it. I couldn’t bear the thought of still being the same in all that time. She then helped me think about what it would be like not to be like this, what I could be doing and what I could be doing in the future. I think that was a real turning point for me, seeing it written down on paper. I thought I have to give this a go because I haven’t got anything to lose by at least trying. She said that I could always have the choice to lose the weight again afterwards, but that it was worth giving it a try.

(interviewer) Kind of like an experiment then?

(Abigail) Yeah, I guess so.

(interviewer) and what happened then?

(Abigail) Well it took a while, I can’t remember how long exactly, but eventually I decided I didn’t want to live like this anymore. I was tired, my bones ached, I felt ill all the time, my hair was falling out, I had no friends, I wasn’t doing anything with my life except for exercising like crazy and not eating. When I was taking laxatives I couldn’t leave the house in case I needed the toilet. I think she helped me realise all this and that there was a glimmer of hope that I could change. She told me it was
going to be a struggle and some days it would be easier to fight than others. She explained that I would have hiccups and would perhaps go back to my old ways but that she would be there to help me. I started to believe her that I might be able to change. But I was scared at the same time if that makes sense. I wanted to change but I didn’t know whether I could.

(interviewer) It sounds as though she helped you to recognise that change was possible and that you could, perhaps, live without anorexia. It is quite well known that the road to recovery can be a rocky one and she described this to you. It seems as though she helped you to realise the reality of what you would be going through.

(Abigail) Yeah I hadn’t thought about it that way before. I think that helped me realise that she did understand what I was going through and for me not to expect miracles. I think I was and still am a bit of a perfectionist and once I set my mind to something I’m going to go hell for leather to get there. I wasn’t allowed to be perfectionist in this. I had to take things slowly step by step. There are no miracles to recovery. It’s a long hard slog. Sometimes I didn’t think I was going to make it and would go back to not eating again, but my mum and my therapist kept me going. I think they believed in me and I really held on to that, they were my life line through this because it was just so hard. Sometimes my therapy would purely be about tears, I’d cry all the way through and my therapist stayed there with me, didn’t push me or tell me I was being stupid. Sometimes I was so angry and didn’t know what to do with myself and started cutting myself. She told me it was something to do with my ways of coping and taught me other ways I could let out my aggression at myself, my anorexia and the whole world. I can’t describe just how hard it all was, but my therapist and my mum kept me going.

4. How would you describe your therapist?
Do you think she understood your problems?
And do you think she was understanding of you as a person?
What effect, if any, did this have on your therapy?
(Abigail) I think I’ve really answered this. I think she understood me much earlier than I gave her credit for. As I said, I wouldn’t even talk at the beginning, let alone let her help me. She stayed with me through all this and didn’t get frustrated or angry with me, and I think I gradually got to the point of trusting her enough to let her in. She never judged me but she did sometimes judge my anorexia. She sometimes said to me that she wasn’t annoyed with me but she was annoyed with the anorexia and how it was preventing me from getting better.

Understanding me – she really did understand me and I’ll always be grateful to her staying with me even when I felt I was in a huge black hole and couldn’t find a way out.

(interviewer) A huge black hole?

(Abigail) Yeah, it’s how I describe how I was back then. It was like I was at the bottom of a huge pit with snakes and spiders all crawling through my body, wanting to poison and kill me. The sides of the hole were smooth so however much I tried I couldn’t get a hand hold or a foot hold to start levering myself up and every time I did I got bitten by the spiders or strangled by the snakes. So eventually I gave up. My therapist and my mum came to understand this hold and started to try and find ways of getting down to me, to find me in this place and work on ways of helping me to get back up again. Eventually they both just jumped in there with me and got stung and strangled too. But they were stronger than the spiders and snakes and they had pick axes to start making holes in the walls. Sometimes I’d fall back right down into the pit, sometimes I’d fall only a few notches. Every time I did they fell back down with me and pushed me up again from behind. I know it sounds a bit rubbish but they saved my life. My therapist kept telling me at the end of therapy that I was the one who had done the hard work, I was the one who kept battling away at the anorexia, at the gargoyle around my neck, gradually prying it loose, but without her help I don’t think I’d have even bothered to start the climb and goodness knows where I’d be now.

(interviewer) Thank you, you made your journey make a huge amount of sense.
(Abigail) I guess it is like a journey, but a road with too many pot holes in it! But it's a journey I'd always recommend to other people who were unsure about whether to get in the car!

5. And now, looking back at your therapy as a whole. What would you say helped you most in terms of your level of recovery from anorexia/bulimia? For example: was it to do with certain techniques or strategies? Was it learning specific skills about how to cope? Was it something to do with your therapist? Something else?

(Abigail) It think it was a combination of everything. I think the most important thing was that I was believed in and understood. I had spent so long in the grips of anorexia, being terrified about what it was doing to me but being helpless to do anything against it. I couldn't trust anyone and didn't really believe that anyone wanted to know me. I didn't deserve to live. I didn't deserve to eat and didn't really deserve anything. I felt guilty about what I was doing to my mum. She was always there for me but all I was doing was hurting her more. And I hated myself even more for this. My therapist helped me understand anorexia as an illness, but one that I had to take control of. Actually I remember her saying quite early on that I wouldn't blame a cancer patient for having cancer so why should I blame myself for my illness. I'm still not quite sure I believe her on this one. I think I should take some responsibility for starving my body and slowly trying to kill myself. I did it - not anyone else.

But certain techniques? I don't think there was anything specific. I think talking about how bad I felt about myself and that I deserved the same things in life that other people had. I think talking about what happened to me as a kid also helped. She helped me to understand that that wasn't all my fault as well, that kids can be very cruel and nasty.

(interviewer) How about now? You mentioned you were very socially isolated when in the grips of anorexia. Are you able to go out now?
(Abigail) Yeah, we concentrated on that quite a lot. She’d give me small tasks to do each week and when I was feeling more energetic I joined a modern dance class. I met a few people there and I even managed to go out and have a good time. I think I’m still quite shy around new people, but I have stated to make some friends now. I like going out with my mum too. We even go out for meals. The biggy for me was having a pizza because I hadn’t had one since I was about 11 and I managed to do that the other week. I now feel proud of little achievements – I know it sounds stupid.

(interviewer) Not at all. It sounds as though the work you did in therapy is still carrying on.

(Abigail) Yeah, all the time. I guess therapy can only take you so far and then you’ve got to do the rest yourself.

6. Again, looking back at your therapy as a whole, were there any aspects that you think prevented you from recovering more quickly?

(Abigail) ME – I can’t say any more than that really.

Section 3

Finally, I would like to ask a couple of questions about how you have coped since your therapy ended.

1. Do you think you have maintained any changes made during therapy, or have you had difficulty staying on track?
   (If so) What or who has helped you maintain your recovery?
   (If not) What do you think would be most useful to you, in terms of staying on track with your eating?

(Abigail) I think most of the time but I don’t think you ever really recover from anorexia completely. I think it’s always there in the back of your mind. I don’t hate
myself so much anymore but sometimes I wake up and look in the mirror and see that
fat person looking back at me and I can’t bear myself for the day. So on those days I
go back to eating my safe foods. I still don’t let myself eat too much or put on
anymore weight. I’m still exactly the same weight as when I finished with my
therapist but it is a safe weight. If I eat too much one day I know I’m cutting back the
next. But now I know it I don’t let it go downhill too much. I’ve also still got my
lifeline, I can go back to my therapist if I’m feeling it’s all getting out of control again.

(interviewer) It sounds as though you have a lot of self awareness

(Abigail) Yes I do now. I’m more in control. I know the signs for going backwards
and I do something about it. I make sure that I sit down and eat 3 times a day and my
mum picks me up on it if she sees me cutting back and losing weight. I appreciate her
for that now. I guess I also have lots to live for. I’ve got a job that I like, I’ve got
things I like to do like dancing that I enjoy, and I don’t want to give that up.

(interviewer) What kinds of things go through your mind on a bad day?

(Abigail) I don’t know how to explain but I just feel so damn guilty all the time. I
feel guilty about what I did to my mum. I feel guilty about being alive and well and
happy, like I still don’t quite deserve it. I can’t quite believe that I’m such a different
person. That’s one thing in therapy, a specific, we concentrated on filling the void
that anorexia left. I didn’t realise my whole life was about what I was and wasn’t
eating. I had been anorexic so long I didn’t know who I could be without it. I think
that’s what the going out was about. She was giving me things to fill the void.

(interviewer) That sounds pretty important, working on ways to have a life without
anorexia, to work out who YOU are, rather than what it is to be anorexic.

(Abigail) I hadn’t thought along those lines but yes I agree. I didn’t know who I was
anymore and I’m a bit more sure of that now. I think there will always be ups and
downs.
For some people it can be that when they are in stressful situations the anorexia rears its ugly head. For others, they can be so relieved to be free of the symptoms that they don’t realise that they are creeping back in.

(Abigail) It’s frustrating but you have to be aware all the time. You have to see it straight away when you’re going back down hill or I believe you will be back at square one. I make sure I eat every day, even more so when I’m getting stressed about stuff. I never want to go back down there. I know I wouldn’t make it back up again.

And finally, looking back at when you completed therapy and how you are now, could you tell me a little about how you have been coping? Is there anything else you think you have needed during this time?

(Abigail) I think I’m doing pretty well. I know I have up and down days. I know at some point I need to put on more weight because my BMI’s only 18.5 and that’s not even in a healthy weight yet. I know I want to have a family one day and that I have to be heavier for that. There’s still so much I haven’t achieved.

(interviewer) Such as?

(Abigail) I haven’t had the guts to go back to university yet. I still don’t know what I want to do with my life. I know I want a family. I know I want a career. But I don’t know quite what I want. Mum says that I have plenty of time, but I’ve wasted so much time already. I’ve spent so long anorexic and wasted so much of my life that I don’t want to waste anymore but I just don’t know what I want to do. It makes me stressed thinking about it too much so I’m kind of ticking along at the moment.

(interviewer) It sounds as though you’re recognising what you need?

(Abigail) You could put it that way. But I think I’m too scared to make a commitment to anything at the moment. I hope that changes soon.
Conclusion

Thank you very much for taking the time to answer all my questions so fully and openly. I truly appreciate it.

Is there anything else you would like to add or anything you think has been missed in my questions, that you think it is important to discuss?

(Abigail) Just that I think anorexia gets a really bad press. We’re all meant to be attention seeking and thoughtless and horrible people. We’re not. I don’t believe that. For me it was the only way I could express for myself the pain I was going through in my life. It was the only way I could get some control over everything that was going wrong in my life. I was terrified of myself and what was going on in my head. Anorexia gave me a way of getting rid of that pain. I could feel numb because I had to spend all my time thinking about not eating.

I think anorexia is very difficult because everyone’s story is different. I now also use a support group on the internet when I’m seeing I’m going down hill and everyone is different. It actually helps me to help other people when they are going through a bad time. I think this support group is really good because people with anorexia all get a chance to talk to each other about what they’re going through and how hard it is to get better. I often share my experiences so that others can see that people can get better.

It’s also very hard to think that everything you’ve done for so many years has been wrong. That everything you’ve believed about yourself and the world has been wrong. It’s very hard to accept that and it took me a long time.

I am better but I don’t think I’ll ever be fully recovered, whatever that means. I think I had it for too long. It’s in a way too much part of me. I think the gargoyle will always be sitting on my shoulder waiting for an opportunity to pounce, but I’ll try not to let his claws dig in again.
(interviewer) Thank you so much again. If you want to add anything at any time, or would like to talk about anything, please don’t hesitate to email me. You have provided such an open and frank account of what you have been through in your battle with anorexia and, if you don’t mind my saying, I think you are incredibly brave to have fought against this awful illness. Thank you so much.