

**Every body tells a story: a heuristic, grounded theory
exploration of the impact of working with clients
experiencing eating disorders on the counsellor's embodied
subjectivity**

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Abstract

Contemporary western consumerist society exposes individuals to a world of aestheticism with emphasis placed on fashioning the physical body into an unrealistic culturally prescribed ideal. Conflating personality and lifestyle attributes with body shape, individuals attempt to create a sense of self through their physical presentation. As a likely consequence, increasing numbers of people are experiencing disordered eating symptoms and psychological therapists are reporting greater numbers of clients presenting with eating disorders. Recognising that therapists are situated within their own body and have their own relationships with food and eating, the thesis explores how the empathic, relational nature of therapy with clients experiencing eating disorders affects those therapists.

A constructivist grounded theory approach to data generation and analysis was initially employed. This was then expanded to incorporate heuristic research analysis practices as the inseparability of the researcher's academic, therapeutic and personal selves from the study became evident. Semi structured interviews were undertaken with eighteen psychological therapists. Five were person-centred counsellors working in general practice, who formed a preliminary study. The main body of the study comprised thirteen therapists specialising in therapy with clients experiencing eating disorders.

In relation to their client work, therapists experienced a range of feelings and also described changes to their own narratives regarding food, eating and their embodied experience. Conceptualising the body as a representation of self, both therapists' and clients' bodies were recognised as a visible form of self-disclosure, and thus symbolic communication tool, within the therapy room.

The therapeutic orientation of the therapists interviewed was shown to influence both their conceptualisations of eating disorders and their interpretations of their own experiences. Acknowledging that therapists work in different ways, the thesis suggests training topics to enhance understanding of the multifactorial nature of eating disorders which therapists can integrate into their practice.

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Chapter 1

Introduction

1.1 Introduction

Contemporary western culture exposes individuals to a world of aestheticism, consumerism and achievement with emphasis placed on fashioning the physical body into an often unrealistic culturally prescribed ideal. It has been claimed that dieting and an insecure body image have become increasingly normative in contemporary society, especially for women and young girls (Daly, 2016; Sands, 2016). Increasing attention has been paid to the male physique in recent years and men and boys are now being subjected to the kinds of sociocultural pressures previously faced by females (Wooldridge, 2016). Sociocultural discourses conflating personality characteristics with the aesthetically pleasing body (Lanzieri & Hildebrandt, 2016; Lupton, 1996, 2013) are arguably contributing to rising numbers of individuals presenting in therapy with symptoms of eating disorders and disordered eating (Daly, 2016).

Eating disorders present “unique challenges” (Warren, Crowley, Olivardia, & Schoen, 2009) for therapists and can expose them to an increased risk of identification with clients (Zerbe, 1993) as everyone experiences their own relationships with food, eating and their body; all of which are subject to the dominant social discourses of the time (Daly, 2016; Derenne, 2006; Orbach, 1986; Rabinor, 1995). Clients attend therapy in order to change or to develop deeper self-understanding, and, due to the empathic nature of the therapeutic dialogue, arguably, therapists are vulnerable to having their own relationships with food, eating and their body challenged. This can become problematic when acknowledging the inter-relationship between discourses attached to food, eating and the body and an individual’s construction of self. These challenges and their consequences are what this study aimed to explore.

1.1.1 Thesis structure

The first chapter of the thesis establishes the research question and argues for its importance as a topic of exploration. The study's position within postmodern and social constructionist paradigms is introduced in order to illustrate its ontological and epistemological perspectives. Recognising that both self and body are relevant concepts in understanding eating disorders, a social constructionist and an embodied phenomenological view of each is posited. The thesis argues that individuals experiencing eating disorders have an objectified (Zerbe, 1993) sense of their body and benefit from moving from this towards a more phenomenological and embodied self experience (Blood, 2005; Orbach, 1986; Sands, 2016). The chapter will conclude with an introduction to the study's methodological approach illustrating its fluid nature in response to the researcher's engagement with the data and research process.

Chapters two, three and four are presented as literature reviews. The first of these, chapter two, situates eating disorders within western twenty-first century consumerist society. A brief historical account of the sociocultural discourses attached to the role of women and their bodies from the Middle Ages to the present day will depict their positioning as female conditions (Botha, 2010; Dalglish & Nutt, 2013) and through this, the marginalisation of the male experience of eating disorders (Forbush, Heatherton, & Keel, 2007; McCormack, Lewis, & Wells, 2014) is illustrated. The body's role in contemporary western society as a representation of self (Halsted, 2015; Jabobs & Nye, 2010; Petrucelli, 2015a) created through the internalisation of socioculturally prescribed aesthetic ideals and their conflation with prized personality attributes (Malson, 1998) will be posited as contributing to a pervading cultural sense of disembodiment (Soth, 2006). As those who experience eating disorders are claimed to experience an exaggerated form of this objectification (Maisel, Epston, & Borden, 2004), the chapter will conclude with an alternative perspective of the body, suggesting that a more embodied experience (Blood, 2005; Orbach, 1986; Sands, 2016) as offered through a phenomenological perspective is necessary to enable people to recover from eating disorders.

Acknowledging that not everyone within western consumerist society develops an eating disorder (Riva, Gaggioli, & Dakanalis, 2013; Ty & Francis, 2013), chapter three turns towards the psychological theories of self-development used by the

therapists interviewed for the research to offer some reasons as to why this might be the case. These therapeutic approaches are recognised as shaping the ways in which therapists conceptualise eating disorders (White & Epston, 1990), work with their clients and interpret their own experience within the therapeutic relationship. Although a notion challenged to an extent within the chapter, the models of therapy discussed favour an essentialist sense of self and thus narrative therapy is offered as an alternative approach more in fitting with the social constructionist underpinnings of this study. Chapter three concludes with an alternative reading of the socioculturally created body and self of chapter two by illustrating the body's symbolic use by clients to enact their subjective experiences (Farrell, 2015; Sands, 2016).

Chapter four turns towards the therapist's experience to show how this can be affected by their client work. The unique challenges of the eating disordered population (Satir, 2013) are acknowledged as having multiple affects for the therapists working with them (Burket & Schramm, 1995; Warren et al., 2009). The potential of these to challenge the therapist's own relationships with food, eating and their body (DeLucia-Waack, 1999; Franko & Rolfe, 1996; Garfinkel et al., 1996; Shisslak, Gray, & Crago, 1989; Warren et al., 2009) will be discussed as well as their implications for the therapist's personal and professional subjectivities. The role of the therapist's body is acknowledged as being particularly relevant (Daly, 2016; Jacobs & Nye, 2010; Orbach, 2003, 2004, 2006; Petrucelli, 2008, 2015b) when working with clients experiencing eating disorders and hence its position within the therapeutic encounter will be discussed. The chapter concludes with a brief discussion of relevant training, self-awareness and supervision issues associated with safe and ethical practice.

Due to the study's exploratory nature, a qualitative approach was taken to the research, which is presented in chapter five. Deliberations as to the most appropriate form of grounded theory (Charmaz, 2006; Corbin & Strauss, 1988, 2008; Glaser, 1992; Glaser & Strauss, 1967) to employ are offered to illustrate the initial intention of finding a balance between social constructionism's notion of the inseparability of researcher and research whilst trying to maintain a degree of objectivity. However, the inseparable nature of my researcher, counsellor and personal selves became increasingly evident and my consequent inclusion of heuristic research (Moustakas, 1990) principles into the study will be discussed.

The chapter ends with a reflexive account of my experience to make this transparent to the reader.

The research participants configured into two data sets; the person-centred counsellors of the preliminary study and the subsequent group of specialist therapists. Their findings are presented in chapters six and seven respectively. The therapists' experiences are discussed in chapter eight illustrating the similarities and differences between the two data groups. Invoking the postmodern notion of multiple realities, the therapist's therapeutic approach, and thus knowledge, is shown to influence their interpretation of their client work and their own experiences. The implications of the challenges to their own relationships with food, eating and their bodies are discussed in relation to the therapists' personal and professional subjectivities. The chapter concludes with a discussion of implications for professional practice. This includes the claim that training in relation to the disorders is essential (Bannatyne & Stapleton, 2014; Williams & Haverkamp, 2010) for all therapists and their supervisors (Hamburg & Herzog, 1990) and suggests relevant topics.

The final chapter summarises the thesis and offers an interpretive summary of the findings to illustrate how psychological therapists can be affected by their work with clients experiencing eating disorders. The key contributions of the study for professional practice and individual therapists are presented before the chapter concludes with an acknowledgment of the limitations of the study and recommendations for future research.

1.1.2 Definitions of relevant terms used throughout the thesis

This study concentrated on the experiences of therapists who worked psychotherapeutically with clients presenting with eating disorders. The terms 'therapist' and 'clinician' are used interchangeably to denote the therapist experience. In relation to the findings, the terms 'counsellor' is used to distinguish the therapists practising from a person-centred perspective in general practice in the preliminary study from the 'specialist therapists' of the main project. These specialist therapists tended to practise in an integrative way and had specific experience in working with clients presenting with eating disorders.

The terms 'identity' and 'subjectivity' are used interchangeably throughout the study to denote an individual's sense of self. The concepts of 'personal' and 'professional' identity or subjectivity are invoked respectively in relation to the individual's general experience of themselves, or in relation to therapists' self-experiences within the therapeutic environment.

Dualism, discussed in chapter two, is an important concept in this thesis and is invoked in relation to individuals' situated experiences of themselves within their bodies. 'Disembodiment' is understood as the disconnected experience of self and body in which the body becomes an object experienced by the individual from the observer's gaze (Starkman, 2016a) which can be modified and manufactured to suit socioculturally prescribed norms (Rathner, 2001; Rice, 2014). In contrast, embodiment or 'embodied subjectivity' (Grosz, 1994) relates to the phenomenological experiencing of the lived-body (Merleau-Ponty, 1962), discussed in chapter two, in which, and from which, the individual experiences themselves in the world. Winnicott's (1960) notion of 'indwelling' is also drawn upon to appreciate the sense of psyche living within the body.

The thesis talks substantially about 'sociocultural influences' and 'sociocultural discourses'. These are conceptualised as the prominent beliefs and values relating to food, eating, gendered identity and body shape or size which individuals are exposed to through engagement with cultural, familial, media and peer attitudes and practices. The study is situated in an arguably patriarchal, white western society, and more specifically, within British twenty-first century consumerist culture in which media outlets, including film, TV printed press, the internet and social media, are particularly influential. As will be discussed in chapter two, there is an intense focus on aesthetic appearance, with idealised body shapes being conflated with personality characteristics and lifestyles (Lanzieri & Hildebrandt, 2016). Body shape and size, food, eating practices and gender roles differ across time and sociocultural situations, and as these differences are too vast to discuss within this thesis, the focus necessarily remains a white western one. As all of the therapists interviewed were white and had been raised within contemporary western culture and did not speak of clients of other backgrounds, the literature drawn upon during the research also takes this perspective.

The psychodynamic concepts referred to by the specialist therapists will be discussed in greater detail in chapter three, but briefly, 'countertransference', in keeping with the way in which the concept is used in other research studies pertaining to eating disorders (Franko & Rolfe, 1996; Kernberg, 1965; Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009), is defined as 'all of the feelings which a therapist experiences in relation to their client'. 'Projective identification' claims that clients unconsciously project their unacknowledged feelings onto the therapist (Petrucci, 2015a; Russell & Marsden, 1998). These phenomena are interpreted as arising from the typical 'alexithymic' disposition (Barth, 2008, 2016; Mathiesen et al., 2015) of individuals experiencing eating disorders which creates difficulty in feeling, identifying or putting language to their feelings. A similar psychodynamic concept to define is that of 'embodied countertransference' (Burka, 1996; Pacifici, 2008; Petrucci, 2001) which encompasses all of the physical feelings and other corporeal phenomena which therapists experience in relation to their clients.

1.2 The research topic and its significance

The aim of the research was to explore the ways in which therapists working psychotherapeutically with clients experiencing eating disorders can be affected by their work. Descriptive narratives of therapists' experiences, analysed through qualitative inquiry, were anticipated to identify the effects upon clinicians' professional and personal subjectivities. These could then be used to inform clinical practice and prepare therapists for the 'unique challenges' (Warren et al., 2009) of the work.

My interest in the subject emerged as a consequence of my personal history and my own experience as a person-centred counsellor working with clients presenting with eating disorders. Recognising food as "a central issue in most peoples' lives (Petrucci, 2015a, p. 17) and acknowledging that everyone has their own relationships with eating and their bodies, I was intrigued to explore whether the empathic engagement of the therapeutic relationship conveyed vulnerability to therapist identification with clients' experiences, and if so, the implications for the therapist. My early reading of the literature suggested that, despite its recognised importance (Thompson-Brenner, Satir, Franko, & Herzog, 2012), the topic remained under-researched (Franko & Rolfe, 1996; Satir et al., 2009; Thompson-

Brenner et al., 2012; Warren et al., 2009). The literature is written across a range of multidisciplinary professions, and hence there is little specifically exploring the experiences of psychotherapeutic therapists, other than individual case studies. Although all clients can induce affective experiences within their therapists, clients experiencing eating disorders can be considered as a “unique population” (Satir, 2013), with salient characteristics, discussed below, which increase this potential.

Firstly, every individual has their own relationships with food, eating and their body, meaning that therapists may find theirs challenged as a consequence of the work (DeLucia-Waack, 1999; Franko & Rolfe, 1996; Garfinkel et al., 1996; Shisslak et al., 1989; Warren et al., 2009). Counsellors and psychotherapists tend to be reflexive practitioners, professionally encouraged to reflect at depth upon their work and its impact on themselves, both within and without the therapy room, thus creating increased opportunity for identification with clients’ experiences (Daly, 2016; DeLucia-Waack, 1999; Zerbe, 1993). As discussed in chapters two and three, an individual’s relationships with food, eating and their body are related to their subjective experiencing (Lanzieri & Hildebrandt, 2016; Lupton, 1996; Ogden, 2010) and hence any challenge to these has potential to affect the therapist’s self-experience. Clients attend therapy to change some aspect of themselves or their behaviours but, acknowledging selves as changeable and created in relationship (Gergen, 2015; Lock & Strong, 2010), the research aimed to explore if the therapist’s self might also be influenced through the therapeutic dialogue.

Secondly, within a given culture therapists and clients are exposed to the same sociocultural discourses regarding body image and food consumption (Daly, 2016; DeLucia-Waack, 1999; Matz & Frankel, 2005). This furthers the potential for identification with clients (DeLucia-Waack, 1999; Hamburg & Herzog, 1990; Zerbe, 1993) and for therapists to experience disturbances in their own eating behaviours and body image perception (Bordo, 1993). Although clients experiencing eating disorders can be considered as psychologically unwell, disordered eating sits on a continuum (DeFeciani, 2016; Piran & Cormier, 2005) whereby some of the behaviours and beliefs are similar to those of people in the general population due to the influence of sociocultural discourses regarding body size and eating practices (Starkman, 2016a).

Thirdly, clients presenting with eating disorders are acknowledged to be challenging to work with (Kaplan & Garfinkel, 1999; Rance, Moller, & Douglas, 2010; Warren et al., 2009; Zerbe, 1992) and as likely to arouse a range of powerful feelings within the clinician (Russell & Marsden, 1998; Zerbe, 1998). Much of the challenge arises from the multifactorial aetiology of eating disorders (Hamburg & Herzog, 1990; NICE, 2017; Tasca & Balfour, 2014), including the physiological effects of their behaviours (Jarman, Swift, & Walsh, 1997; Satir et al., 2009; Tasca, Ritchie, & Balfour, 2011), which is not often covered in psychotherapy training (Spotts-De-Lazzer & Muhlheim, 2016) and clients' interpersonal difficulties (Tasca & Balfour, 2014). Although these difficulties and the potential for intense therapist reactions were recognised over forty years ago (Cohler, 1975), there remains only a limited amount of research into the effects of the work upon therapists (Franko & Rolfe, 1996; Satir et al., 2009; Thompson-Brenner et al., 2012; Warren et al., 2009).

The multifactorial aetiology (Kaplan & Garfinkel, 1999; NICE, 2017; Tasca & Balfour, 2014) and the subjective experiences of eating disorders create therapeutic challenges for therapists and it is difficult to devise a definitive treatment protocol effective for all clients (Jarman et al., 1997; Petrucelli, 2016). Cognitive-behavioural therapy (CBT) has been the most researched and widely acknowledged treatment model (Tasca & Balfour, 2014) and recently published NICE guidelines (2017) propose either eating disorder focused CBT or a manualised focal psychodynamic treatment protocol (MANTRA). However, not all of the literature concurs with this and some authors propose the adoption of more integrative approaches (Barth, 2016; Natenshon, 2012; Tasca & Balfour, 2014; Zerbe, 2016).

Another feature, discussed in section 1.5.2, is the increasing number of clients presenting with the conditions (Thompson-Brenner et al., 2012), meaning that it is "highly likely that counsellors will see eating disorders in the therapy room" (Furstand et al., 2012, p. 319). Increased exposure to socioculturally defined idealised bodies in the media, the rise of social media (Barth, 2016) and the relocating of eating disorders away from their historical positioning as essentially female-bound conditions (Dalglish & Nutt, 2013), which will be discussed in chapter two, may all be contributing to this increase. As greater numbers of individuals present for treatment, dedicated services find it difficult to cope with the demand (Jarman et al., 1997) resulting in increasing levels of clients presenting to

other services and clinicians (Jarman et al., 1997; Thompson-Brenner et al., 2012). An increasing focus on time-limited work in contemporary practice due to financial pressures on healthcare providers (Zerbe, 2016) also makes it difficult for therapists to offer the longer term therapy which eating disorders typically require (Ward, Ramsay, Turnbull, Benedettini, & Treasure, 2000; Zerbe, 2016). As eating disorders also evidence poor recovery rates and a high attrition rate (Rance, Clarke, & Moller, 2014) knowledge and competency levels of non-specialist therapists can be challenged.

Despite the challenges noted above, research considering the experience of the clinician when working with clients presenting with eating disorders is currently limited (Franko & Rolfe, 1996; Satir et al., 2009; Thompson-Brenner et al., 2012; Warren et al., 2009), especially in relation to counsellors and psychotherapists. The majority of articles are cross-disciplinary studies exploring the experiences of a range of professionals rather than the exclusive focus on psychotherapeutic therapists in this study. Arguably, this is an important distinction as the therapeutic relationship can be viewed as a privileged one due to its confidential nature, the centrality afforded empathy (McLeod, 1999; Rogers, 1951) and the likelihood that clients attend therapy in order to achieve subjective understanding or change. The empathic collaboration of the therapeutic relationship is recognised as the “holy grail of psychotherapy effectiveness” (Wooldridge, 2016, p. 21). Engaging at empathic depth enables the counsellor to step, as far as is possible, into their client’s experiential world (Rogers, 1951) to an extent not always necessary within other professional relationships. When considering empathy as a relational process in which the client’s experiences are discussed and their meaning co-created through therapeutic dialogue (McLeod, 1999) the potential for therapist over-identification with client experiences (Daly, 2016; DeLucia-Waack, 1999; Hamburg & Herzog, 1990; Zerbe, 1993) becomes evident.

In recognition of the challenges introduced above, clients presenting with eating disorders arguably have significant potential to affect their therapists’ experiences both within and without the therapy room. The research therefore intended to explore both the therapist’s professional experience whilst actively working with clients and any effects on their own relationships with food, eating and their body. Identified effects upon therapists’ personal and professional subjectivities could then be used to inform professional practice. In order to gather this kind of data

therapists with experience of working with the client group were interviewed to collect a range of descriptive narratives which could then be analysed to produce a “constructed interpretation” (Fassinger, 2005, p. 158). The methodological procedure followed throughout this study is briefly described in section 1.6, before being discussed in depth in chapter five.

1.3 Situating the research

Having asserted the value of the research question, section 1.3.1 will introduce the social constructionist position of the study and its philosophical influences. In section 1.3.2 the focus shifts to the individual’s experience within that cultural situation to illustrate how this is then brought into the therapy room, the therapeutic relationship and the phenomenological experiences of both therapist and client. As eating disordered behaviours revolve around the eating, restriction or purging of food, the section concludes in section 1.3.3 with an introduction to the psychological and sociocultural discourses attached to food and to the infant’s early feeding experiences in the establishment of an individual’s sense of self.

1.3.1 Positioning the research

Situated within postmodernist and social constructionist paradigms, the thesis recognises , the existence of multiple realities (McNamee, 2014) and thus denies the modernist notion of a discoverable objective truth. Knowledge is interactive and interpretive (Anderson, 2014) and created through the relationships between the researcher, the data and the participants. The researcher cannot be separated from the social situation they are studying (Chard, 2014) and in contrast to the modernist objective position, the inquirer’s voice becomes an integral part of the story. Bringing their own history and narratives to the study, researchers can interpret their findings only through the experience and discourses currently available to them. The findings of this study therefore, are acknowledged as being dependent on the particular participants who presented, with the experiences they shared, and their interpretation is necessarily informed by the subjective knowledge I, as researcher, brought with me.

Social constructionism moves away from the modernist notion of an essentialist inner self to be discovered and instead recognises a self which is fluid and

changeable (Lock & Strong, 2010). Selves are created through relationship with others and social practices and are always historically and culturally situated (Gergen, 2009, 2015; Harter, 2012). The notion of self is important to this thesis in relation to the perspective taken on the subjectivities of the therapists interviewed and individuals experiencing eating disorders, which will be discussed in chapters two and three. In chapter two, sociocultural discourses relating to food, eating and the body will be shown to be culturally and historically situated and their role in creating an individual's identity will be made explicit. Unquestioned internalised discourses (Petrucci, 2016) pertaining to masculine and feminine bodies will be shown to have a particularly powerful influence over the ways in which individuals establish their sense of self. For the majority of people, these discourses are changeable over time and their identity is fluid, created and changed through ongoing dialogue with others (Elliott, 2014; Gergen, 1991, 2009, 2015). In contrast, the individual who develops an eating disorder creates a fixed self narrative (Gergen & Kaye, 1992; McLean, 2016) based in part, upon these discourses.

1.3.2 Situating the individual within their body

Although eating disorders convey significant emotional pain, much of their distress is directed towards the body and hence it is necessary to consider the psychological and sociocultural discourses pertaining to it. The body is arguably unique in that it can be considered as both subject and object (Grosz, 1994; Synnott, 1993) and experienced as something that the individual both has, and is situated within (Crossley, 2004). Dualism, which has been dominant in western thought for the past three hundred years (Chard, 2014), is an important concept for this study and in chapter two it will be argued that it established an objectified approach to the body which has significant implications for the disordered eating experience (White & Epston, 1990). Soth's (2006) claim that disembodiment has become the norm within western society will be invoked to illustrate contemporary culture's ongoing tendency towards objectifying the body in order to create a self established through aesthetic discourses.

Currently dominated by the thin female and muscular masculine aesthetic, twenty-first century western consumerist society implies that individuals, in order to be acceptable and successful, should present a culturally prescribed ideal body shape. It is increasingly normative that women especially, are on diets or experience some

level of dissatisfaction in relation to their weight and body shape (Daly, 2016; Rabinor, 1995; Sands, 2016; Shipton, 2004). Through meanings 'inscribed' upon bodies (Hepworth, 1999) conflating body shape with personality traits and life-style attributes (Lanzieri & Hildebrandt, 2016), an individual's subjectivity can be seen to be socially constructed and understood as a product of the culture in which they are situated (Fischler, 1988; Lupton, 1996). Petrucelli (2015a, p. 13) claims that the contemporary body is both an "aesthetic wrapper of the self" whilst being simultaneously a "central signifier of one's identity." These factors are particularly powerful in the experiences of individuals experiencing eating disorders and it is claimed that, in relation to their sense of disembodiment and allegiance to sociocultural discourses ascribed to them that anorexia and bulimia are "the crystallization and exaggeration of Western culture" (Maisel et al., 2004, p. 38).

It is thus within this sociocultural backdrop that the subjective experiencing of the individual needs to be considered. A purely social constructionist approach to identity formation is however lacking for the purposes of this research as it neglects the phenomenological experience and the biological body (Rice, 2014). Moving away from the concrete physical body with its sociocultural inscriptions, the final section of chapter two will introduce the notion of Merleau-Ponty's (1962) "lived body", turning the thesis towards phenomenological understandings of self and corporeal experiencing. From this position, the body can be thought of as the medium through which an individual presents themselves to the world and the immediate site of their interaction with others. This is a more 'embodied subjectivity' (Grosz, 1994) acknowledged as reminiscent of Winnicott's (1960) notion of 'indwelling' or of psyche being situated within the body. Ways in which an individual holds and dresses their body can be indicative of how they feel about themselves within that body, and in this way, it becomes the external and visible manifestation of the person's inner life and subjectivity (Halsted, 2015; Lanzieri & Hildebrandt, 2016; Lupton, 1996; Ogden, 2010). As a consequence of their tendencies towards alexithymia (Barth, 2016) and dissociation from their emotional experience (Barth, 2016; DeLucia-Waack, 1999; Zerbe, 1993), clients experiencing eating disorders are especially prone to expressing their affects and subjectivity through the concrete medium of their body (Farrell, 2015; Petrucelli, 2016; Sands, 2016). It needs to be recognised however, that this embodied self is still situated within contemporary culture and thus subject to dominant sociocultural discourses.

The significance of this will be discussed in chapter three in relation to the client's subjective experience and from the perspective of the therapist in chapter four.

1.3.3 Positioning eating disorders

Although a perception beginning to change, eating disorders tend to be considered as female-bound conditions (Botha, 2010; Bunnell, 2016; Dalglish & Nutt, 2013). Current literature recognises that the male experience of eating disorders has been marginalised (Forbush et al., 2007; McCormack et al., 2014) and that men and boys have been neglected in both research and clinical practice (Greenberg & Schoen, 2008; McCormack et al., 2014). In response to this and to changing gendered norms, as discussed in chapter two, diagnostic criteria within DSM-V (APA, 2013) and recently published NICE guidelines (2017) have been rewritten to more fully encompass the male experience.

Despite the claim that disordered eating practices and body image insecurities are becoming increasingly normative in western culture (Daly, 2016; Hudson, Hiripi, Pope, & Kessler, 2007; Rabinor, 1995) the majority of people do not develop eating disorders (Riva et al., 2013; Ty & Francis, 2013). This suggests that cultural influences alone do not create the conditions, and must therefore be recognised as "only one part of a much larger mystery (Petrucci, 2015a, p. 13). In consideration of this, psychological and emotional influences on the development of the psyche and corporeal self will be discussed in chapter three. This is potentially problematic for a thesis claiming social constructionism as its main influence. However, eating disorders arguably need to be recognised as historically positioned social constructs and much of their experiencing has been interpreted through the psychotherapeutic discourses of the therapists treating them. This is the case both within much of the literature cited throughout this thesis and the narratives of the therapists interviewed.

The focus of the thesis therefore, becomes more psychologically oriented in chapter three when the psychotherapeutic approaches employed by the therapists interviewed within the research are presented. Person-centred counselling, cognitive-behavioural therapy and psychodynamic theory will be shown to influence how therapists conceptualise clients' presentations of eating disorders and thus their interpretations of their own experiences. The theories of self development

evident within these therapies are potentially problematic for this thesis. Through their recognition of an essentialist self, they tend to pathologise the individual and situate the problem within the client (White & Epston, 1990), thus allowing little reflection upon the person's place in their given historical sociocultural situation. Although not discussed by any of the therapists interviewed in this study, narrative therapy (Dallos, 2004; Maisel et al., 2004; White & Epston, 1990) is introduced as an alternative approach which externalises problems, locating them in sociocultural discourses and allowing for the rewriting of clients' subjective stories (Maisel et al., 2004; White & Epston, 1990). Recognising the value which this thesis places on understanding clients' early attachment experiences in establishing their relational narratives, attachment narrative therapy (Dallos, 2004, 2014; Dallos & Denford, 2008; Dallos & Vetere, 2009) is offered as a means of integrating this originally psychodynamic concept into a social constructionist approach to therapy.

1.3.4 Food and feeding in the formation of self

Considering the individual's experiencing and presentation of their body, the role of food needs to be contemplated as its eating or restriction has a direct influence upon corporeality (Fischler, 1988; Lupton, 1996; Ogden, 2010; Petrucelli, 2015a). Discussed in chapters two and three, individuals experiencing eating disorders imbibe food with power (Lester, 1997; Malson, 1998) and control it in an attempt to manage their affective life and self-experiencing (Robinson, Mountford, & Sperlinger, 2013; Striegel, Bedrosian, Wang, & Schwartz, 2012; Sweeting, Walker, & MacLean, 2015; Thompson-Brenner et al., 2012). Contemporary sociocultural discourses inscribe meanings upon food, all of which can be employed in the individual's attempt to create and present an acceptable self-presentation, which will be discussed in chapter two.

Food gains further power when its roles as a form of nurturance and in the early establishment of self are considered. From birth, food and feeding act as a mirror through which individuals begin to experience themselves and gain reflections as to how they are perceived in the world. As discussed in chapter three, infants are completely dependent on their caregivers for the satisfaction of their needs; the gratification of hunger arguably being the most vital of these to ensure physical survival. As a consequence of these connections with feeding and early relating experiences, an individual's relationship with their body, food and eating habits

become inextricably linked with their subjectivity (Lanzieri & Hildebrandt, 2016; Lupton, 1996; Ogden, 2010). Relationship patterns form in early infancy which are carried into adulthood and observed in the ways in which the individual relates to life, themselves and others (Orbach, 1986). Chapter three will elucidate how these relationships are symbolically acted out through the eating disordered experience and corporeality, both within and without the therapeutic relationship.

1.3.5 The physical bodies within the therapy room

The bodies of therapists and clients are clearly present in all therapeutic encounters, but arguably have special significance when working with clients presenting with eating disorders. Experiencing fraught or dissociated relationships with their own bodies (Barth, 2016; DeLucia-Waack, 1999; Zerbe, 1993) these individuals afford considerable attention to their own physicality and that of those around them (Daly, 2016; Fairburn, 2008; Kaplan & Garfinkel, 1999; Lowell & Meader, 2005; Rance et al., 2014; Warren et al., 2009). The physical body is significant when working with clients experiencing eating disorders when it is considered both as a symbolic representation of the individual's sense of self (Giddens, 1991; Halsted, 2015; Jabobs & Nye, 2010; Lanzieri & Hildebrandt, 2016; Petrucelli, 2015a) and the concrete medium through which they display that which they cannot express in words (Daly, 2016; Farrell, 2015; Orbach, 1986; Sands, 2016; Zerbe, 1993).

From a sociocultural perspective, the discourses conflating the aesthetic body with personality and gendered characteristics can be read by either the therapist or the client, through the other's body. From a phenomenological perspective and as Merleau-Ponty (1962) claims, the body is always present and inseparable from an individual's experience of themselves and others. In relation to therapy, the bodies of both client and therapist are visible to the other from first meeting and in this way, can be viewed as always visible forms of self-disclosure (Daly, 2016; Jarman et al., 1997; Orbach, 1986). How the therapist feels about their body and how they present themselves within it will be on display for the client to see and hence it is imperative that the therapist is able to model a stable body image and appear at ease within their own physicality (Daly, 2016; DeLucia-Waack, 1999; Orbach, 1986, 2003); a phenomenon which is discussed in chapters four and eight.

Despite this visibility however, little attention has been afforded to the effect of the therapist's body upon the therapeutic encounter, especially in relation to work with clients experiencing eating disorders (Daly, 2016; Fairburn, 2008; Lowell & Meader, 2005). The body is also often neglected within the literature relating to the psychotherapies (Daly, 2016; Rance et al., 2014; Shaw, 2003), and yet by failing to observe the two bodies in the therapy room, it is claimed that therapists are potentially missing an important source of therapeutic communication and understanding (Shaw, 2003).

1.3.6 Embodied countertransference

Extending the focus on the therapist's body, another concept introduced within the research was that of 'embodied countertransference' (Barth, 2001; Burka, 1996; Pacifici, 2008; Petrucelli, 2001), defined in section 1.1.2. As a consequence of the typically dissociated way in which clients presenting with eating disorders experience their subjective selves and bodies (Barth, 2016; DeLucia-Waack, 1999; Zerbe, 1993), there is a tendency to project unacknowledged feelings and experiences onto their therapist, leaving the practitioner open to a range of somatic phenomena. This concept will be discussed further in chapter three and examples of the phenomenon in the literature will be presented in chapter four. Embodied countertransference is a psychodynamic notion and hence not all therapists may be aware of it, nor use it to interpret therapeutic experiences. As with the findings from Franko and Rolfe's (1996) study, this was an occurrence described only by the specialist therapists interviewed and potential reasons for this are discussed in chapter eight.

1.4 Defining eating disorders

Although not all clients presenting in therapy experiencing eating disorders are medically diagnosed, the diagnostic criteria most commonly used are summarised below to further establish their social and historical positioning. These medical definitions can be helpful for clients in accessing treatment and recognition of symptomatic presentations, but they fail to give any indication of the individual's subjective experiences which will be briefly introduced in section 1.5.3.

1.4.1 Medical diagnoses of eating disorders

The American Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders is a widely accepted diagnostic manual and brief résumés of the criteria for eating disorders published in DSM-V (APA, 2013) are offered below. Reducing the conditions to an objectified list of symptoms and behaviours affords no recognition of them as disorders of self and body, situated within a specific historical sociocultural background. Medical diagnoses are afforded power as they inform professionals and influence how they conceptualise their patients and clients. They can be criticised as being culturally influenced disempowering constructions which situate problems within individuals (Maisel et al., 2004), removing any recognition of the role that the client's personal, cultural and familial situations may play in their experience. This medicalised approach furthers western culture's dualistic nature, viewing clients as depersonalised objects to be treated by experts.

DSM-V (APA, 2013) can be criticised for conferring with the historical positioning of eating disorders as essentially female conditions (Botha, 2010; Bunnell, 2016). Previous editions of the manual focused on the female experience and the diagnostic criteria effectively excluded males from satisfying them, especially in relation to anorexia (Wooldridge, 2016). Reflecting the sociocultural changes discussed in chapter two in relation to gendered roles, the diagnostic criteria are changing (Wooldridge, 2016) and were rewritten in the fifth edition of DSM (APA, 2013) to more fully encompass the male experience.

Within DSM-V (APA, 2013) anorexia is characterised by emaciation, the relentless pursuit of weight loss, an unwillingness to maintain a normal or healthy weight, distortion of body image and an intense fear of gaining weight. Bulimia is described as recurrent and frequent episodes of eating unusually large quantities of food followed by compensating behaviours such as purging, excessive exercising or fasting. A feeling also present, according to the criteria, is lack of control around the eating behaviours. Binge eating disorder, previously a sub-category of EDNOS (eating disorder not otherwise specified), was given its own category in DSM-V (APA, 2013). The disorder is described as encompassing recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances and as with bulimia, the episodes are accompanied by

a feeling of lack of control. The behaviour needs to occur at least once a week for a minimum period of three months. Acknowledging the continuum (DeFeciani, 2016; Piran & Cormier, 2005) which exists between diagnostically defined eating disorders and the disordered eating often engaged in by the general population, DSM-V (2013) also recognises the difference between binge eating disorder and non-pathological over-eating.

Before moving away from DSM-V (APA, 2013) diagnoses, the male experience of eating disorders needs to be considered. Although men and boys experience anorexia, bulimia and binge eating disorder, the statistics are still weighted towards females. Due to the sociocultural definitions of masculinity and femininity, there is debate in the literature as to whether 'muscle dysmorphia' could more accurately be categorised as a male manifestation of an eating disorder (Dalgliesh & Nutt, 2013; Murray, Griffiths, & Mond, 2016; Murray, Rieger, Touyz, & Garcia, 2010), rather than its current situation within DSM-V (APA, 2013) as a body dysmorphic disorder. With an intense focus on gaining weight (McCormack et al., 2014; Murray et al., 2010; Murray & Touyz, 2012; Ousley, Cordero, & White, 2008) rather than the weight loss of anorexia, muscle dysmorphia manifests more typically within males but is conceptually similar to anorexia (Mangweth et al., 2001; Strother, Lemberg, Stanford, & Turberville, 2012).

1.4.1.1 Prevalence of eating disorders in the UK

Statistics vary, but general consensus in the literature is that the number of women experiencing eating disorders in the UK increased during the 1970s and 1980s (Gordon, 2001). Although numbers seem to have plateaued since then, it is claimed that dieting and body image concerns are becoming increasingly normative in western consumerist society, especially for women (Daly, 2016; Rabinor, 1995; Sands, 2016). Due to the positioning of eating disorders as essentially women-centric conditions (Botha, 2010; Bunnell, 2016; Dalgliesh & Nutt, 2013; Räisänen & Hunt, 2013), discussed in chapter two, and the historical female focus of diagnostic criteria and therapeutic measurement tools (Stanford & Lemberg, 2012), the numbers of males recorded as experiencing the conditions has remained low. However, as popular culture's focus on the male aesthetic increases (Maine & Bunnell, 2008), gender roles change and the diagnostic criteria increasingly accommodate the male experience (Wooldridge, 2016), and consequently, the

notion of men developing eating disorders is becoming more accepted and recognised (Locker, Heersacker, & Baker, 2012).

It is difficult to ascertain accurate figures regarding the prevalence of eating disorders, but statistics from a report commissioned by the British national eating disorders' charity, 'Beat' (2015), estimates that more than 725,000 people in the UK are affected by an eating disorder. It also claims an increase in prevalence between 2000 and 2009 from 32.3 people to 37.2 per 100,000 (*ibid.*, p. 22). NICE, the National Institute for Health and Care Excellence (2017), estimates that around 11% of people experiencing eating disorders are male, but a 2007 study (Hudson et al., 2007) suggests that this figure may be as high as 33%. It is impossible to ascertain definitive numbers as the figures can only include those who seek professional help in organisations that collect statistics. There are potentially many more people with undiagnosed eating disorders who either access private therapy or do not present for support.

Acknowledged as having a relatively poor recovery rate, statistics show full recovery in only 46% of cases, improvement but no recovery in 33% and the remaining 20% maintain a chronic eating disorder (Farrell, 2015). The conditions also have a higher suicide rate than the general population and than that of many other psychological disorders (Warren et al., 2009). Anorexia has the highest mortality rate of any psychiatric condition with between 10% and 20% of sufferers dying (Farrell, 2015). As well as suicide, death can occur from physiological complications arising as a consequence of the weight-control behaviours (Jarman et al., 1997; Satir et al., 2009; Tasca & Balfour, 2014). Acknowledging these statistics as further evidence of the difficulty inherent in treating eating disorders, it has been claimed that therapeutic work with clients experiencing the conditions could be classified as a specialist area (Natenshon, 2012; Williams & Leichner, 2006). However, the increasing prevalence of both eating disorders and disordered eating in western society suggests that the presentation will become more common in all therapy rooms (Fursland et al., 2012; Jarman et al., 1997).

1.4.2 The subjective experience of eating disorders

In relation to the more subjective and narrative domain of therapy, diagnostic definitions give no indication of the individual's personal experience and pay no

attention to the relational developmental factors which contribute to the manifestation of an eating disorder. The subjective experiencing of eating disorders and how this affects clients' presentations within the therapeutic relationship and consequent challenges for therapists will be discussed in depth in chapters three, four and eight. These subjective experiences are briefly summarised below to allow the reader to begin forming a sense of how clients' selves may be symbolised within their particular presentation.

Individuals who develop anorexia tend to have an inadequately formed sense of self (Duker & Slade, 1988; Tasca & Balfour, 2014). With a fear of being themselves, they want to fade away (Malson, 1998) and want to take up as little psychic and physical space in the world as possible (Orbach, 1986). Their typically thin body visibly illustrates the difficulty they experience accepting nourishment which is echoed in a seeming reluctance to receive the relational nurturance on offer in the therapeutic relationship (Russell & Marsden, 1998). In contrast, those experiencing bulimia are likely to have a more inconsistent and chaotic sense of themselves and approach to life (Duker & Slade, 1988). With an ambivalent relationship towards nurturance, they tend to crave love and support and yet find it difficult to accept when it is offered (Farrell, 1995). In the therapy room, the client experiencing bulimia may appear to be engaging effectively, yet upon leaving is likely to discard everything; metaphorically purging the contents of the therapy (Lawrence, 1987; Zerbe, 1998) before they are able to digest its meaning and assimilate the learnings and nurturance (Russell & Marsden, 1998).

Characteristically experiencing a poor sense of self, binge eating disorder often manifests in individuals who place everyone else's problems and concerns before their own. Typically suppressing their personal needs and feelings through the 'stuffing down' of food, binges become an attempt to manage their difficulties in self-regulation and self-soothing (Malavè, 2015). In the therapy room, this can manifest in the client finding it difficult to voice, or even to be aware of their own thoughts and feelings (Duker & Slade, 1988). As discussed in chapter three, muscle dysmorphia is debated in the literature as a possible male manifestation of an eating disorder (Murray et al., 2010) and is considered as such within this thesis; however, I could find no studies pertaining to its subjective experience.

1.5 Methodology

Having introduced the research topic, situated it within its sociocultural position and summarised the nature of eating disorders, section 1.6 introduces the study's methodological trajectory. The necessity of extending the original intention of employing grounded theory techniques to include heuristic research practices will be presented. The participants of the study will be introduced in section 1.6.2 before the presentation of myself as researcher, in section 1.6.3.

1.5.1 Methodological considerations

Taking account of my personal eating disordered history, my simultaneous work as a counsellor and my existing knowledge of eating disorders, I initially endeavoured to employ a methodology which would allow for exploration of detailed narratives collected from therapists, whilst also ensuring that my personal prejudices were minimised. A qualitative approach was deemed appropriate due to the study's exploratory nature and intention of capturing individual therapists' experiences (Hallberg, 2006). Recognising the impossibility of completely 'bracketing-off' (Jootun, McGhee, & Marland, 2009; McLeod, 2001; Rennie, 2000) my personal experiences, I accepted that I could not remove myself entirely from the study within its social constructionist stance. I therefore sought a methodology which would allow for some personal inclusion and reflection whilst maintaining rigorous methods of data collection and analysis.

Traditional grounded theory (Glaser & Strauss, 1967) initially appealed due to its positioning of the researcher in a more objective mindset, prioritising participants' experiences and thus ensuring that the findings remained grounded in those narratives. Adopting the positivist need for rigour and logical reasoning, the approach offered a systematic way of gathering and analysing participants' data with less emphasis on the researcher and co-construction of knowledge (Rennie, Phillips, & Quartaro, 1988). However, this approach was deemed too objective for this study as my personal investment in the subject area also needed recognition.

Corbin and Strauss's (Corbin & Strauss, 1988, 2008) more interpretive approach to grounded theory was then considered as it aligned more with the postmodern perspective of this thesis and recognised reality as a product of interpretation and

construction. With its relativist ontology acknowledging multiple meanings and ways of knowing, this approach granted greater researcher presence in the interpretation of the data. However, the overly prescriptive formulaic methods of coding (Glaser, 1992) which Corbin and Strauss (1988, 2008) relied upon to generate categories retained too much emphasis on post-positivist thought.

Aligning more with the social constructionist slant of the thesis, the constructivist approach to grounded theory (Charmaz, 2006) was thus decided upon.

Recognising that truth and meaning arise from engagement with the world this approach allowed for the co-creation of findings through the interaction between the researcher and the researched (Silverstein, Auerbach, & Levant, 2006). The researcher's influence upon the interpretation of the findings is acknowledged, thus allowing for their greater presence (Anderson, 2014; Charmaz, 2006). Although not objective, the researcher is separate from the researched phenomena (Merry & Levers, 2013) and knowledge is created through the interaction between the researcher and the data. With no objective truth to discover, the findings can only ever be one possible version of reality, influenced by the participants, the social situation and the researcher (McNamee, 2014).

However, as the research progressed and with an increasing realisation of the inseparability of researcher from research situation, I became aware of the study's escalating impact upon myself throughout my engagement with the preliminary study. Therefore, and as discussed in chapter five, it became apparent that the grounded theory approach was somewhat lacking for this particular project with myself as researcher. The ontological and reflexive positioning I held as a counsellor was unavoidably influencing my engagement with participants, the subsequent data, the literature and my experience of conducting the research; all of which needed to be afforded attention.

As I became further embedded in the subject, I understood myself to be engaging reflexively in a manner reminiscent of heuristic research's 'immersion' phase (Moustakas, 1990). The impact of conducting the research upon me as a researcher, counsellor, and on a more personal level, became increasingly apparent and I considered that the material arising within me had potential value for informing my reading of the literature, the research interviews and data analysis (West, 2001). As the methodology evolved, I was aware of its parallels with my

counselling approach and my reflexive way of working with clients (Etherington, 2001a, 2004a, 2004b, 2004c). Heuristic research practices, with their emphasis on reflexivity, replicated this way of working and it seemed appropriate to recognise those existing skills as an integral part of my subjectivity and thus to employ them within the research.

From the postmodern perspective, methodology can be considered as fluid and evolving in response to the emergent research, and rather than choosing a fixed method at the outset, the researcher has the option to shape their own research process (Simon, 2014). Considering knowledge as created within relationship, this enables the methodology to be informed by the researcher's developing interaction with the research (Bava, 2014). Hence, progressing into the main body of the study, heuristic research methods of analysis were employed alongside the already established grounded theory protocols in order to create a 'heuristic grounded theory' methodology.

Although this created a 'bricolage' approach (McLeod, 2001), this flexibility allowed for the changing demands of the study to be accommodated. It also reflected the fluid and integrative way of working suggested with clients experiencing eating disorders (Barth, 2016; Natenshon, 2012; Petrucelli, 2016; Satir, 2013; Wooldridge, 2016). Acknowledging the social constructionist idea of selves being influenced by other selves and discourses, this methodological adaptation illustrates how researchers, data and methodologies are inseparably entwined.

The shift arose through the ontological reflexivity I brought with me as a counsellor and my increasing recognition of the inseparability of researcher from both the research and the cultural context. Having initially attempted to create distance from my counselling ontology, I realised that this was problematic and I instead began to see research "as a personal journey of discovery" (Bager-Charleson, 2014, p. 3). Du Plock (2014, p. 125) claims that "paying attention to the researcher's own reactions will add to the research" and that through this process, changes are incorporated into the study. The focus of my research then shifted from its primary intention of producing academic knowledge towards a more practice based research study. Rather than simply focusing on the exploration and understanding of therapists' experiences, it increasingly sought to generate knowledge which would transform both my own and other therapists' practice.

As a consequence of the unanticipated affects of conducting this research upon myself, hindsight led me to consider if an autoethnographical approach (Ellis, 2004; McIlveen, 2008; Meekums, 2008; Muncey, 2010; Wall, 2008) would have been more appropriate, allowing more extensive use of my own subjective experience. When I embarked on the study it was from the role as researcher and I intended, perhaps naively, to use the phenomenological concept of 'bracketing' (McLeod, 2001), defined as a process of putting aside one's beliefs, not making judgements and remaining open to the data (Jootun et al., 2009), to set aside my personal and counsellor identities. However, my engagement with the research quickly led me to realise that, in the same way that selves cannot be separated from their cultural position, my personal and counsellor subjectivities could not be kept apart from my researcher identity. Recognising the reciprocal nature of these three aspects of myself, a more equal weight could potentially have been afforded to each of them. To an extent which I had not anticipated, the research process caused me to reflect upon, and rewrite some of my own history, thus altering my personal narrative. My therapeutic approach towards my work with clients was also changed as a direct consequence of my engagement with the study; a powerful and unsettling challenge to my professional subjectivity. Significant not only for myself, this alteration of my own subjectivity mirrors the potential for the therapists within this study to find their own experiences influenced through their work.

Although an autoethnographical approach to this study would have been interesting, it would have afforded different results and would have been a much more exposing experience for myself as researcher, and other people involved in my life story. The reflexive writing I include in chapter five, allows for a more limited presentation of my personal experience to illustrate the more pertinent ways in which this research affected me personally and professionally which limits the degree of my exposure. This kind of reflexive account is also recognised as being increasingly common in qualitative therapy studies as a rhetorical device, "allud[ing] to the humanistic notions of authenticity, trustworthiness or transparency" (McLeod, 2001, p. 201). The approach taken, combining grounded theory and heuristic research discussed in chapter five, seemed more appropriate as it ensured that the focus remained more on the participants than it did on myself.

Incorporating heuristic research's notion of 'indwelling' (Moustakas, 1990), alternative forms of knowledge, other than those relying on intellect, played a role in

the research process. Further illustrating the inseparability and constant interplay of my counsellor and researcher subjectivities, my knowledge creation throughout the study was not merely a cognitive process, but a more embodied and intuitive one; much as I would practice in the therapy room. Building on Aristotle's concept of *phronesis* (Svenaeus, 2014; Tyreman, 2000), or practical knowledge and intelligence, it was impossible for me to disconnect from the ontological position I held as a counsellor engaging in simultaneous clinical work. Understanding gained throughout my education and ongoing practice provided me with a "heart knowledge" (Nieminen, Mannevaara, & Fagerstrom, 2011) that I could not ignore and which continuously influenced my thinking, analysis, reading and writing. This concept will be expanded in chapter five.

1.5.2 The research participants

Having briefly described the methodological direction of the study, this current section introduces the research participants and their recruitment procedures; both of which will be discussed in greater detail in chapter five. Eighteen counsellors and psychological therapists, with varying levels of experience of working with clients, either diagnosed with an eating disorder or engaging in disordered eating practices, were interviewed during the data generation process.

Although therapeutic orientation and therapist experience of working with clients presenting with eating disorders had not been specified in the recruitment material, all five participants in the preliminary study were person-centred counsellors working in general practice with only limited knowledge and experience of clients presenting with the conditions. This created its own saturation point (Charmaz, 2006; Glaser & Strauss, 1967) and, through the process of theoretical sampling (Corbin & Strauss, 1988, 2008), guided the research towards the recruitment of specialist therapists with greater experience of the field for the main body of the study. The person-centred counsellors and specialist therapists thus configured into two distinct data sets whose experiences could be compared. Knowledge gaps were visible between the two groups which suggested possible training implications for trainee and non-specialist therapists. The differences which emerged between the findings will be presented in chapters six and seven before being discussed in chapter eight.

The configuration of two data sets led also to consideration of the effects of differing therapeutic approaches upon clinicians' conceptualisations of eating disorders and thus their own experiences. Whilst the counsellors remained within their person-centred practice, the specialist therapists recognised the efficacy of therapeutic flexibility and integrative practice and tended to draw on a range of therapeutic interventions in their work, with an emphasis on the psychodynamic elements (Starkman, 2016a; Tasca & Balfour, 2014) of eating disorders. This more integrative way of working, and the impossibility of devising a definitive treatment protocol (Jarman et al., 1997; Petrucelli, 2016; Satir, 2013; Tasca & Balfour, 2014), will be discussed in chapter eight. This also evidences the notion of multiple realities and the recognition that, depending upon the psychotherapeutic discourses which therapists subscribe to, their interpretation of both their own and their client's experiences will differ.

1.5.3 The researcher

Before concluding this introductory chapter, it is necessary to introduce myself as the researcher, as my presence within the study became an increasingly visible element of its methodology. As a forty-four year old white British female who has lived all of my life in England, I have been subjected to the sociocultural discourses of the western consumerist culture in which this study is situated. As a counsellor, I have personal experience of working with clients presenting with eating disorders, and I also have a personal history, throughout my late teens and twenties, of both anorexia and bulimia. When I embarked upon this study I had no intention of disclosing any elements of my personal narrative or history. However, as per the methodological progress introduced in 1.5.1, it became evident that my personal experiences and subjectivity could not be completely detached from the research, and to ensure transparency within the study, had to be given a voice.

The personal journey I have travelled across the course of this study was not anticipated at its outset. Its trajectory is evidence of the interaction between researcher and research, and the potential for studies to inform and change their inquirer. The process of interpretive and reflexive reflection on the data and literature created associations for myself which both changed and deepened my previous understandings of my own experience and my ongoing therapeutic practice. This in turn afforded a deeper engagement with the emerging findings

and the literature resulting in a more thorough reflexive and reflective process between the data, the participants, my expanding knowledge and my own experience. I include my experience as a reflexive writing monologue in chapter five.

1.6 Conclusion

This chapter has introduced the research topic of therapists' experiences of working with clients experiencing eating disorders. As complex conditions presenting numerous challenges to therapists' professional and personal identities, eating disorders were recognised as a topic worthy of exploration (Thompson-Brenner et al., 2012). The discourses which both therapists and their clients are exposed to in relation to food, eating and the body were introduced in order to position both eating disorders and the therapeutic relationship within contemporary western consumerist society.

The study's main philosophical perspective has been established through the chapter's discussion of its postmodern, social constructionist approach to knowledge creation. My initial allegiance to using a grounded theory approach to the exploration of therapists' experiences was introduced before adapting this to more fully encompass my subjective experience of conducting the research, thus illustrating the inseparability of the researcher from the research context and emerging knowledge.

Chapter two begins by discussing the positioning of the body in western consumerist society to illustrate how bodies and selves are socially constructed. Through a brief historical depiction of embodied thought in the western world, and especially that relating to the female, influences on women's embodiment today will be elucidated. Within this, the inter-relatedness of the body with the individual's subjectivity will be elicited as this is a key element in understanding the eating disordered experience.

Chapter 2

Disordered eating in western culture

2.1 Introduction

Sociocultural discourses throughout time have affected meanings attached to food, eating, body shapes and gendered identity constructions (Bruch, 1973; Crastopol, 2001; Fischler, 1988; Lawrence, 1987; Lupton, 1996; Sollberger, 2014). Everyone within a culture is affected to some extent, but arguably these discourses have increased significance for those who develop eating disorders and consequently, for the therapists who work with them. Accepting that eating disordered practices have been socially constructed throughout history (Duran, Cashion, Gerber, & Mendez-Ybanez, 2000), the positioning of them in contemporary western culture will be discussed within this chapter. A brief historical commentary will demonstrate their positioning as female-centric conditions (Botha, 2010; Bunnell, 2016; Dalgliesh & Nutt, 2013; Morgan, 2008; Robinson et al., 2013) which led to the experience of eating disorders within males being marginalised (Forbush et al., 2007; McCormack et al., 2014). This is beginning to be recognised and rectified in the literature, and in section 2.7.2, the present day experiences of men and boys in relation to body image and eating concerns will be discussed.

Both subjectivity and the body are arguably significant elements of the experiencing and understanding of eating disorders and hence their inseparable nature is considered in sections 2.6 and 2.8. This thesis draws largely on a social constructionist notion of self in section 2.6, but, recognising this as objectified and disembodied in western twenty-first century consumerist society (Burkitt, 2008; Shaw, 2003; Soth, 2006), it also recognises the phenomenological self experience of (Merleau-Ponty, 1962) as a more embodied subjectivity (Grosz, 1994) in section 2.8. This embodied self however, is recognised as situated within contemporary society and thus subject to the influence of sociocultural discourses.

In contrast to the psychological notion of an essential inner self to discover (Lock & Strong, 2010), social constructionism asserts that self is situated within discursive

relations and that self and culture are interdependent (Lock & Strong, 2010; McLean, 2016). From this social constructionist perspective, the body is not merely a fixed physical object, but can be conceptualised as “an interpersonal, linguistic, cultural, co-creation” (Sands, 2016, p. 28) situated within a particular sociohistorical time. Individuals transform their bodies through diet, exercise, body art and surgery and it becomes an “object of cultural inscription” (Hepworth Pg 99) enunciating and displaying the rules of a given culture (Orbach 2004). The body is significant as its physical presence can be thought of as the concrete way in which individuals exist in the world (Crossley, 2006). Physical appearance is of primary importance in the evaluation of others (Dakanalis et al 2015) and when external appearance is considered symbolically as “a way of giving external form to narratives of self identity” (Giddens, 1991, p. 62), altering the body has “profound social significance” (Crossley, 2006, p. 12) in relational terms. Particularly in contemporary western consumerist culture the body is recognised as a signifier of identity (Halsted, 2015; Jarman et al., 1997; Petrucelli, 2015a).

Dieting and body consciousness are increasingly normative in western society (Daly, 2016; Rabinor, 1995; Sands, 2016) as people aim to create an acceptable version of self through the achievement of the aesthetic ideal and its conflated personality and lifestyle attributes (Lanzieri & Hildebrandt, 2016; Lupton, 1996, 2013). This has created a disembodied experience of self (Burkitt, 2008; Shaw, 2003; Soth, 2006) and the eating disordered experience can be considered as an exaggerated version of this phenomenon (Maisel et al., 2004). The contrasting understandings of embodiment as a lived experience versus the socially constructed body (Baillie, 2012) are particularly relevant for the eating disordered experience as it is claimed that individuals living with the conditions benefit from moving away from contemporary culture’s disembodiment (Soth, 2006) towards a more embodied self experience (Sands, 2016).

According to Duran et al. (2000, p. 28) dominant cultural demands place “strict standards upon women and men dictating ideal appearance.” These sociocultural factors both promote and maintain eating disorders (Riva et al., 2013), with western society’s values of appearance significantly contributing to eating pathology (Daly, 2016). However, not everyone in western culture develops an eating disorder (Riva et al., 2013; Ty & Francis, 2013) and hence cultural influences have to be acknowledged as only part of their cause (Petrucelli, 2015a). Therefore, some of

the psychological factors which contribute to their development and maintenance will be discussed in chapter three in relation to the psychotherapeutic approaches of the therapists interviewed for this study.

To contextualise the contemporary positioning of eating disorders in western culture adopted in this thesis, it is helpful to consider the historical and sociocultural discourses which have influenced their recognition and understanding; relevant ideas and events from the Middle Ages onwards will be presented in sections 2.3 – 2.5. Before this though, the role of food is considered in section 2.2 to illustrate its power and meaning for individuals who use it to influence their physical body and, as a consequence, their subjectivity.

2.2 Food and the body

The embodied experience is inextricably entwined with food as its eating or restriction enables the individual to influence their body for reasons of health, aesthetics or self-expression. Although food is fundamental for physical survival and is a “central issue in most peoples’ lives” (Petrucci, 2015a, p. 17), its significance goes beyond simple nutritional sustenance (Curtin, 1992; Fischler, 1988; Lester, 1997; Lupton, 1996; Orbach, 1986, 1999; Woolf, 2013). There are multiple complex discourses attached to food (Bruch, 1978; Curtin, 1992; Ogden, 2010) creating values reflecting an individual’s identity (Petrucci, 2015a) and position within society (Bruch, 1973; Crastnopol, 2001; Fischler, 1988; Lawrence, 1987; Lupton, 1996; Sollberger, 2014). The physiological experience of hunger is biological but an individual’s food preferences must also be recognised as products of their familial and sociocultural environment (Lupton, 1996, 2013; Ogden, 2010; Sollberger, 2014). Considering the body as an external expression of identity (Crossley, 2006; Giddens, 1991), the food eaten enables people to construct their subjectivity through their nutritional consumption and behaviours (Hepworth, 1999) and the notion that “‘you-are-what-you-eat’ becomes a reality” (Petrucci, 2015a, p. 21). The significance of an individual’s relationship with food becomes apparent when it is considered as a microcosm of their relationship to life itself (Roth, 2010). In relation to clients presenting with eating disorders, the ways in which they regulate their affects with food will be mirrored in how they approach their relationship with the therapist (Petrucci, 2015a).

The unique nature of food as a liminal substance which crosses bodily boundaries, changing from an external object into an internally used source of fuel for physical existence and transformation infuses it with power (Curtin, 1992; Fischler, 1988; Lester, 1997) and through this process, the food eaten quite literally becomes the individual (Fischler, 1988; Lupton, 1996; Ogden, 2010). By traversing the boundary between 'me' and 'not-me', food is used to negotiate self-boundaries in relation to culturally constructed discourses regarding subjectivity and gender identity (Lester, 1997), and like other transitional substances it acquires "enormously powerful symbolic potential" (ibid. 1997, p. 487). Food is thus afforded power for the individual experiencing an eating disorder who conflates their physical body with their subjective self (Halsted, 2015; Lanzieri & Hildebrandt, 2016; Lupton, 1996, 2013; Petrucelli, 2015a) and feels that by controlling what they eat, and therefore, how they look, they can control who they are (Lupton, 1996; Petrucelli, 2015a). This is especially relevant in contemporary western society in which it is claimed that a person's body defines who they are (Halsted, 2015; Jabobs & Nye, 2010; Lanzieri & Hildebrandt, 2016; Petrucelli, 2015a).

Ascribing such power to food leaves the individual fearing that through its consumption they will lose control of not just their eating, but of their self-boundaries (Lester, 1997), thereby risking the destruction of an already fragile sense of self-integrity (Malson, 1998). The typical concrete thinking style of the individual experiencing an eating disorder (Duker & Slade, 1988) creates a sense of terror at the thought of assimilating food into the body and its consequently becoming part of themselves (Levens, 1995). An element of the eating disordered experience is situated in the attempt to create a sense of independence by denying the body's physical need for food and the individual's psychological needs for nurturance and relationship with others (Wooldridge, 2016). Therefore, food, via the basic human need to eat, becomes a powerful threat to this sought after sense of autonomy (Curtin, 1992).

Historically, feeding has been intimately connected with the female experience as biologically, women were considered to be the essential food providers for their babies (Bynum, 1987). A "primal association" was thus formed between food and mother (Chernin, 1985, p. 98) and, as discussed in chapter three, this relationship plays a significant role in psychological experiencing and self-development. However, the advent of formula milk means that feeding baby is no longer limited to

mother, thus allowing fathers and other caregivers to play a greater role in feeding and nurturing, thereby influencing childhood development and attachment patterns. Despite this, and as will be evidenced in chapter three, much of the literature relating to eating disorders and attachment remains written with mother as primary caregiver (Pilecki & Józefik, 2013; Rice, 2014) and denoting disturbances in the early mother-child relationship as contributing to their development (Barone & Guiducci, 2009; Gander, Sevecke, & Buchheim, 2015; Wooldridge, 2016).

As the family environment provides the initial exposure to the social aspects of eating, it is unsurprising that, as discussed in chapter three, familial factors are a key influence in the development of eating disorders (Duran et al., 2000; Wooldridge, 2016). Illustrating the significance of food in an individual's early attachment experience, feeding is recognised as the primary form of relating in the initial months of life, and food thus becomes "one of the most important early experiences of mutual regulation" (Wooldridge, 2016, p. 99). Food, in its role in the resolution of the discomfort generated by hunger (Bowlby, 1969) becomes inextricably entwined with the development of attachment patterns (O'Shaughnessy & Dallos, 2009). Caregivers' attitudes towards the baby, its body and the feeding process will affect the infant's relationship towards both food and relational intimacy for the duration of their life (Levens, 1995; Lupton, 1996; Orbach, 1986). As Petrucelli (2015b, p. 37) claims, neuroscience is "confirming that our ability to manage emotions is directly tied to our early attachment experiences."

Food is recognised as a "particularly compelling selfobject substitute" (Sands, 2003, p. 106) in its role as bridge between self and other, and in the transmission of soothing and comfort (Sands, 2003). When the caregiver has difficulty empathically responding to the infant's hunger needs, the child's developing capacities for self-regulation are deeply impacted and growing self-object functions are impaired (Wooldridge, 2016). When less than adequate attachments, discussed in chapter three, have been formed, food and eating behaviours can be used to enact unresolved conflicts from early care-giving relationships (Schneider, 1991). Food therefore, as the first source of nurturance and comfort from another upon whom the infant is dependent, becomes enmeshed with the satisfaction of needs, and to some extent, explains why the eating disordered individual regulates affect through their use of food (Robinson et al., 2013; Sands, 1991; Striegel et al., 2012; Sweeting et al., 2015; Thompson-Brenner et al., 2012).

Having considered the role and significance of food and its consumption in the individual's development and experience, the chapter moves on to illustrate the changing sociocultural meanings attached to food and bodies, and especially until recently, those of the female. Through this, one of the inherent complexities for therapists when working with clients presenting with eating disorders will become apparent as sociocultural influences on an individual's embodied experience are made explicit.

2.3 Eating distress in the Middle Ages

Anorexia nervosa was not formally identified until 1873, but history shows that food and body control have always been adopted by individuals in an attempt to express their subjective situation. Although the symptoms and behaviours are similar, the meanings attached to these experiences are affected by contemporary cultural discourses. Illustrating the beginning of the positioning of eating disorders as feminine conditions, the literature focuses on the experiences of the 'female fasters' (Brumberg, 2000) in the Middle Ages. Their stories provoke discord as to whether these early fasters were suffering from anorexia in the way that it is understood today or from a different condition (Bell, 1985; Brumberg, 2000; Bynum, 1987; Vandereycken & Deth, 1994). This thesis suggests that the experiences of the 'female fasters' mirror the current day anorectic experience, but due to contemporary sociocultural discourses, different meanings are attached to the symptoms, behaviours and expression of self-experience.

As with the modern day experience of anorexia, the medieval female fasters restricted their food intake in denial of their physical and aesthetic needs (Brumberg, 2000). However, and when considering the power of contemporary discourses in affecting meaning of an individual's experience, the motivation for doing so was different. Christian beliefs dominated during the Middle Ages and thus the social history of eating in the west is considered as "widely informed by Christendom" (Sollberger, 2014). From this Christian perspective, corporeal discipline was concerned with satisfying religious and spiritual concerns as opposed to the aesthetic and hedonistic significance of today (Williams & Bendelow, 1998). Within Christianity's patriarchal structure the female body with its uncontrollable biological cycles became equated with physical desires and sin (Brumberg, 2000; Bynum, 1987; Lawrence, 1995; Lelwica, 1999). Women were considered spiritually

inferior to men, with their only hope of salvation resting with practices of self-sacrifice, suffering and submission (Lelwica, 1999). Entangling fasting with self-discipline and negation of physical needs, religious females pronounced divine inspiration and penance of their human body in pursuit of becoming united with Christ as their motivation for food abstinence (Vandereycken & Deth, 1994). Illustrating how historically situated discourses influence meaning, Bartky (1990) recognises a similar contemporary phenomenon in her “fashion-beauty complex” which, in an increasingly secular culture she argues has replaced the church in establishing dominant ideals of femininity. She writes that the complex “generates a sense of shame and inferiority in relation to the body, akin to original sin, but then offers salvation and relief of those feelings” (ibid., 1990, pg 34) through the attainment of a culturally prescribed idealised body.

2.4 The civilising body

Progressing from the Middle Ages, the period from 1600 to 1900 witnessed increasing secularisation across Europe and a cultural shift towards industrialisation and medicalisation (Vandereycken & Deth, 1994). Within this changing societal position the connections between fasting and religion began to loosen and the motivations of women restricting their food intake began to change (Bell, 1985; Bynum, 1987; Vandereycken & Deth, 1994). As scientific discourse became increasingly prominent, the ‘fasting girls’ (Brumberg, 2000) were increasingly referred to physicians rather than the clergy, who, with their greater understanding of human biology, approached the women with increasing scepticism (Vandereycken & Deth, 1994). Concurrently, Cartesian dualism became prominent with Descartes’ (1596 – 1650) writings illustrating an increasing separation of the mind and body in western thought. Descartes’ thinking established the hierarchy of mind over nature and the separation of consciousness (mind) from the body which objectified the natural world and created the dualism of subject and object. The developing scientific discourse of the time enabled him to site the body within early objective science, viewing it as a machine and separating subjective experiencing from this (Grosz, 1994). The dualist position remains evident in the twenty-first century in which Soth (2006, p. 46) claims that “we have lost any sense of identification with the body.” Arguably, this position removes consideration of the socially responsive nature of the embodied self (Chard, 2014) and contributes to the objectified view of the body and subjectivity evident within problematic body

image and the experience of eating disorders (Barth, 2016; DeLucia-Waack, 1999; Zerbe, 1993).

Privileging the male experience, the dualist position equated masculinity with rational thought, logic and the mind, whilst the irrational and uncontrollable corporeal experience was attributed to the feminine (Grosz, 1994). Early psychoanalytic thought at the end of the nineteenth century reinforced this perspective as hysteria was designated as a female malady by the male doctors of the time (Hepworth, 1999; Malson, 1998). Considering the influence of these social discourses upon the female body, the subordination of the feminine body and experience in western culture becomes apparent.

Scientific and medical discourses from the nineteenth century onwards reinforced dualism with the body becoming increasingly viewed as an object of the natural sciences. This objectified approach created a body which could be seen, understood and worked upon, but which left little space for the subjective experiencing of the individual; a position which Soth (2006, p. 114) argues has resulted in a sense that “disembodiment is the human condition” in the twenty-first century. The civilising process continued, and as discussed in section 2.4, by the Victorian era, the privacy and restraint of the physical body and emotions had become a powerful signifier of the individual’s position in society (Brumberg, 2000).

2.5 The identification of anorexia

Sociocultural discourses from the Victorian era onwards can be considered to have further contributed to the early positioning of eating disorders as class and gender bound conditions. In 1873 ‘anorexia nervosa’ was first named by English physician Sir William Withey Gull (1816-90) and became a recognised medical condition (Brumberg, 2000; Vandereycken & Deth, 1994). A contemporary of his in France, neurologist Dr. E.C. Laségue (1816-1883), concurrently labelled the self-starvation symptoms his patients were experiencing as “l’anorexie hysterique” (Brumberg, 2000) PAGE 117. Unable to locate an aetiology for anorexia within the physical realm, both Gull and Laségue began to look towards the psyche (Hepworth, 1999). Despite both doctors documenting cases of anorexia in young males, they drew on contemporary theories of femininity and hysteria, describing it as an affliction affecting mostly young females (Hepworth, 1999). Anorexia’s classification as a

'nervous disease' labelled it as pathological and introduced the use of medical and scientific discourses in its management (Hepworth, 1999).

The evolving roles attached to food and young women within middle class Victorian culture illustrates the increasing influence of sociocultural factors on female aesthetic appearance and the beginnings of the positioning of eating disorders as a female middle-class conditions (Brumberg, 2000). Brumberg (ibid.) describes how the physical presentation of the young woman was paramount in acquiring a desirable suitor to confirm her family's place in society. The middle-class mother took responsibility for her daughter's development, leaving the young woman with limited capacity for autonomous self-development (Brumberg, 2000). As discussed in chapter three, difficulty in establishing a self-construct or creating a fixed self-narrative in relation to external discourses (Gergen & Kaye, 1992) is recognised as a key factor in the development of eating disorders (Duker & Slade, 1988; Tasca & Balfour, 2014; Ty & Francis, 2013).

Due to the plentiful nature of food for the Victorian middle classes, it began to emerge as a symbol of morality and as a signifier of the family's place in society (Brumberg, 2000). Food became increasingly equated with work and drudgery as plumpness shifted from being a sign of prosperity to an indication of work and the lower classes (Brumberg, 2000). The ready availability of food meant that middle class parents were able to use it as a means of punishing or rewarding their children (Vandereycken & Deth, 1994) thus affording increased emotional meanings to it. The widespread easy availability of food across the social classes today means that eating disorders are no longer so class based; contemporary western eating behaviours are not influenced as much by scarcity, tradition and ritual, but rather to "motives like pleasure, amusement, healthiness and body shaping" (Sollberger, 2014, p. 246).

Following Christian ideology, the feminine Victorian appetite, and therefore the female body, became "a barometer of a woman's moral state" (Brumberg, 2000, p. 179). As for the 'female fasters' of the Middle Ages, 'good women' eschewed physical carnal pleasures, controlling their appetites for sex and food and therefore remaining slim, whilst 'evil women' gave in to those appetites and thus became overweight (Lelwica, 1999). Hence it became imperative that young women were seen to be in control of their corporeal appetites and desires, resulting in the thin

female body becoming increasingly valued as a symbol of good moral and social standing (Brumberg, 2000). Modern western society's equating of thin female bodies with the socioculturally admired traits of control and restraint can be seen originating here. For the young girl, refusing her family's food became a powerful way to assert herself in a controlled and discreet way which suited Victorian values (Brumberg, 2000).

This early situating of anorexia established eating disorders within discourses of femininity, social class and pathology, and associated them with the role, experience and body shape of women. Botha (2010) recognises the history of anorexia as an "essentially psycho-medical notion of a female condition" (ibid., pg 4) and acknowledges that the current notion of anorexia still draws on "taken for granted dominant historical and cultural discourses" (ibid., pg 4). As will be discussed in section 2.7.2, this has had a detrimental impact on the masculine understanding and male experience of eating disorders.

Throughout the discussion so far, the role of the body in the presentation of anorexia has been evident. Before considering the situation of eating disorders in the twenty-first century, the thesis therefore turns to a discussion of the body in postmodern western culture to illustrate its place in an individual's subjective experience.

2.6 The body in postmodern western culture

Foucault's work, with his worldview of a culture being established in practice at a particular time and place, is helpful in understanding the perspective taken in this thesis and will be drawn upon in section 2.6.1. This section will also begin the argument, drawn upon throughout the remainder of section 2.6, that the body in western consumerist society has become objectified, creating a dualist subjective sense of disembodiment (Burkitt, 2008; Soth, 2006), which is a significant feature of the experience of an eating disorder (Barth, 2016; Zerbe, 1993).

2.6.1 Foucault

Foucault describes a body and self socially and historically situated and produced within discourses of power. The body is viewed as a concrete form upon which

dominant discourses and power relations operate to produce humans as subjects (Foucault, 1975) with subjectivity being constructed within language and social discourses. For Foucault, subjectivity is individually constructed as a social activity and from this perspective its relational nature becomes apparent. With no essential self to discover, identity is assembled according to the dominant cultural discourses available at the time. Foucault grants individuals freedom in relation to this, claiming that people can choose to embrace dominant cultural virtues, in ways that show their 'truth'. Personal truth for Foucault however, cannot be separated from cultural truths and, as in the case of people who develop eating disorders or body image concerns, a cultural virtue in the form of the attainment of the idealised body and its concomitant personality and lifestyle attributes, can become a personal and unquestioned reality (Petrucci, 2016). Despite this acknowledged freedom, Foucault argues that individuals shape their bodies in expected ways as social expectations infiltrate society in such a way that they are made to seem natural (Gremillion, 2003) and thus "[s]ocial and cultural discourses become inscribed on a docile body" (Hepworth, 1999, p. 99). As a result of the process of subjectification (Diamond & Quinby, 1988; Rabinow, 1984) individuals become subjects of particular discursive formations through the operation of power. Discourses gain their influence by prescribing and shaping human behaviours and action according to socioculturally assigned norms (Rice, 2014).

The idea of Foucault's 'docile bodies' (Foucault, 1975) illustrates the role of external agencies in an individual's construction of their body and subjectivity as cultural expectations are internalised and acted upon. The disciplined self-surveillance practices individuals engage with in terms of dieting, weighing, mirror-checking, exercise and other forms of body modification to manipulate their bodies into sociocultural ideals can be considered as "technologies of the self" (Foucault, Martin, Gurman, & Hutton, 1988). Individual subjectivities are created and presented upon the body through the person's often unconscious introjection of social norms (Petrucci, 2016) and the comparison of the individual's self and their body to peers and sociocultural ideals. Such self-surveillance practices, alongside powerful media representations, result in bodies becoming viewed and experienced as objects, reinforcing the "pervasive disembodiment" (Soth, 2006) and dualist nature of embodied experience in contemporary western society (Burkitt, 2008; Shaw, 2003).

Using the 'panopticon' of Bentham's writing, Foucault (1975) describes prisoners internalising the rules constant surveillance of the prison so that they become self-policing subjects (Crossley, 2006; Lock & Strong, 2010). In a similar way, individuals ascribe to, and internalise, contemporary sociocultural discourses which then come to constitute their identity (Halsted, 2015; Lanzieri & Hildebrandt, 2016; Lock & Strong, 2010; Petrucelli, 2015a). Bartky (1988) uses the concept of the panopticon to conceptualise the constant checking of appearance in the mirror as a relentless form of self-surveillance creating a self-conscious reflexivity (Waskul & Vannini, 2006). This sense of reflexive embodiment establishes an experience in which object and subject are the same and yet a temporal split occurs between them, generating the lived sense of separation (Crossley, 2006) which creates self-objectification. Crossley (2006) embeds this reflexive embodiment within social norms to create a sense of embodiment fashioned through reflexive looking glasses and from his interactionist perspective, reflexive embodiment is relational as a result of the groups in which individuals position themselves. As opposed to the self-policing reflexivity evident in Foucault's theories, Crossley (2006) posits that reflexive embodiment arises through the basic self-consciousness and bodily awareness that social interaction necessitates. The individual disciplines the activities of their own body, with the social assistance of the gaze of others (Lock & Strong, 2010). The idea of the 'norm' is at the heart of surveillance and these norms serve as models against which the self continually judges, measures, disciplines and corrects itself (Blood, 2005). For people experiencing eating disorders or problematic body image concerns, this reflexivity is a constant concern and serves to create and maintain a dualist, objective and dissociated corporeal experience (Burkitt, 2008; Soth, 2006).

Drawing on Foucault's view of the body as socially produced and not just as a biological object, feminists, such as Orbach (2009), Bartky (1990) and Bordo (1993), understood it as a medium for power and social control (Blood, 2005). Bodies are constructed through practices of body management (Bordo, 1993) and power relations come into being via the actions of individuals as they discipline themselves in accordance with dominant norms and ideals. The reflexive embodiment created via this process of self-surveillance then assures the automatic functioning of power (Blood, 2005) and external control (Crossley, 2006). Unlike Foucault, whose theory did not take gender into account, Bartky (1988, 1990) and Bordo (1991, 1993) stress that the cultural construction of the body is

always gendered. As illustrated through the changing experiences of women in relation to the sociocultural influences on the body, the focus throughout the early and mid twentieth century was on the regulation and discipline of female bodies in relation to dominant norms of femininity. The power of social control thus produced women's bodies through practices of body management (Bordo, 1993). However, as discussed in section 2.7, society has changed over the last few decades and men and boys are becoming increasingly subjected to similar pressures (Dakanalis, 2015; Locker, Heesacker, & Baker, 2012).

Furthering this cultural dualist disembodiment (Burkitt, 2008; Soth, 2006), Piran and Cormier (2005) use Fredrickson and Roberts' (1997) 'objectification theory' to examine the social discourses that construct women's bodies as objects to be gazed at and the adverse impact such objectification has on women's self and body experiences. Although Piran and Cormier's (2005) work focuses on the female experience, it would seem plausible that it could also encompass the masculine, especially as objectifying portrayals of men have increased over the past three decades (Martins, Tiggemann, & Kirkbride, 2007). Through objectification theory, women have been socialised in western culture to view themselves as aesthetic objects (Heath, Tod, Kannis-Dymand, & Lovell, 2015) to be manipulated to fit society's ideal (Rice, 2014). The body monitoring which is necessary to achieve this results in the individual exhibiting increasing levels of self consciousness which motivates higher levels of surveillance to appearance (Lanzieri & Hildebrandt, 2016). Society's idealised images are used as the frame of reference through which self is evaluated and the individual adopts the observer's perspective, seeing their body as an object and placing value on their self based on these cultural idealisations (Lanzieri & Hildebrandt, 2016). Such self-objectification manifests in persistent critical body surveillance in order to adhere to internalised cultural ideals, which for individuals who cannot achieve such physical perfection can lead to a sense of embarrassment or shame (Finlay, 2005; Piran & Cormier, 2005). Viewing self and the body in this way necessarily creates a separation from the individual's subjective self which becomes increasingly objectifying and alienating (Finlay, 2011). In relation to therapists, the danger inherent in unconscious adherence to objectification theory is that they view their client's body as an object, rather than attuning also to its subjective and embodied experience.

2.6.2 The contemporary western consumerist body

Sociocultural influences upon the human body and subjectivity have become increasingly ubiquitous throughout the twentieth and early twenty-first centuries due to the escalating proliferation of mass media representations on TV, film, in print and online (Barth, 2016). Advances in technology and social media have extended the cultural domain for body image scrutiny and insecurity (Barth, 2016) and concurrently, body dissatisfaction has risen over the past 25 years (Riva et al., 2013). Higher levels of exposure to media images have resulted in increased body self-consciousness (Shilling, 1993) and the reinforcement of body shape as a signifier of identity (Petrucci, 2015a), femininity, masculinity, morality and subjectivity (Burka, 1996; Lelwica, 1999; Synnott, 1993; Zerbe, 1992). Within contemporary western society, there is “a cultural trend to view humans as objects” (Todres, 2007, p. 63) and consequently, the body has become a post-modern fashion accessory with individuals seeking to create their sense of self through their physical presentation (Soth, 2006).

Thin female and lean muscular male bodies have become synonymous with control, happiness, success and other culturally prized qualities whilst the overweight body equates with unhappiness, lack of restraint and other perceived negative personality traits (Malson, 1998). The overweight body has thus become a visible symbol of all that is morally bad, leading to the recognition that for many, becoming fat is their greatest fear (Bordo, 1998; Chernin, 1981). This fear becomes part of the internal discipline of power (Foucault, 1975) which is now the ‘cultural norm’ (Daly, 2016; Sands, 2016) for many women and is becoming increasingly true for men in the early twenty-first century (Wooldridge, 2016).

Consumerism contributes to the objectified experience of self through its conflation of personality characteristics with body size (Lanzieri & Hildebrandt, 2016), and consumption has become one of the ways in which individuals create, and define themselves (Klein, 1993). The slender female or muscular male physique have become representative of a well-managed self and an individual in control (Bordo, 1993). Daly (2016) suggests that in a fat phobic culture, consumerism encourages the creation of need, over-consumption and indulgence, whilst simultaneously promoting the self-restraint of the thin body or the self-determination of the muscular one. When socioculturally defined beautiful bodies are used in

advertising campaigns for goods and services, an association is created between the two, developing a lifestyle aspiration in the consumer's mind. Lelwica (1999) describes this as the "salvation myth" whereby the images create a promise of something better and "a quasi-religious fantasy that promise[s] fulfilment through a body that is thin" (ibid.1999, p. 52). The accumulation and consumption of goods then becomes a substitute for the genuine experiencing of the self (Giddens, 1991) as individuals ingest the values attached to them and internalise them as self-values (Falk, 1994). In a similar vein, exercise and diet programmes, nutrition products and plastic surgery offer the opportunity for individuals to manufacture the 'perfect' body, thereby establishing it as "a product that can be personally re-created or even purchased" (Rathner, 2001). The body has thus been replaced with 'body-image'; "an inscribed surface" (Malson, 1998, p. 146) signifying a personality (Petrucci, 2015a) or lifestyle.

For people with an inadequate sense of self, which, as will be discussed in chapter three, is a characteristic feature of the eating disordered experience (Duker & Slade, 1988; Tasca & Balfour, 2014; Ty & Francis, 2013), socioculturally produced images offer a template for the personhood and lifestyle they seek to create. This can contribute to the challenges therapists encounter providing therapy to clients experiencing eating disorders, which will be illustrated in chapter four and the subsequent findings and discussion chapters. The subjective symbolism inherent in the eating disordered experience for the individual will be considered in chapter three, but in relation to the sociocultural experience of consumerism, the following quote from Williams and Bendelow (1998, p. 75) illustrates how eating disorders can be considered as a symbolic display of current culture:

"Whilst bulimia expresses the unstable double-bind of consumer capitalism, anorexia (i.e. the work ethic in absolute control) and obesity (i.e. consumerism in control), embody an attempted 'resolution' of these cultural contradictions."

Similarly, Daly (2016, pg 47) notes that sociocultural influences offer contradictory messages about appetite "by stressing the need for bodily control and obsession in a fat-phobic culture, whilst simultaneously encouraging over-consumption and indulgence." Recognising the difficulty in satiating one's body's desire for food in a way that balances nutritional needs, hunger, appetite and pleasure (Daly, 2016),

individuals are increasingly preoccupied with their body image, but experience only limited pleasure in their embodiment (Bordo, 1993).

2.6.3 Body image discourses

When considering media influences, the role of experimental psychology's objective approach to measuring body image needs to be acknowledged in order to illustrate how this has contributed to body image discourses, and in particular that of 'body image problems', which have become endemic in current western society (Blood, 2005). With their quantitative laboratory experiments objectively measuring the individual's perception of the size of their physical body, experimental psychologists ignore the impact of both sociocultural and libidinal environments on subjective corporeal experiencing (Blood, 2005; Lelwica, 1999). This objectified approach to research, based on ontological assumptions of duality where body is reduced to an object with fixed properties (Baillie, 2012), reinforces mind-body dualism and the cultural disembodiment (Soth, 2006) discussed above.

Blood (2005) claims that these discourses have informed public attitudes through the inclusion of articles and quizzes based upon them in women's magazines. Introducing discourses of body image, dieting and self-improvement into public consciousness normalises women's bodies as flawed and in need of constant remedial work (Blood, 2005), promoting the idea of the objectified body and self-surveillance practices. Blood (ibid) also argues that removing socio-cultural influences has encouraged the siting of body image problems within the individual, thus creating the condition as an individual pathology and removing cultural responsibility.

The growing market for male fitness and bodybuilding magazines, which began to expand in the 1980's (Pope, Phillips, & Olivardia, 2002) has had a similar impact on the experiencing of males and their bodies. Research has shown that exposure to representations of idealised bodies in mass media contributes to the development of negative body image, body dissatisfaction, and a desire for the slim figure among females and the muscular amongst males (Morry & Staska, 2001; Warren & Rios, 2013). Magazines, television, film and the internet have increasingly associated idealised body shapes with happiness and success and the consistent social

reinforcement of such appearance ideals promotes their internalisation (Thompson-Brenner et al., 2012).

An alternative perspective from within the relativist social constructionist position conceptualises body image problems as situated within a specific historical cultural position. Accepting the socially embedded nature of embodiment (Blood 2005), body image becomes subjective and intimately entwined with cultural experience (Wooldridge, 2016). The struggles of the individual experiencing negative body image or eating distress are then understood to be partly caused by external factors, rather than being pathologically individual (Blood 2005). Hence, a more appropriate definition of body image for this thesis is one which Warren and Rios (2013, p. 193) posit, claiming it as “a reflection of how a person views his or her body in comparison to cultural norms and ideals rather than a reflection of one’s actual body dimensions.”

2.7 Eating disorders in the twenty-first century

It has been suggested that eating disorders are “one of the most sensitive barometers of cultural change” (Rathner, 2001, p. 1) and that their increase is in part due to changing gender roles in western society. These changes are documented below to illustrate how they have influenced the eating disordered experience for both females and males. Section 2.7 continues the historical narrative of eating disorders as essentially female conditions, paused in section 2.5, to take the account through the twentieth century and into the twenty-first. Sections 2.7.1 and 2.7.2 illustrate how changes in the interest afforded to the male body and the masculine gendered role are bringing men and boys into the present-day eating disordered narrative.

Throughout the twentieth century, the feminine aesthetic ideal changed according to developments in culture and gendered role expectations. The increase in the number of females experiencing eating disorders in the latter decades of the twentieth century (Gordon, 2001) has been considered as a repercussion of the shifting female role within culture (Cantrell & Ellis, 1991). As Brumberg (2000) documents, the early twentieth century saw major changes in the social lives of women as females began to engage increasingly in continuing education and work outside of the home. Haute couture became de rigueur for those who could afford

it and the thin, stylised body was viewed as “a sign of modernity that marked [a woman] for more than traditional motherhood and domesticity” (ibid, pg 242). Concurrently, clothing manufacturers gained the mechanical means to produce mass market clothes introducing the notion of standardised sizes (Brumberg, 2000). This created a measure for women to compare their body against; thereby introducing pressure to ensure their body fit prescribed clothing sizes.

As Brumberg (2000) documents, the western world moved through the 1930's and into World War II and although the thin body was still admired, alongside the introduction of rationing, dieting became viewed as inappropriate and trivial compared to the concerns of war. Rationing also meant that material was not available for clothes and hence the idealised physical aesthetic lost some of its power. This changed again in the 1950s as a cultural backlash to the deprivations of war and the curvaceous body briefly came back into fashion as a signifier of nutritional abundance (Matz & Frankel, 2014). This did not last long however, and by the 1960s and 1970s another cultural revolution was underway as the second wave feminist movement swept across the western world and women began to demand and acquire greater parity with men (Blashill, 2011; Klein, 1993). The idealised thin female body, still in prominence today, came into vogue around this time, beginning with the model, Twiggy (Lelwica, 1999; Matz & Frankel, 2014). During the 1980s, a new emphasis on physical fitness and athleticism emerged and the ideal feminine body became stronger and more toned (Brumberg, 2000), before another turn to the waif-like 'heroin chic' (Matz & Frankel, 2014) body of the 1990s. The early twenty-first century has been dominated by arguments regarding 'size zero' and many girls and women continue to aspire towards often unrealistically thin bodies.

Alongside these cultural changes, the incidence of eating disorders and disordered eating began to increase amongst women and girls throughout the 1970's and into the late 1980's (Gordon, 2001). Prior to this, the conditions were virtually unknown by the general public and rarely seen in medical or psychological practice. This began to change as the experiences of prominent media personalities such as Karen Carpenter, Princess Diana and Jane Fonda in the 1980's introduced eating disorders to public consciousness (Brumberg, 2000). The literature from the 1970s onwards shows an increase in interest in disordered eating (Hepworth, 1999) as professionals began to seek more understanding of the phenomenon (Gordon,

1990). During this period, psychoanalyst Hilde Bruch (1973, 1978) was instrumental in recognising the influence of both social factors and family dynamics, discussed in chapter three, on the development of eating disorders. Bruch (1973, 1978) described the media portrayal of women and 'the ideal body' as a significant contributory factor, along with the growing diet industry which began to expand following the end World War Two.

The commentary thus far has concentrated on the female experience illustrating the woman-centric positioning of eating disorders (Botha, 2010; Dalglish & Nutt, 2013; DeFeciani, 2016; Morgan, 2008; Robinson et al., 2013) in contemporary western society. However, the changing experiences of the feminine have necessarily had implications for men, and as the masculine role has changed, men have begun to turn to their bodies to modulate and resolve their stresses as women have previously (Maine & Bunnell, 2008).

2.7.1 The changing male experience

The historical cultural privileging of the masculine in western society led to men being revered for their professional and academic achievements (Matz & Frankel, 2014) rather than the physical attributes of women. Men typically had more varied avenues through which they could claim their social status than females (Baird & Grieve, 2006) and hence body image was not such a significant determinant of male self-esteem. However, this focus is shifting and many men now judge physical attractiveness as a measure of their own, and others', personal and professional success (Maine & Bunnell, 2008).

The aesthetic focus on the male body began later than on that of the female but by the 1980s, the representation of muscular male bodies was becoming increasingly apparent in mainstream western media (Pope et al., 2002). In the 1950s and 1960s large gyms did not exist as they do today and were typically used only by bodybuilders (Klein, 1993) who discovered the muscle enhancing ability of steroids in the 1950s (Mangweth et al., 2001; Olivardia, Pope, & Hudson, 2000; Pope et al., 2002). The 1970's onwards saw a vast expansion of gyms and health clubs as society's focus shifted towards physical fitness and gym membership became an indicator of success and social acceptance (Klein, 1993). Within these environments, men became increasingly aware of each others' bodies and women

were becoming more critical of those of men (Gray & Ginsberg, 2007). By the 1980s the “roided body” (Klein, 1993, p. 34) was evident in Hollywood films and was being increasingly promoted in the media as dozens of fitness and bodybuilding magazines began to proliferate the market (Pope et al., 2002). Concurrently, and especially prevalent for the gay community, AIDS became a public health issue and muscularity became an attractive contrast to the frailty of the illness (Drummond, 2005; Pope et al., 2002).

The past thirty years have witnessed a significant rise in the number of images of male bodies in the media (Martins et al., 2007) and popular culture’s increasing focus on muscularity has had a major influence on male body ideals (Halliwell, Dittmar, & Orsborn, 2007). Sociocultural pressures to achieve an idealised body are affecting young men and the concomitantly increasing levels of body dissatisfaction experienced (Olivardia et al., 2000) are similar to those occurring in females (Gardner & Brown, 2014). Just as the idealised thin body is unrealistic for most women, the current muscular ideal of the male body is unattainable for the majority of men (Halliwell et al., 2007).

The mesomorphic muscular male body is associated with cultural discourses of masculinity and has become symbolic of a man’s social, financial and sexual success (Olivardia et al., 2000). These discourses can be powerful influences on a man’s self perception (Maine & Bunnell, 2008) and as a consequence of the internalised sociocultural associations between muscularity and masculinity, many men seek a sense of their maleness through the creation of a muscular body (Olivardia et al., 2000). Increased body fat, especially around the chest or hips, can be perceived as feminine and hence experienced as a challenge to a man’s masculinity (Olivardia et al., 2000). In a case study Maine and Bunnell (2008) present a male who described feeling “embarrassed” at having a “girl’s disease” and felt that the fat on his chest formed breasts which served to confirm his sense of emasculation.

Comparable to the ways in which dolls such as Sindy and Barbie are recognised as influencing young girls’ ideas of female bodies (Dittmar, Halliwell, & Ive, 2006), action figures can be considered to have had a similar effect on those of boys (Derenne & Beresin, 2006). Pope et al (2002) documented that action figures produced between 1964 and 1998 consistently became more muscular with

increasingly smaller waists, and larger chests and biceps, beyond realistic human attainment. They also claimed that the average Playgirl male model “lost roughly 12lbs of body fat whilst gaining roughly 27lbs of muscle” (Pope et al., 2002, p. 47) leaving them with bodies that were measured to be unattainable without the use of anabolic steroids.

2.7.2 Gender roles and the experiencing of self

The internalisation of culturally produced notions of masculinity and femininity are powerful influences on an individual’s subjectivity (Maine & Bunnell, 2008).

Through the attainment of the aesthetically prized body, individuals attempt to acquire socially constructed ideals of femininity, masculinity and selfhood. Their internalised gender role, which is related to their overall “self-perception, self-esteem, body image, and body satisfaction” (Hepp, Spindler, & Milos, 2005, p. 227) is displayed through this embodied presentation.

Males and females are socialised differently within cultures (Woodside, 2004) dependent on dominant discourses. Girls and boys become gendered adults by compelling their bodies and selves to conform to contemporary sociocultural ideas of what it means to be a woman or a man (Rice, 2014). These social constructs become pervasive and individuals tend not to question them (Petrucci, 2016), considering them as “physiological rather than ideological” (Rice, 2014, p. 55). The socialisation process begins in infancy when male and female infants have been shown to be treated differently and exposed to different gendered clothes, toys and experiences (Orbach, 2004, 2009). Boys in western culture tend to be encouraged to suppress emotions which, as a consequence of the dualism discussed earlier in section 2.4 are still typically viewed as feminine. Males are instead encouraged to be strong and to avoid talking openly about their feelings or appearing emotionally vulnerable (Currin, Schmidt, & Waller, 2007), which has implications for their presentation in therapy.

The changing gender roles in western culture have contributed to rising levels of male body insecurities with men increasingly experiencing pressure to meet mainstream society’s definition of masculine (Strother et al., 2012). As women have gained parity with men in many areas of life (Blashill, 2011; Klein, 1993) the male body “is growing in relative importance as a defining feature of masculinity”

(Olivardia et al., 2000, p. 50) and muscularity is one of the few remaining grounds in which men can distinguish themselves from women (Blashill, 2011; Klein, 1993). The hyper-masculine muscled body can be read as rooted in a growing threat to male privilege (Klein, 1993) and an attempt by men to restore feelings of masculine self worth (Gillett & White, 1992).

The “masculinity hypothesis” proposed by Blashill (2011) establishes the idea that, as a consequence of the increasing parity between men and women (Klein, 1993), the destabilisation of traditional ways of achieving masculinity has resulted in the increased importance of the muscled body as a way of claiming and communicating masculinity (Griffiths, Mond, et al., 2015; Klein, 1993). Conversely, the “femininity hypothesis” proposes that conformity to the feminine gender norms of “niceness, passivity, deference to others and interpersonal dependence” (Griffiths, Mond, et al., 2015, p. 109) is a risk factor for eating pathology. Murray et al. (2013) found that men with anorexia had elevated levels of conformity to these feminine qualities, with Griffiths et al (2015) suggesting that both genders who adhere to these traits are more likely to seek approval from others and may attempt to achieve this through the pursuit of the culturally prescribed ideal gendered body.

A recent rise in eating disorders seen in males (Locker, Heesacker, et al., 2012) is claimed to be due to this changing social and cultural climate regarding masculine bodies. It seems that “[g]ender role norms may play a crucial role in the male experience of eating disorders” (Griffiths, Mond, et al., 2015, p. 108) with the muscular body increasingly becoming the way in which men communicate their masculine qualities to others. Men who feel lacking in the “traditional masculine norms” of “dominance, power, status, confidence, sexual success and the exercise of physical and emotional self-control” (ibid, pg 108) tend to feel pressured to achieve a larger, more muscular body. Greater adherence to these masculine norms has been linked to the presence of muscle dysmorphia (Murray et al., 2013), a condition discussed in chapter three as a possible manifestation of an eating disorder in males.

Having established the experiences of body and self as influenced by sociocultural discourses and argued that subjectivity is largely disembodied in contemporary western consumerist society (Burkitt, 2008; Shaw, 2003; Soth, 2006), the thesis now offers an alternative perspective. Through their typical dissociation of psyche

and soma (Barth, 2016; Zerbe, 1993) individuals with eating disorders tend to take western culture's disembodiment to an extreme and it has been claimed that recovery involves the individual establishing a more embodied subjectivity (Sands, 2016). Therefore, it becomes necessary to consider embodiment in terms of "the twin aspects of 'being' and 'having'" (Crossley, 2006, p. 2), recognising that bodies exist in two dimensions. The body is both a physical object which inhabits the world and which others see and judge, but it is also the place from which each individual experiences their unique sense of subjectivity (Merleau-Ponty, 1962; Shaw, 2003). In order to incorporate more of this subjective experiencing, section 2.8 introduces the phenomenological body attempting to transgress objective dualism and enable consideration of the body as experienced by the individual from within both their body and their cultural context (Grosz, 1994; Young, 2005).

2.8 The phenomenological body

The phenomenological or lived-body is "primordially relational" (Todres, 2007, p. 5) and, having both a participative and aesthetic realm, it is "the place' where intimate understanding of both experience and language happen" (ibid.). Phenomenological selves are created within a given historical sociocultural environment whereby self and world are "experientially related and consciousness is shared with others through language, discourse, culture and history" (Finlay, 2011, p. 21). The body, as a representation of the self, becomes the expressive site of feelings and subjectivity is created through intersubjective relationships rather than a separate, detached experience of self (Lock & Strong, 2010).

Merleau-Ponty (1962) attempted to offer a non-dualist ontology in his recognition of humans as both mind and body. In contrast to philosophical discussions within which the body is often neglected and simply considered as an object ordered to perform by a transcendental mind he recognised the significance and always present state of the body. Describing the indivisibility of the inner and the outer Merleau Ponty (1962) claimed that the mind is inseparable from the body and its situated, physical nature. The body *is* the individual and through the lived experience of that body, the detachment of subject from object, or mind from body is denied. The material body, through its senses and physical presence, allows for experiencing of the world and it is through perception of this bodily experience that the individual is able to make sense of the world. Merleau-Ponty (ibid.) places

perception at the centre of human understanding and experience and attempts to get closer to lived reality through recognition of this 'lived-body'. Understanding emerges as the individual perceives affects experienced through the interrelationship of mind and body. Merleau-Ponty (ibid.) theorised consciousness as being embodied and sought to reconnect the individual to the body's pre-objective relationship with the world; much as needs to occur for recovery from an eating disordered experience (Sands, 2016).

Of special relevance for this thesis is Merleau-Ponty's claim that "[i]t is through my body that I understand other people" (1962, p. 216). As will be discussed within chapters three, four and eight, the bodies within the therapy room can be considered to have increased significance when working with clients experiencing eating disorders. Due to the role which the body plays in experiencing life for both therapist and client, Shaw (2003) argues that therapy must be an embodied experience. To encourage the development of therapeutic embodiment the therapist needs to be adequately connected to their own body (Daly, 2016; DeLucia-Waack, 1999; Orbach, 1986, 2003) and thus consciously aware of its experiencing (Sands, 2016). In relation to the client presenting with an eating disorder, who is likely to be dissociated from their body (Daly, 2016; DeLucia-Waack, 1999; Orbach, 1986, 2003; Zerbe, 1993), it is necessary to consider how this disconnection limits the client's experiencing and how this affects the therapist and the therapeutic relationship, discussed in chapter three. This also introduces the concept of intercorporeality suggesting that the experience of being embodied is mediated through constant interactions with other human bodies (Weiss, 1999, p. 5). Within the therapy room this means that the bodies within the therapeutic relationship will be communicating their own individual messages; a concept which will be discussed further in chapters three and four.

The idea of the phenomenological body takes the thesis closer to the subjective experiencing of the individual within their body but, as with the social constructionist ideas discussed earlier, it does not explain why some people within a given culture fall prey to eating disorders and others do not (Riva et al., 2013; Warren & Rios, 2013). Following the therapeutic orientations of the therapists interviewed for this study, psychological theories of self, which situate eating disorders within the individual's development and experience, are considered in chapter three. This is not meant to pathologise the individual but, in recognition of eating disorders'

multifactorial aetiology (Delvecchio, Di Riso, Salcuni, Lis, & George, 2014; NICE, 2017; Starkman, 2016a; Tasca & Balfour, 2014; Wooldridge, 2016), to allow accommodation of the influence of their developmental experiences. From the perspective of this thesis, these psychological and relational phenomena need also to be recognised as culturally and historically situated. Shifting the focus from the sociocultural objective external gaze introduced in this chapter, to the subjective internal perspective, the psychological theories discussed in chapter three will be used to illustrate how eating disordered behaviours and subjectivities contain much more meaning to the individual than simply cultural fit and achieving a prescribed aesthetic ideal.

A further concept drawn upon for understanding an individual's eating disordered experience, which more accurately encompasses the approach of this thesis, is the feminist 'body becoming' theory (Rice, 2014). This model claims that both social constructionism and psychology are lacking in their ability to describe an individual's subjective development and experience of self. It claims that social constructionism omits the individual's embodied experience, interpreting self solely through sociohistorical concepts, and affording no recognition of the role of the individual's psyche. Psychological theories are also considered inadequate as they universalise experience and locate self-development, and thus pathology, within the individual. Drawing on Grosz's (1994) analogy of the Möbius strip to illustrate the continuous interplay of body, mind and culture, individual subjectivity is recognised as being created through ongoing interactions between physiology, psyche and society (Rice, 2014). Echoing Merleau-Ponty (1962), self and body cannot be separated and the embodied self is recognised as a concept depicting the inseparability of physicality from psyche. The development of subjectivity and the body are dynamic processes, continuously open to change and responsive to changing stimuli within social, psychological and physiological contexts.

Before concluding this chapter regarding the inseparability of body and self and their positioning within contemporary culture, it is necessary to draw attention to the implications of the above discussion for therapists working with clients experiencing eating disorders, who are the focus of this thesis.

2.9 The therapist's body

Accepting that it is impossible to remain immune from the influences of one's sociocultural situation (Halsted, 2015) therapists must be acknowledged as having been exposed to the same influences as their clients (Daly, 2016; Derenne, 2006; Orbach, 1986; Rabinor, 1995). The literature claims that female therapists in western culture are likely to have had personal experience of the body image issues and other female pressures to which their clients have been subjected (Bilker, 1993; DeLucia-Waack, 1999; Duker & Slade, 1988; Hamburg & Herzog, 1990; Satir et al., 2009) and may experience a similar pressure to conform (Daly, 2016; Derenne, 2006). Therapists can find themselves sharing their clients' values and aspirations around the idealised body and control of food (Duker & Slade, 1988). As a result of these shared experiences it may be that female therapists are more easily able to relate to (female) clients presenting with eating disorders than can their male counterparts which can potentially increase therapeutic engagement (DeLucia-Waack, 1999; Hamburg & Herzog, 1990; Satir et al., 2009). Although there is currently a gap in the literature in relation to the experiences of male therapists working with male clients with eating disorders, consideration needs to be afforded to the potential of their being affected by their work in similar ways as sociocultural pressures for an idealised masculine body increase (Wooldridge, 2016).

Perhaps as a result of lower levels of shared sociocultural experience, research indicates that male clinicians tend to experience more negative reactions towards clients with eating disorders (Thompson-Brenner et al., 2012). However, it needs to be acknowledged that this is in relation to female clients presenting with eating disorders. Studies have also shown that male therapists are more likely to decline to treat (female) eating disordered clients than their female counterparts (Burket & Schramm, 1995; Satir et al., 2009). Within this, questions are raised regarding not only how the gender of therapists might affect work with this client group, but also how therapists of different cultures who have not been exposed to western sociocultural influences to the same extent may experience the work. Due to time and space constraints, it has not been possible to afford attention to these elements within this thesis.

Therapists working with clients presenting with eating disorders will also have their own phenomenological experience of their body which they will carry with them into the therapy room and therapeutic relationship (Finlay, 2011). Illustrating the relational aspect of the body, both therapists' and clients' bodies are on constant display for the observation of the other (Daly, 2016), which will have implications for the therapy. These aspects will be discussed in detail in chapter four.

2.10 Conclusion

From the social constructionist leanings of the research, this chapter has guided the reader through the historical development of socially inscribed meanings upon the body and considered how this has contributed to the current positioning of eating disorders as a female phenomenon (Botha, 2010; Bunnell, 2016; Dalgliesh & Nutt, 2013; Morgan, 2008; Räisänen & Hunt, 2013; Robinson et al., 2013). Ways in which females learned to control their eating, and hence their body, in order to protest against patriarchal dominance (Bartky, 1988) or to conform to sociocultural expectations were presented. The changing meanings ascribed to female self-starvation were explored in order to demonstrate the significance of changing contemporary cultural influences (Bell, 1985; Brumberg, 2000; Bynum, 1987; Vandereycken & Deth, 1994). Despite its positioning as a medical pathology, the recognition of anorexia nervosa in the late nineteenth century marked the first acknowledgement of a psychological component to the condition and also further situated eating disorders within the female experience (Hepworth, 1999).

Through this discussion, the roles which food, eating and culturally prescribed aesthetics play in creating an individual's identity (Halsted, 2015; Lanzieri & Hildebrandt, 2016; Ogden, 2010; Petrucelli, 2015a) were made evident. This is important for understanding troubled relationships with food as it highlights the external factors which influence individuals' behaviours and motivations. It also draws attention to the dangers inherent in viewing eating disorders as arising solely from pathological development within an individual. Eating disorders and disordered eating need to be understood within the wider cultural context in which they arise as this has implications for treatment. When culture places a high value on thinness or muscularity, it can be difficult for treatment providers to challenge their clients' beliefs (DeLucia-Waack, 1999), but by understanding the influences on these beliefs, therapists are in a better position from which to engage empathically

with clients. Recognition also needs to be afforded to the idea that both therapists and their clients are subjected to these same influences (Daly, 2016; Derenne, 2006; Orbach, 1986; Rabinor, 1995). If therapists are not aware of the impact these factors have upon themselves, it can hinder their understanding and exploration of their influence on clients' experiencing.

From this, it is possible to appreciate how bodies, gendered roles and subjectivities in contemporary western culture are very much socially constructed. However, this approach needs to be critiqued in relation to this current thesis as it has been shown to maintain the notion of mind-body dualism. The body disappears in its materiality and is known only through the filter of discourses inscribed upon it (Falk, 1994). From this epistemological position, practices of knowledge and power discipline the body, giving the mind ultimate power (Falk, 1994, p. 5) and in this way, the eating disordered individual vanquishes their subjective sense of self, attributing it instead to their body.

The phenomenological body offers an alternative epistemology for thinking through the bodies in the therapeutic relationship and Merleau-Ponty's (1962) lived-body theory was suggested as allowing for embodied subjectivity (Grosz, 1994) to be considered whilst also recognising the impossibility of removing sociocultural influences. Neither social constructionism nor the embodied phenomenological experience however, account for why only a minority of individuals within western culture develop eating disorders (Riva et al., 2013; Ty & Francis, 2013). Hence, to gain some understanding of this, the psychological theories of self employed by the therapists interviewed for this study are discussed in chapter three.

Chapter 3

Psychological Theories of Self

3.1 Introduction

As ascertained in chapter two, despite being subject to the same sociocultural discourses as those people who experience eating disorders, the majority of people in contemporary western consumerist society do not develop the conditions (Riva et al., 2013; Ty & Francis, 2013). In this chapter therefore, the focus turns to the internal and psychological developmental processes which shape an individual's self-experience to consider possible reasons why some individuals turn to control of food and their bodies in potentially dangerous ways.

The most prominent differentiating factors are that those who develop eating disorders display an inadequately developed sense of self (Duker & Slade, 1988; Tasca & Balfour, 2014; Ty & Francis, 2013) and have difficulties with affect regulation (Barth, 2001, 2008). Early relational developmental experiences can contribute to this and individuals with a disposition towards eating disorders turn to food and their body as a means of managing affects (Robinson et al., 2013; Sweeting et al., 2015; Thompson-Brenner et al., 2012) and creating a coherent sense of self (Demidenko, Tasca, Kennedy, & Bissada, 2010; Troisi, Massaroni, & Cuzzolaro, 2005). When feelings are experienced as physical sensations, the person perceives them as residing in their body and consequently interprets that it is the body which needs soothing (Barth, 2016). Eating disordered behaviours are then adopted in a concrete attempt to soothe that body and thus manage feelings (Barth, 2016; Sands, 2016). Through the appeasement of early caregivers, infants who grow up to experience eating disorders tend to develop similar personality characteristics. They are described as being kind, perfectionist, sensitive, compliant and overly aware of other peoples' needs and feelings, with a tendency to please or protect other people to the detriment of themselves (Bruch, 1973; Dolton, 2000; Duker & Slade, 1988). Within this generalisation, the different eating disordered presentations have their own attributes which will be discussed in

section 3.5. The consequences of these traits for how the individual presents within their body and within the therapeutic relationship will also be shown.

The gendered experience of eating disorders is raised in section 3.7 through a discussion of the possible placement of muscle dysmorphia as a male presentation of an eating disorder (Dalglish & Nutt, 2013; Murray et al., 2010). Although beginning to change, as posited in chapter two, eating disorders remain culturally positioned within feminine discourses and consequently the literature is weighted to a large extent towards the experiences of women (Dalglish & Nutt, 2013; Greenberg & Schoen, 2008; Strother et al., 2012). This consequently biases the discussion in this chapter of the subjective experiences of eating disorders towards the female perspective.

The chapter begins with a discussion of four psychotherapeutic approaches towards working with clients experiencing eating disorders. The humanistic person-centred approach, cognitive-behavioural therapy (CBT) and psychodynamic schools are presented in sections 3.2 to 3.4 as these were the models used by the therapists interviewed. Through this, it will be shown that therapeutic orientation affects the interpretations that therapists place on their clients' presentations and their own experience within the therapeutic relationship (Jarman et al., 1997). Narrative therapy will then be briefly discussed as it sits within the social constructionist focus of this thesis and offers an alternative way of conceptualising therapy. The discussion begins in section 3.2 with person-centred therapy as this encompassed the researcher's own therapeutic position at the outset of the research, as well as being the treatment approach of the first group of counsellors interviewed for the preliminary study.

3.2 Eating disorders from a person-centred perspective

From a person-centred perspective, eating disorders can be understood as arising from an inauthentic or inadequately developed sense of self (Duker & Slade, 1988; Kuriloff, 2001; Tasca & Balfour, 2014; Ty & Francis, 2013). From this position, the eating disorder creates rules for living, and through these, comes to constitute the individual's identity (Malson, 1998; Tierney & Fox, 2009, 2010) and way of being in the world. This lack of self creates difficulties in the therapeutic relationship as the client has no firm base from which to engage and will find it difficult to acknowledge

and express their own thoughts and feelings (Duker & Slade, 1988). Their tendency to please and protect people (Dolton, 2000; Duker & Slade, 1988) will extend to the therapist and they may minimise or deny their own experience so as not to risk upsetting the therapist or presenting themselves as less than the “perfect client” (Dolton, 2000).

In contrast to the socially constructed self introduced in chapter two, Rogers’ (1951, 1961) phenomenological theory of personality development posits the existence of an inner authentic self which therapy seeks to discover. However, relational influences are still evident as Rogers’ (1951, 1961) theory suggests that the individual experiencing an eating disorder has developed a self-concept removed from their own authentic organismic experiencing in response to experiential relationships with early caregivers and peers. An external locus of evaluation develops whereby the individual lives so as to please the significant others in their life rather than listening to their own inner experiencing, thereby creating a ‘false self’ (Winnicott, 1960) in relation to the perceived expectations of others. To cope with the pain of living incongruently from this false self, food and weight control strategies are employed to manage feelings and inter- and intra- personal stresses (Tasca & Balfour, 2014). Concretising the intolerable experience of their needs and desires onto their body the individual attempts to control them through the eating disordered behaviours; their body thus becomes the problem (Barth, 2016; Sands, 2016). Controlling hunger and other needs in this way shifts the individual’s self-experiencing further away from their proprioceptive physiological and embodied subjectivity. The external eating rules then leave them further disconnected from their authentic self enabling them to attribute their distress to the eating behaviours or weight (Pipher, 1994). The numbers on the scale, the calories or nutritional content of the food and sociocultural ideals then become the individual’s external loci of evaluation; the rules followed to please significant others thus being usurped by those of the eating disorder. Despite Rogers’ assertion of the existence of an authentic inner self, sociocultural influences upon subjectivity and the body are evidenced as the individual turns to cultural discourses relating to body shape in order to establish a sense of self.

With an identity created through the discourses of their eating disorder it becomes increasingly difficult for the individual to contemplate its relinquishment as losing it effectively means self-annihilation (Zerbe, 1998). This ego-syntonic experience

(Toman, 2002; Wooldridge, 2016; Zerbe, 1998) is considered one of the reasons why therapy with this client group is challenging. As a key element of recovery, a number of writers recognise the importance of enabling the individual to rediscover, or begin to accept, their own authentic sense of self (Bruch, 1978; Dolton, 2000; Duker & Slade, 1988; Farrell, 2015; Garrett, 1998; Lawrence, 1995; Lelwica, 1999), thus reducing the power of external sociocultural and familial discourses upon their subjective experience.

It is not just people diagnosed with eating disorders who can be understood to experience this inadequate sense of self. As discussed in chapter two, familial and sociocultural expectations can leave individuals, including therapists, believing that they should look and behave in ways other than those which their private self would choose. Media projections, through their depictions of masculinity and femininity imply that men and women should look and behave in prescribed ways (Lanzieri & Hildebrandt, 2016; Lupton, 1996, 2013), and in an attempt to conform, individuals lose touch with their authentic selves. In a society where image is highly prized, it takes an individual with a strong sense of self to reject cultural norms and allow themselves and their body to be natural (Pipher, 1994).

3.2.1 Person-centred counselling in the therapy room

The humanistic therapist approaches their clients with an open mind and attempts to place any explanatory frameworks aside (Bager-Charleson, 2014).

Acknowledging the influence of sociocultural discourses upon an individual's psyche however, means that consideration must be afforded as to how possible this is in practice. From their shared sociocultural environment the experiences of therapists and clients experiencing eating disorders may share some similarities (Daly, 2016; DeLucia-Waack, 1999; Matz & Frankel, 2005). Therapists' own self-evaluations may be influenced by external sociocultural factors and hence their provision of the core conditions of person-centred counselling can be compromised. Offering empathy involves the therapist, as far as they are able, entering the client's internal frame of reference in an attempt to perceive the world and self-experiencing of that individual from their perspective (Rogers, 1951). For the therapist who shares the client's cultural ideals this may create difficulties keeping their own and their clients' material separate which can cause unconscious collusion (Barth, 2016; Hamburg & Herzog, 1990). The offering of congruent

unconditional positive regard (Rogers, 1951, 1961), a core condition of person-centred therapy, may also be compromised for the therapist who is unable to experience a genuine acceptance of either their own body or that of their client, if influenced by unquestioned internalised sociocultural discourses regarding the idealised body (Petrucci, 2016).

Person-centred counselling's non-directive style can be criticised as contributing to the anxiety that clients experiencing anorexia in particular, engender in their therapist (Hughes, 1997; Jarman et al., 1997). The person-centred counsellor's trust in their client's inner processing and actualising tendency (Rogers, 1951, 1961) can compromise work with those experiencing eating disorders. Typically intelligent individuals, clients may appear to be insightful but have a tendency to use their intellect as a defence against their feelings (Barth, 2001, 2008, 2016; Dolton, 2000) which, as will be illustrated in 3.3.1 has negative connotations for therapeutic engagement. More directive interventions (Jarman et al., 1997) can be necessary when clients are not able to recognise the severity of their condition, due either to the intractability of the symptoms (Warren et al., 2009) or the physiological effects of starvation (Gottlieb, 2015; Kaplan & Garfinkel, 1999). However, such interventions can be experienced by the client as the removal of control (Jarman et al., 1997) and the introduction of another external locus of evaluation.

A further limitation of the non-directive nature of person-centred therapy applies for the typical client experiencing bulimia or compulsive eating who is ashamed of their behaviours (Lawrence, 1987) or the individual with anorexia who is reluctant to disclose the true extent of theirs. In these cases, "detailed inquiry" to "ask the difficult questions" (Petrucci, 2015a, p. 22) can be more effective to ascertain the true extent of the client's experience. Without this directive stance there is potential for collusion with the disorder (Jarman et al., 1997) and the risk that life-threatening changes are undisclosed (Hamburg & Herzog, 1990).

The alexithymia typically experienced by clients presenting with eating disorders (Barth, 2008, 2016; Mathiesen et al., 2015) means that they struggle to express their emotions in words (Zerbe, 1993) and their lack of proprioceptive awareness creates difficulty for the recognition of bodily sensations and feelings in any but their strongest forms (Barth, 2016). These are clients who appear bright and articulate (Barth, 2008) and more capable and confident than they feel (Barth, 2016), but who

lack the ability to verbalise their feelings (Zerbe, 1993); consequently, therapists risk over-estimating their competence (Hamburg & Herzog, 1990). With no understanding of alexithymia it can be difficult for the therapist to appreciate clients' inability to use words to process their affects and emotions (Barth, 2008, 2016) and to integrate the psychological meanings of their experience (Barth, 2016). Struggling to put their experiences into words (Zerbe, 1993) they need additional direction and encouragement, but when this is not experienced, the approach of the person-centred counsellor can be felt as abandonment (Hamburg & Herzog, 1990). Considering speech and language as an expression of an individual's bodily belonging in the world (Burkitt, 2008), alexithymia necessarily limits an individual's expression and presentation of self, and thus engagement in the therapeutic dialogue.

3.3 Cognitive-behavioural therapy

With its focus on symptom reduction (Gottlieb, 2015) and changing the thoughts and behaviours which maintain eating disordered presentations rather than exploring their causes (Fairburn, 2008; Tasca & Balfour, 2014) cognitive-behavioural therapy (CBT) is more directive than the person-centred approach. Due to clients' characteristic alexithymia (Barth, 2016), CBT type interventions directed at affect regulation and mindfulness can be effective (Barth, 2016) in enabling clients to challenge their behaviours and thought patterns around food, eating and body size (Kaplan & Garfinkel, 1999). They can also be implemented to assist with affect regulation (Barth, 2008, 2016). As many of the beliefs to be challenged will have been created in response to familial and sociocultural discourses around subjectivity and the body, it can be difficult for therapists to encourage clients to change these thoughts. The directive nature of cognitive-behavioural interventions can be experienced as intrusive and overpowering (Hamburg & Herzog, 1990), reminiscent of the merged mother (Russell & Marsden, 1998), discussed in section 3.4 and enhanced-CBT has been criticised for placing similar emphasis on controlling the eating behaviours as the psychopathology which it aims to counter (Griffiths, Murray, & Touyz, 2013).

CBT is primarily concerned with challenging internalised discourses that impinge on the individual to create a socioculturally defined idealised self, but through its cognitive focus Tasca and Balfour (2014) claim that the individual's subjective

experience is lost. CBT also fails to address the developmental elements of the individual's attachment functioning and symptom adoption which confer vulnerability towards developing eating disorders.

CBT has a strong evidence base as a successful treatment approach for eating disorders and for many years has been the most highly researched treatment model in the UK (Natenshon, 2012). Fuller (2017), however claims that psychology research favours CBT as there is a belief that it is more scientifically based and therefore, more amenable to short term outcome studies. Although recently published NICE guidelines (2017) recommend the use of eating disorder focused CBT or a manualised focal psychodynamic protocol, no firm consensus is reached in the literature regarding the most effective approach to treatment and it is claimed that current evidence does not support any particular individual psychotherapeutic approach (Hay, Bacaltchuk, Stefano, & Kashyap, 2009; Wooldridge, 2016; Zipfel et al., 2014). NICE guidelines have become the driving force behind evidence based research in the UK and the randomised control trials (RCTs) used to study CBT represent the 'golden standard' of research (Bager-Charleson, 2014). The validity of random control trials however, needs to be questioned as clinicians typically do not implement strictly manualised protocols, as they are used in research studies (Natenshon, 2012; Wooldridge, 2016). Therapists are more likely to respect the uniqueness of each client (Natenshon, 2012) and thus integrate interventions from various models (Wooldridge, 2016). Despite CBT's evidence base, research suggests a low recovery rate with at best 50% of patients benefiting from symptom focused treatments (Accurso et al., 2016; Castellini, Montanelli, Faravelli, & Ricca, 2014; Furstand et al., 2012). Enhanced CBT for bulimia evidences a recovery rate of 50% and clients experiencing anorexia typically show a 25% recovery rate with CBT (Zipfel et al., 2014).

Despite the affective experience being documented in the diagnostic criteria, it is not the target of evidence based treatment (Zerbe, 2016) and the individual's interpersonal and intrapsychic experiences are not addressed (Griffiths et al., 2013; Zerbe, 2016). CBT and other symptom focused therapies can be criticised as being objectified and as considering what the person is doing, rather than who they are (Tasca et al., 2011), thus paralleling western culture's dualism discussed in chapter two, privileging cognition and rationality (Athanasiadou & Halewood, 2011). Focusing on behaviours maintains the client's focus on the concretisation of their

symptoms (Barth, 2016) and leaves no room for exploration of the meaning of the symptom for the individual. Petrucelli (2016) argues that understanding this meaning is vital for recovery as the eating disordered symptom holds dissociated parts of the individual's self and relational history which need recognition and repair.

3.3.1 Cognitive-behavioural therapy in the therapy room

Affording less consideration to the client's phenomenological experience and attachment narratives, CBT can leave clients experiencing the therapeutic encounter as mirroring their overly responsive and inadequately attuned early parenting relationship (Hamburg & Herzog, 1990; Zerbe, 1993). There is thus little opportunity for the client to experience a reparative nurturing environment and the therapist can be left feeling limited when therapy offers no space for the exploration of clients' relational and interpersonal issues (Gottlieb, 2015). CBT can be experienced as controlling and arising from the therapist's need to be seen to be helping, which for clients already struggling with issues of control, can be detrimental to their treatment (Cohler, 1975). Placing too much emphasis on symptom management and providing techniques to eliminate eating disordered behaviours without understanding the symbolism and needs hidden within them can leave the client with unresolved issues which may then be expressed in other ways (Sands, 1991).

Although CBT, with its emphasis on cognitive challenge, would appear to be beneficial for clients experiencing eating disorders who often present as articulate and intelligent, their tendency to hide behind words (Barth, 2001, 2008) can be problematic. Dissociated from their bodies and feelings, eating disordered clients use their verbal and cognitive strengths to mask the alexithymia which can cause the establishment of unrealistic therapeutic expectations (Barth, 2016). As discussed in section 3.5, the typical eating disordered client is extremely perceptive and compliant and consequently is easily able to ascertain what the therapist expects of them (Dolton, 2000). The therapist can thus erroneously believe that the client is engaging effectively and showing signs of improvement (Duker & Slade, 1988).

Research shows that those therapists who enjoy treating clients experiencing eating disorders find greatest satisfaction from addressing the underlying

psychodynamic issues rather than behavioural and symptomatic management (Hamburg & Herzog, 1990). As discussed in section 3.4, the attachment elements of psychodynamic theories in relation to treating eating disorders appear to be gaining greater recognition by some authors as essential components of therapy (Natenshon, 2012; Tasca & Balfour, 2014; Tasca et al., 2011). It is also recognised that it is beneficial to focus not just on eating symptomatology but on ways in which the disorders are maintained through “maladaptive self-regulatory, comparison and attachment processes” (Ty and Francis 2013 Pg 169).

A final limitation of CBT relevant for this study is that it does not necessarily require the empathic depth of the person-centred and psychodynamic approaches. Its dualist attitude potentially reduces the therapist’s need to engage at empathic depth and hence arguably limits the profundity of affective reactions of the therapist. Evidenced in Jarman et al.’s (1997) study, a social worker who took a pragmatic and directive approach to this work was shown to be less affected by it than professionals who offered a more empathic experience. As discussed in chapters seven and eight, the psychologists interviewed for this research, who practiced from a CBT stance, typically experienced fewer personal reactions to their clients and talked of a more distant type of relationship than the other therapists interviewed.

3.4 Psychodynamic theories

As a consequence of the therapeutic conceptualisations of eating disorders used by the specialist therapists interviewed for this study psychodynamic though became more prevalent as the research progressed and these understandings are presented below. Despite many clinicians using psychodynamic interpretations in their work (Tasca & Balfour, 2014) they have remained on the periphery of clinical thinking and mainstream research of eating disorders (Barone & Guiducci, 2009). Psychodynamic theories offer an interpretation as to how the individual’s sense of self develops as a consequence of attachment and relational experiences in infancy, and also the implications for how clients experiencing eating disorders engage in therapy and the world.

3.4.1 Attachment theory

Attachment theory situates eating disorders within early relational experiences and problematic developmental conflicts, especially those around separation in infancy (O'Shaughnessy & Dallos, 2009) and the transition into mature sexuality (Farrell, 1995). Although it is well-established that these disruptions in attachment play a central role in the development and maintenance of eating disorders (Bruch, 1973, 1978; Dallos, 2004; Koskina & Giovazolias, 2010; Palazzoli, 1974; Ty & Francis, 2013) clinical practice and research has tended to overlook interventions based on attachment theory (Barone & Guiducci, 2009; Ty & Francis, 2013).

It is generally agreed that clients presenting with eating disorders display insecure attachment styles (Barone & Guiducci, 2009; Gander et al., 2015; Troisi et al., 2005), with a prevalence estimated of between 70% and 100% (Delvecchio et al., 2014). There is discord in the literature as to the specific associations between attachment style and eating disorder subgroups, although much of this seems to arise due to varying interpretations of the terms used (O'Shaughnessy & Dallos, 2009). Most studies have been conducted on only anorexia and bulimia and because of the different methods used, it is difficult to make any assertive claims (Gander et al., 2015). However, it appears evident that insecure or avoidant attachment patterns typically correspond to the lived experience and presentation of clients with eating disorders who find it difficult to discuss feelings, relationships and conflicts (Dallos, 2004).

Furthering the person-centred approach's understanding of the inadequately developed sense of self discussed in section 3.2, insecure attachment experiences leave the individual struggling to achieve a stable, coherent and differentiated identity (Demidenko et al., 2010; Troisi et al., 2005), resulting in a poorly established self-concept and reduced levels of body and self acceptance (Duker & Slade, 1988; Tasca & Balfour, 2014; Ty & Francis, 2013). This creates low self esteem and difficulties recognising, accepting and voicing their own needs and wants (Eichenbaum & Orbach, 1982). These characteristics, coupled with a fear of rejection (Troisi et al., 2005), create tendencies towards perfectionism and the need to please and seek approval from others (Ty & Francis, 2013). Seeking external validation in this way leaves individuals more susceptible to social comparison and sociocultural pressures (Bamford & Halliwell, 2009) which, alongside their poor

sense of self establishes a vulnerability towards internalisation of the contemporary culturally idealised body and its associated personality characteristics (Ty & Francis, 2013).

The insecurely attached individual will experience difficulties with emotional regulation (Ty & Francis, 2013) which can lead to maladaptive strategies to manage emotions through food and control of the body (Robinson et al., 2013; Sweeting et al., 2015; Tasca & Balfour, 2014). Ty and Francis (ibid.) also note that avoidant attachment styles can create distancing behaviours in the individual who employs eating pathology as a substitute for relationships. From an attachment theory perspective, eating disorders can be understood as externalising behaviours which divert attention away from the individual's relational difficulties and towards the more attainable external goal of the socioculturally prescribed idealised body in order to gain the approval of others (Troisi et al., 2005).

Perfectionism as a personality trait has been recognised as a specific risk factor for the development of both anorexia and bulimia, but not necessarily for binge eating disorder; it is also a characteristic which persists in the individual after recovery (Forbush et al., 2007). Clients' inclinations towards perfectionism have implications for their therapeutic engagement and hence the therapist's experience within the relationship. Individuals may approach therapy with unrealistic expectations of themselves, the therapy and the therapist (DeLucia-Waack, 1999). Aiming for perfection within themselves, they may also seek it from the clinician (Zerbe, 1992) and hence can feel let down if the therapeutic experience does not live up to their expectations. If progress is not happening at the rate the client would like or they experience relapses, they are likely to engage in self-blame, viewing themselves as failures, thus reinforcing their characteristic low self-esteem (Kaplan & Garfinkel, 1999). Wanting to be seen by the therapist as perfect, the client will present with a desire to please and therefore will be unlikely to challenge their therapist, express any negative emotions or to report any relapses (DeLucia-Waack, 1999). All of this has implications for the efficacy of therapy as the therapist can only work with the self and information that the client offers. Aware of these tendencies, experienced clinicians can challenge clients, but inexperienced practitioners, unaware of these typical behaviours, may be vulnerable to missing such experiences (Kaplan & Garfinkel, 1999) or to over-estimating their patient's competence (Hamburg & Herzog, 1990) and well-being.

3.4.2 Object Relations

From the psychodynamic perspective, relationships with mother and other early caregivers are especially pertinent. Much of the literature relating to the development of eating disorders focuses on the infant as female and mother as main caregiver (Pilecki & Józefik, 2013), with some authors still claiming that the relationship with the mother is the most problematic (Barone & Guiducci, 2009; Gander et al., 2015; Pilecki & Józefik, 2013; Rice, 2014). Psychological theorising of the 1960s and 1970s focused on pathological elements of the mother-child relationship; a position which should be recognised as overly simplistic and guilt inducing (Hepworth, 1999; Wooldridge, 2016). This was possibly due to the socioculturally constructed gender roles during these decades but it also needs to be recognised that in western culture, females, and thus mothers, still tend to be defined as infants' main caregivers (Pilecki & Józefik, 2013; Rice, 2014). The role of the father has been recognised as pertinent in the field of eating disorders (Gale, Cluett, & Laver-Bradbury, 2013), but has been largely neglected in the literature. This is especially true in relation to attachment experiences with father for which there are currently only a small number of studies published (Gander et al., 2015).

Zerbe (1993) understands that exploring early maternal attachment experiences in therapy is not an act of 'mother-blaming', but is rather an attempt to explore the developmental affiliation in order to gain a more complete picture of the relationship to the principal caregiver. The feminist criticism of 'mother-blaming' is now tempered as it is recognised that attachments can be disrupted not just through early relational experiences, but also because of factors including cultural pressures, family dysfunction, sexual abuse, genetics and chemical imbalance (Pearlman, 2005). Contemporary psychodynamic models are less individualising and are acknowledging the role of social and cultural context in an infant's development (Tasca & Balfour, 2014) and the experiences of other family members.

Psychodynamic attachment theory understands the individual's inadequate self-construct (Duker & Slade, 1988; Tasca & Balfour, 2014; Ty & Francis, 2013) as arising from difficulties in negotiating the early parental individuation (O'Shaughnessy & Dallos, 2009; Russell & Marsden, 1998). In infancy there is total dependency on caregivers for providing nourishment and nurturing. In the early

days of life, all infants have limited, if any, sense of themselves as separate beings and are unable to distinguish the 'me' from the 'not me' (McDougall, 1989). The caregiver is experienced as an extension of the baby which provides the infant with food and other nurturing on its demand of needs. To begin the process of individuation and establishing a strong individual sense of self, the infant needs its caregivers to recognise them as a separate being and to respond empathically to their discrete demands (Orbach, 1986). These early experiences are significant as how the infant learns to relate to early caregivers has implications for how the individual will relate to others and the world, including food, throughout their life (Levens, 1995; Lupton, 1996; Orbach, 1986). For those who enter therapy, this also applies to the therapeutic relationship which, especially at the outset, can be experienced as symbolic of the client's early relationship with mother (Burka, 1996) or other significant caregiver.

Russell and Marsden (1998) discuss this early developmental stage between mother and female infant in relation to the eating disordered client. In summing up Russell and Marsden's (ibid.) work I follow their female bias in order to maintain clarity in the writing, and also to illustrate that much of the literature is written using female pronouns (Morgan, 2008). Russell and Marsden (ibid.) claim that in enabling her infant to develop the ability to recognise and manage her own somatic experiences, the infant needs mother to accurately recognise them and raise them to the symbolic level. If mother is able to provide this function successfully, the infant develops her own internal space for reverie alongside recognition of her own body as separate from mother's. When this is successfully negotiated, the infant learns to recognise and verbalise her somatically experienced needs and drives, and is able to accept them as part of herself. When mother is not able to achieve this, the infant's ability to distinguish her bodily self from her psychological self is thwarted and the dissociated experience of mind and body (Barth, 2016; Zerbe, 1993) is introduced. This then paves the way for a future tendency towards concretising internal affects onto the physical body. The infant also needs mother to be able to hold and contain her painful emotions so that she can learn how to tolerate and regulate them for herself. When mother provides an inadequate experience of this, she offers no soothing experience for her baby to internalise and the infant grows up with a limited capacity to tolerate feelings. The individual's capacity to regulate affect has been directly tied to attachment experience (Fonagy, Gergely, Jurist, & Target, 2003), which, Petrucelli (2015b) claims is being confirmed

by neuroscience. Eating disorder symptomatology arises in the future as a means of the individual soothing their intolerable and unmanageable affects (Barth, 2001, 2008; Robinson et al., 2013; Striegel et al., 2012; Sweeting et al., 2015).

For individuals who develop eating disorders, both the empathic attunement received from mother in infancy and the separation experience were problematic (Shipton, 2004). A baby whose needs are not accurately met, doubts their own experiencing, believing that mother, and therefore others, know best (Bruch, 1973). They lose the opportunity to learn how to discriminate and express their own needs and become instead a receptacle for whatever is projected onto them (McDougall, 2001). This leads to a “paralysing sense of ineffectiveness” (Bruch, 1973, p. 254) with the individual feeling unentitled or powerless to voice and put their own needs and wishes into action (Eichenbaum & Orbach, 1982). In the therapy room, this is enacted by clients who appear passive but are struggling to access their own thoughts and feelings; the consequences of this will become apparent in section 3.6 and within chapter four. The infant whose needs are not adequately met comes to feel that they are unacceptable, and to protect both their own psyche and to please mother, they create a ‘false self’ (Winnicott, 1960), as discussed in section 3.2 in relation to person-centred therapy. This self is devoid of its own needs and instead expresses only those which it knows mother can receive and satisfy; thus illustrating the social constructionist notion of a self forming in relation to others. Such maternal failures in attunement also have consequences for how the child relates to their own body as they develop an inadequate sense of proprioceptive awareness, leaving them unable to listen to their body’s internal cues (Barth, 2016).

3.4.3 The role of the father in the family

Despite a recognition that the father-daughter relationship plays a significant role in the development and maintenance of eating disorders in females (Jones & Morgan, 2010), the role of the father is noted in the literature as a neglected issue (Barone & Guiducci, 2009; Gale et al., 2013). The Cochrane Library has no systematic reviews regarding the father-child relationship in relation to eating disorders (Gale et al., 2013). The majority of literature pertaining to the psychological development of eating disorders maintains a recognition that the relationship with the mother appears to be the most problematic (Barone & Guiducci, 2009; Gander et al., 2015; Pilecki & Józefik, 2013). Consideration should be afforded as to whether this is due

to sociocultural positioning of parents and the expectation that mothers still tend to provide most of the childcare (Pilecki & Józefik, 2013; Rice, 2014). It could be questioned as to whether this will shift in coming years due to the changing gender roles and sociocultural situation of men within western culture discussed in chapter two.

3.4.4 The body in psychodynamic thought

Although not always explicit in therapeutic practice, psychodynamic theory could be considered as placing more significance on the role of the body in the development of the individual's subjective experience than the previous two therapeutic approaches discussed. Therapists working from this perspective therefore potentially have more awareness of the role that the body plays in an individual's subjective and relational development and experiencing than those working from either the person-centred or cognitive-behavioural schools.

In his statement that the ego is "first and foremost a body-ego" Freud (2010, c.1923, p. 27) recognised that an infant's sense of self begins to form through early bodily relating and proprioceptive sensations. Infants communicate through their bodies before speech develops and any trauma within this dyadic relationship can disrupt the infant's relationship with, and ability to listen to, their body (Rumble, 2009). "[T]he earliest sense of self is rooted in the body in the preverbal experience" (Rabinor, 1995, p. 91) and an infant's subjectivity is experienced somatically in relation to how primary caregivers respond and relate to its physically experienced and communicated needs (Aron, 1998; Orbach, 1999). The baby needs adequate handling to accept their body as part of themselves and to feel that the self dwells in and throughout it (Athanasiadou & Halewood, 2011). The infant will experience both emotional and physiological needs which it needs caregivers to successfully interpret as incorrect understanding, and hence ineffective resolution of expressed needs, can cause the infant to begin doubting its own self experience. For individuals who go on to develop problematic eating behaviours, the confusion of physiological hunger symptoms with emotional experiences can be introduced by a caregiver who attempts to satisfy the baby's emotional needs with feeding (Bruch 1973).

3.4.5 The missing body

Despite the above assertion of increased corporeal attention in psychodynamic theories, Orbach (2003) believes that the body has become secondary to the mind within psychotherapy and is now seen as an adjunct to psychological processes. Mirroring the values of the dualist patriarchal elements of western culture discussed in chapter two, Orbach asserts that privileging of the mind contradicts Bowlby's (1969) 'attachment theory' which she reads as also being a physical model (Orbach, 2004). Hence for Orbach (1986, 1994, 2003, 2006, 2009) and latterly for Sands (2016), the psychodynamic developmental theories discussed above apply as much to the development of the physical body as they do to that of the psychological self.

From this perspective, the body is conceived as a physical entity in its own right which needs to experience itself in relationship with another body to change and grow rather than simply being a vehicle for the self (Orbach, 2003). Paraphrasing de Beauvoir (1997, c. 1949), Orbach (2004, p. 149) asserts that "the body is made, not born" and restating Winnicott, claims that "there is no such thing as a body, there is only a body in relationship with another body" (Orbach, 2003, p. 11). The female infant's body especially, is prey to mother's projection of her own body image issues (Orbach, 1994) and, illustrating the intergenerational interaction between mother and daughter, Gerstein and Pollack (2016) claim that these can be internalised by the infant who grows up unconsciously living with mother's culturally acquired problematic body beliefs. Although Orbach (2003, 2004) and Gerstein and Pollack (2016) write from the female perspective, it would seem appropriate to apply the intergenerational concept to men and male infants.

Drawing further on Winnicott's (1971) theory, Orbach (1994) develops his concept of the 'false self' to write of the 'false body', which the infant develops to hide feelings of discomfort and insecurity around their perceived unaccepted natural body. In Orbach's theory therefore, it becomes necessary for the client experiencing an eating disorder to resolve their corporeal developmental deficits as well as those of their psyche. Sands (2016) asserts that when working through the client's experience of their body that both the physical and symbolic elements need to be explored and accepted in order to facilitate a sense of embodiment (Sands, 2016). The therapist thus needs to allow their own body to be present within the therapeutic encounter for use by their client's corporeal self in the same way as

their psyche conventionally is for their psychological self (Orbach, 2003, 2004, 2006; Sands, 2016). To achieve this, therapists need to both experience and present, a stable sense of their own body to the client (Daly, 2016; Orbach, 2003, 2004, 2006; Sands, 2016); a point elaborated upon in chapter four.

Echoing Merleau-Ponty's (1962) claim that the body is always there, the therapist's body is always present (Daly, 2016) and alive (Sands, 2016) within the counselling room, and as such, becomes a powerful transference object for the client (Daly, 2016). Therefore, any anxiety which the therapist experiences in relation to their own body is likely to impact the quality of the therapy and risk reinforcing the client's own insecure relationship with their body (Daly 2016). If the therapist's anxieties around their body are too powerful, the client may re-enact their early embodied development and adopt a further false body (Orbach, 2004) in order to protect the clinician (Daly, 2016). The more congruently a therapist can discuss clients' reactions to their body, the more useful it becomes as a therapeutic tool (Daly, 2016) to enable the client to resume and repair the development of their body self (Sands, 2016). Allowing its use as a container to "metabolize [sic] the patient's unprocessed sensory states into experiences" (Sands, 2016, p. 35) the therapist can help the client bring such feelings into conscious awareness which can then be discussed and assimilated into a new narrative.

Despite its arguably deeper understanding of self-development, psychodynamic theory can be criticised for pathologising the individual by situating problems primarily as defects within their psyche and ignoring the influence of wider sociocultural influence (White & Epston, 1990). Although traditional psychodynamic approaches individualised self-development, seeking an essential inner self (Lester, 1997), newer models are becoming less individualised and are recognising the relational and sociocultural aspects of self-development (Tasca & Balfour, 2014). There is however, a danger of attachment formation exploration being experienced as blame or criticism of parents, rather than simply as a tool of understanding how the individual's early experience affected their developing subjectivity (Dallos, 2004; Zerbe, 1993). Mothers, fathers and other caregivers are all influenced by their own developmental and life experiences and the sociocultural situation in which they were both raised and are raising their children. Parents experience sociocultural pressures to be the 'perfect' mother or father or to create the 'perfect family' (Dallos,

2004) and by attempting to fulfil these roles run the risk of inhibiting their child's subjective development.

In answer to these criticisms and in recognition of the social constructionist perspective taken in this thesis, a fourth approach to understanding and working with clients experiencing eating disorders is introduced in the following section. Although narrative therapy was not discussed by any of the therapists interviewed for this research, it is a model which accommodates the social constructionist elements discussed in this thesis and contemporary thinking in the field of therapy (Piran & Cormier, 2005).

3.5 Narrative therapy

The field of counselling has seen a growing trend in recent years to incorporate the impact of social discourses and structures into theory and practice (Piran & Cormier, 2005). Recognising, as this thesis does, that individual subjectivities are shaped by familial and social discourses, narrative therapy offers an approach advocating the externalisation of problems and a movement away from individual pathologisation (White & Epston, 1990). Eating disorders are thus located in cultural discourses (Nylund, 2002) rather than the inner selves of the previously discussed therapeutic approaches. Narrative therapy acknowledges the individuality of each client and their narratives and claims that there can be no "one-size-fits-all approach" (Maisel et al., 2004, p. 2) for working with eating disorders.

At the heart of the narrative approach is the postmodern and social constructionist idea that individuals do not simply perceive the world, but instead, interpret and create their own (Cowley & Springen, 1995). Some experiences and discourses are given more weight than others through the importance which individuals attach to the various familial, peer and cultural pressures which determine the patterns that define them (White & Epston, 1990). Considering selves, knowledge and meaning as fluid, contextualised and created within relationships (Gergen, 2015; Gergen & Kaye, 1992; Lock & Strong, 2010), therapy is the place where therapists can enable clients to create different narratives and establish new understandings about themselves, the world and their relationships (Madigan, 2011; Maisel et al., 2004; White & Epston, 1990).

In acknowledgement of the value that this thesis has placed on attachment theory, an alternative reading of this psychodynamic concept is offered which fits more readily with the social constructionist perspective. Through 'attachment narrative therapy' Dallos (2004) claims that attachment patterns can be explored to gain an understanding of how the clients and their family interacted with each other rather than pathologising or apportioning blame. Through this exploration, therapists can help clients recognise the narratives they hold about the self, others, and the world, in relational and affective terms (O'Shaughnessy & Dallos, 2009). The narratives an individual holds about themselves can then be 're-authored' within the therapeutic relationship, thus creating a more effective life story. Arguably, the person-centred construct of the authentic self can also be viewed as an unhelpful self-narrative and thus challenged.

Rather than apportioning blame to clients or family members narrative therapy emphasises that difficulties within families arise from problem saturated conversations (Dallos, 2004) and pathologising stories (White & Epston, 1990) which are fuelled by family beliefs and sociocultural discourses. These stories, rather than being considered as internal to the individual or their family are located within culturally shared discourses (Dallos, 2004). Looking at the role of the family in the child's development, narrative therapy recognises that family members carry their own narratives and through their familial interactions, shape the narrative that the child develops. Narrative therapy recognises social constructionism's notion of multiple realities and thus clients have options to re-design their own stories and formulate their own version of truth through the therapeutic dialogue (Madigan, 2011).

There is an established dominant narrative in western society which tends to pathologise and internalise problems, presenting them as arising as a consequence of individual personality, biological or organic flaws and deficits (Dallos, 2004). The previous therapeutic approaches discussed have arguably been historically aligned to this, along with the victim blaming aspects of patriarchy's "powerful grand narrative" (Parry & Doan, 1994, p. 53). As the therapy world begins to open itself to social constructionist ideas (Piran & Cormier, 2005), narrative therapy offers an alternative way of externalising problems (Dallos, 2004; White & Epston, 1990) thus removing the focus from individual pathology and situating eating disorders within the cultural context (Maine & Bunnell, 2008; Nylund, 2002).

A narrative approach also allows for a connection with the individual as a person as opposed to the identity they may have assumed through their eating disordered narrative. Terms such as 'anorexic' or 'bulimic' pathologise and imply totalising language, which labels the individual and aids the tendency of the eating disorder to shape and define the individual's identity (Dallos 2004). From a narrative therapy perspective, clients have become stuck in the relational and eating disordered stories they have told themselves (Gergen & Kaye, 1992), which have been largely shaped by the narratives and meanings of others (Parry & Doan, 1994). As clients tell their stories within the therapeutic relationship, their narratives can be deconstructed and changed.

3.6 Eating disorders in the therapeutic relationship

Having considered conceptualisations of self in an individual who develops an eating disorder, the focus now turns to consider how this translates more specifically into the embodied subjective experiencing of the different presentations. As illustrated throughout section 3.5, each of the disorders bring their own characteristics into therapy which affect how the client presents in the room, engages in the therapeutic relationship and consequently the therapist's experience. Understanding the aetiology and presentation of the different eating disorders is arguably necessary in order to make sense of the many affective and somatic experiences reported by therapists and as Satir (2013) claims, therapists need to understand eating disorders in order to understand their clients.

Potential physiological consequences of the behaviours and their implications for therapy and the therapist's experience are also discussed in relation to each of the disorders. Therapists may need to decide when the client's physical health is at risk and in need of physiological intervention, so as not to put clients' lives at risk (Williams & Haverkamp, 2010). This has implications for the therapeutic relationship if the therapist needs to breach confidentiality in order to gain medical care for their client (DeLucia-Waack, 1999). Despite the significance of this for both client and therapist experience, there are no studies considering how the feelings of clinicians towards working with this client group might be affected by their awareness of these medical risks (Thompson-Brenner et al., 2012).

The remainder of section 3.6 is written in relation to the female client's experience mirroring the current literature. Although it could perhaps be reasonably assumed to be so, further research into the presentation of male clients, especially in relation to internalised gendered roles, is needed to determine if their presentation is the same. The subjective experience of each of the disorders is presented with a depiction as to how this transcends into the client's likely engagement within the therapeutic relationship. As the eating disorders are symbolic of clients' relational and affective experience, they will regulate, as they do with their food, how much of the therapist they "can take in or spit out" (Petrucci, 2015b, p. 45).

3.6.1 Anorexia

Anorexia can be recognised as "the distress of a self embodied in a very real and historically significant way" (Jabobs & Nye, 2010, p. 486). Its symptoms can be considered as adapted behaviours used in an attempt to create a sense of self. Locating anorexia within, and produced by, the pervading Cartesian dualist discourses of Western culture, Malson (1998) claims that self has become equated with mind and the individual thus perceives a need to control her body in order to retain the integrity of a self-controlled, disciplined self. This identity is promoted through the idealised body of western consumerist society and its concurrent discourses and discursive practices (Malson, 1998; Polivy & Herman, 2007) discussed in chapter two. The individual's sense of self becomes defined by the condition (Tierney & Fox, 2009, 2010) and as a consequence of their identity becoming enmeshed with dieting, the individual's mood, well-being and self-image are dangerously tied to their weight (Polivy & Herman, 2007).

The emaciated self-starved body can be considered as a visible representation of an individual's history of developmental and interpersonal problems (Hughes, 1997). The thin and undernourished appearance is a very visceral image (Farrell, 2015) which can instil in others an increased sense of responsibility and a wish to nurture (Hamburg & Herzog, 1990). Through the psychodynamic lens these are the very things that the individual experiencing anorexia is denying herself and can thus be interpreted as the client's unconscious projection of denied needs (Hughes, 1997). From the infant's experience of having her needs inadequately understood and satisfied, she learned to suppress them and abolish the needy part of herself, symbolised through her shrinking body size (Orbach, 1986). Ensuring that she

does not give in to those needs, and especially that of hunger, enables her to maintain a sense of identity (Lawrence, 1987).

The restrictive eating behaviour of the individual experiencing anorexia can be considered as mirroring the restrained expressivity of herself and her body (Baerveldt & Voestermans, 1998). Her emaciated body is experienced as visible and concrete proof that she has eradicated her needs and what she experiences as her unacceptable self (Orbach, 1986). Seeking perfectionism as she does, this visible eradication is perceived with a sense of achievement (Vandereycken & Deth, 1994) in relation to aesthetic ideals. Furthering her dualist experience, it is also proof that her body is of no consequence compared to her all-powerful mind (Lester, 1997). Hunger is experienced as a temptation to give in to bodily desires (Lupton, 1996) but by ignoring it, and hence overcoming it, a sense of power is achieved. The notion of gaining weight or loosening control of her eating behaviours is terrifying as weight gain equates to losing control of inner needs and desires and consequently, her self (Bordo, 1998).

Therapy can be considered as a source of nourishment which the client experiencing anorexia will typically struggle to accept (Russell & Marsden, 1998) and may thus appear aloof and ambivalent. Rather than a refusal to participate, this presentation can be more accurately understood as indicative of the individual's typical withdrawn relational pattern and her tendency of not allowing herself to receive or give nurturance (Strober, 2004; Wooley, 1991). It can also be a consequence of the physiological effects of starvation (Hamburg & Herzog, 1990) which contributes to the notoriously difficult therapeutic relationship (Hughes, 1997). Understanding her psyche as strongly defended against any kind of intrusion (Strober, 2004), either nutritional or relational, the client experiencing anorexia will find it difficult to allow any of the therapist's emotional connection or therapeutic interventions to be integrated into her self-construct (Orbach, 1986) or re-authoring of her self-narrative (Madigan, 2011).

The client's fear of relationship and emotional connection will also compound the difficulty she experiences in engaging therapeutically. As a result of the inadequate empathic attunement received in infancy, clients experiencing anorexia tend to develop a fear of connection which they equate with dependency, enmeshment and the risk of self-annihilation (Steiner-Adair, 1991). By allowing herself to become

dependent upon the therapist, the client fears the engulfment and loss of self that she experienced earlier in life in relation to an overly close mother (Russell & Marsden, 1998) or other caregivers.

Hughes (1997) describes how by unconsciously refusing to make progress in therapy, the client experiencing anorexia keeps control of the therapist and her own sense of self. Through this process, she remains reassured that the therapist is still involved, yet at the same time is able to reinforce her belief that no one can give her what she needs, thereby confirming her early maternal experience. Enmeshed with this is the patient's enactment of her struggle to separate from her family. Unable to negotiate her way through the adolescent separation phase, the individual experiencing anorexia is caught in a battle between establishing her autonomy by separating from her family and desperately wanting to remain the dependent child (Koskina & Giovazolias, 2010; Minuchin, Rosman, & Baker, 1978). This will be re-enacted in the therapy room as the client cannot afford to allow herself to make progress, which would ultimately mean separation and growing up (Hughes, 1997).

3.6.1.1 Physiological complications of anorexia

Many of the physiological complications of anorexia arise as a consequence of starvation, which as Keys' (Tucker, 2007) classic experiment in the 1940's showed, severely impacts an individual's physical and psychological functioning. The medical complications can be wide ranging (Furstand et al., 2012) and include weakness, loss of muscle strength, loss of bone density, amenorrhoea, infertility, damage to the endocrine system and damage to the internal organs which can ultimately result in their failure. Low weight and lack of calorie intake can also result in cognitive decline, depression, OCD, anxiety and other disturbances of mood (NICE, 2017). The depletion in cognitive functioning has implications for the ability of clients to engage in therapy (Gottlieb, 2015; Kaplan & Garfinkel, 1999; Vandereycken, 1993), as at low weights, clients are unable to engage in the kind of abstract thought necessary for deep psychological exploration (Duker & Slade, 1988). Therapists who are unaware of this may attribute their client's seeming lack of engagement or progress to ambivalence to treatment rather than a genuine inability (Kaplan & Garfinkel, 1999; Vandereycken, 1993).

3.6.2 Bulimia

Bulimia is less visible than anorexia as the individual is likely to be within the accepted normal weight range and will tend to present a façade of success and effective coping (Duker & Slade, 1988). As someone with a poor sense of self and difficulty managing her own feelings, she presents as compliant (Pearlman, 2005) and in control in order to gain the approval of her significant others, including the therapist (Dolton, 2000). Hidden beneath this however, is the disorganised, chaotic, bad and often angry person the individual perceives herself to be (Lawrence, 1987). This conflict is acted out through the eating behaviours with the purges recognised as her attempt to expel the perceived unacceptable parts of herself. This inner conflict results in a very precarious sense of control over herself and her life. Bringing this with her when she enters therapy, she will attempt to control the therapist and the therapeutic space so as to ensure that she maintains her precarious sense of control (Hughes, 1997).

Another psychodynamic reading of the bulimic ritual (Farrell, 1995) views the binge and purge pattern as a re-enactment of the individual's early relationship with mother. A potentially nourishing relationship has become destructive and mother, experienced as overwhelming and unsatisfactory, needs to be gotten rid of. Farrell views purging as an attempt to "work out what is 'me' from what is 'not-me'" (ibid., p. 56), with binges revealing the need for nurturance and connection, and the purges an attempt to gain separation and self-definition (Sands, 1991). Mirroring this experience in therapy, the client experiencing bulimia will appear to be engaging with therapy, but will then feel a need to eliminate it (Shipton, 2004), metaphorically 'vomiting back' the therapeutic interventions (Zerbe, 1998) rather than digesting and assimilating them to create subjective change.

In infancy, the individual who develops bulimic eating patterns was often over-stimulated (Farrell, 1995) and thus felt that her needs were usurped by a 'too good mother' who forced herself and her needs upon the child (Bruch, 1973). By not allowing the infant the opportunity to fully feel and express her own needs, or to tolerate the sensation of unsatisfied desires, she developed a sense that she was not entitled to experience the fulfilment of needs or the pleasure that comes from their expression and satisfaction (Bruch, 1973). With limited experience of attuned nurturance in infancy, the adult living with bulimia has difficulty knowing how to

request or accept support for herself and thus will often seemingly reject connection, pushing the therapist and the therapy away (Russell & Marsden, 1998; Steiner-Adair, 1991). As a consequence of mother's overstimulation the child experienced nurturance as overwhelming and a negation of her own experience, which can create an ambivalent sense of engagement within the therapeutic relationship (Russell & Marsden, 1998).

Not having learned how to contain and process her feelings from an adequately attuned mother, bulimic behaviours also reflect a difficulty in processing emotions and experiences (Barth, 2008, 2016; Russell & Marsden, 1998). This will be re-enacted in the therapeutic process when the client finds it difficult to acknowledge, experience and process the contents of the therapy (Shipton, 2004). The client needs her therapist to contain her feelings and experiences in a way in which mother was unable to do for her in infancy so that she can begin to develop the capacity to manage her own feelings (Russell & Marsden, 1998). Feeling unworthy of the therapist's care and attention and thus appearing falsely compliant (Pearlman, 2005) she may appear to be engaging with the therapy. However, this could be just in order to please the therapist, and if she has not learned how to accept nurturance and allow it inside herself, she will metaphorically purge the experience as soon as she leaves the therapy room (Lawrence, 1987).

The inherent shame associated with bingeing and purging behaviours (Lawrence, 1987) means that clients will typically struggle to disclose in any detail the intricacies of their behaviours. Therapists need to be attuned to this and encourage the client to talk in detail about their behaviours. Orbach describes reliving the intimate details of a binge as a way of giving the experience back to the client in order to prevent her splitting it off and thus enabling her to take ownership of it (Orbach, 1986).

3.6.2.1 Physiological complications of bulimia

Clients presenting with bulimia tend not to present at the dangerously low weights of those experiencing anorexia and hence medical intervention tends to be needed less frequently. Potential physical complications of bulimia however, can arise as a consequence of the purging behaviours. Vomiting, laxative and diuretic abuse can result in disturbances to clients' fluid and electrolyte balances, damage to their

gastrointestinal tract and dental complications (NICE, 2017). As when working with individuals experiencing anorexia, therapists need to be able to recognise when their clients are in need of medical support. The effects of bingeing and purging on clients' blood sugar levels also need to be taken into account as this can impact on their mood and ability to concentrate (NICE, 2017), both of which may affect therapeutic engagement and thus influence the therapist's experience of their client.

3.6.3 Binge eating disorder

Binge eating disorder is the most prevalent of the eating disordered diagnoses (Starkman, 2016a) and yet the literature concentrates on the subjective experiences of anorexia and bulimia. As with anorexia and bulimia, a combination of biological, psychological, and social factors combine to thwart the development of a healthy embodied self, which Starkman (2016a) notes as a core factor in the development of the condition. Malavé (2015) claims that binge eating represents the individual's way of being in the world. Typically an individual who 'swallows whole' other peoples' needs and demands upon her she attempts to take control by taking the world inside her via food (Garrett, 1998). The individual who binge eats tends to have little sense of her self-boundaries or personal needs. Being dissociated from the part of herself that enables her to acknowledge those needs, she finds it difficult to ask for appropriate things for herself (Lawrence, 1987) and hence turns to food in an attempt to satisfy these undefined cravings. Because food is not what she is really seeking, it fails to satisfy her and she keeps eating in this futile way (Lawrence, 1987; Orbach, 1998). Her inability to control her eating may be symbolic of her difficulty in saying 'no' to people and establishing firm self boundaries. Within the therapeutic relationship, these clients again find it difficult to recognise and voice their own needs, feelings and experiencing (Eichenbaum & Orbach, 1982).

Similar to anorexia and bulimia, insecure attachment can result in those who binge eat turning to food and eating disordered behaviours as a means of dealing with intra- and inter- personal stresses (Tasca & Balfour, 2014). Early developmental deficiencies and caregivers who failed to supply adequate empathic attunement restricted the infant's ability to develop a firm sense of self. The individual grew up

yearning for the closeness and intimacy which was not received in infancy and uses food as a way of silencing this craving (Toman, 2002).

As with anorexia, binge eating disorders are often visible via the client's body size. Without the purging compensation of bulimia, overeating can become evident through the overweight or obese body. Not all clients will present this way however depending on whether their bingeing behaviour is sustained or intermittent. Due to sociocultural beliefs regarding the idealised body, this presentation may instil negative reactions in some therapists towards the client's overweight body (Yalom, 1991). Symbolically, the physical corpulence can be viewed as a shield which keeps other people at a distance from the individual's self experience (Leach, 2006), but consequently leaves them feeling isolated and depressed (Toman, 2002). It also illustrates a tendency to keep their own feelings hidden inside (Lawrence, 1987), with the increased corporeality being a physical representation of those unexpressed emotions. The overweight client does not tend to instil the sense of responsibility which the anorexic client can; instead, their physical size symbolically communicates that people should remain at a distance. Used to taking care of others and keeping things to themselves, the individual who binge eats will typically project an attitude of wanting to be left to get on with it on their own (Toman, 2002). Despite their yearning for intimacy, they tend to experience difficulty in allowing others to get psychologically close; including the therapist.

3.6.3.1 Physiological complications of compulsive eating and binge eating disorder

The physiological effects of compulsive eating or binge eating disorder are not as immediately risky as for anorexia or bulimia and complications tend to be the medical consequences associated with obesity (NICE, 2017). Again, clients' ability to concentrate sufficiently to engage therapeutically may be impacted as a result of fluctuating blood sugar levels or mood fluctuations.

3.6.4 Disordered Eating

The phenomenon of 'disordered eating' also needs recognising as it has implications for understanding the aetiology, pathophysiology and treatment of clients (Sands, 2016; Tanofsky-Kraff & Yanovski, 2004). Disordered or controlled

eating and exercising are increasingly common in western culture (Daly, 2016; Sands, 2016; Shipton, 2004) as individuals seek to achieve the socioculturally prescribed perfect body shape. Clients presenting with disordered eating issues do not experience the inadequate self-construct (Ty & Francis, 2013), fixed self-narrative (Gergen & Kaye, 1992) or problematic attachment narratives (Dallos, 2004) of those fulfilling eating disorder diagnoses to the same degree, and their motivation for controlling their weight and body comes more wholly from the sociocultural pressures discussed in chapter two. With no need to correct inadequately experienced early nurturing experiences, the therapeutic focus becomes directed more specifically towards the individual's reasons for wanting to achieve the perfect body and challenging their socioculturally induced beliefs.

However, as with the eating disorders, the individual who is extensively controlling her food intake or body size may become subject to some of the physiological consequences of lack of food or low weight as described for the individual experiencing anorexia above. The discussion relating to the different eating disorders has taken a female perspective as this is how the literature is written. Wanting to acknowledge that men and boys experience eating disorders too, section 3.7 explores the male experience.

3.7 Muscle dysmorphia and the male experience of eating disorders

Although as previously discussed in chapter two, eating disorders remain predominantly positioned within female discourses (Botha, 2010; Bunnell, 2016; Dalgliesh & Nutt, 2013; Robinson et al., 2013), this is beginning to change in response to sociocultural trends in relation to gendered roles (Wooldridge, 2016). Modifications to the diagnostic criteria which have been historically directed towards the female experience were made within DSM-V (2013) and recently updated NICE guidelines (2017) to more fully encompass the male experience.

There is some debate in the literature as to whether the different genders experience eating disorders in the same way, but it is claimed that males and females share more common ground than is often recognised (Maine and Bunnell 2008). The presentation of eating disorders in men is comparable to that of those in women on most variables (Olivardia, Pope, Mangweth, & Hudson, 1995;

Räisänen & Hunt, 2013; Tantleff-Dunn, Barnes, & Larose, 2011) and “the psychological underpinnings of disordered eating are similar across genders” (Locker, Heesacker, et al., 2012, p. 98). For both men and women, the disorders communicate relational and subjective difficulties resulting in a “tendency to subvert oneself in the context of interpersonal relationships” (Locker, Heesacker, et al., 2012, p. 99). It is therefore appropriate to infer that male clients experiencing anorexia, bulimia or binge eating disorder will present similarly in the therapy room to their female counterparts and that their early developmental histories will have followed similar patterns.

There are however, some differences between the gendered experiences (Derenne & Beresin, 2006), most of which relate to the sociocultural discourses (Murray et al., 2010) pertaining to femininity and masculinity discussed in chapter two. The increasing parity between men and women (Blashill, 2011; Klein, 1993) in recent decades has destabilised traditional representations of masculinity, leaving fewer ways for men to distinguish themselves (Blashill, 2011). Consequently, they have turned to their body with an increasing focus on the area of biggest natural muscular gender difference, concentrated on the chest and shoulders, and thus work towards increasing their upper body size (Gray & Ginsberg, 2007). A potential outcome of this drive for muscularity is ‘muscle dysmorphia’; a condition whereby men believe they look small when in reality they may be of normal size or even unusually muscular (Dakanalis, 2015; Dakanalis et al., 2015). When first identified in a study of male bodybuilders, muscle dysmorphia was termed “reverse anorexia” (Pope, Gruber, Choi, Olivardia, & Phillips, 1997). The condition has a strong conceptual similarity with anorexia (Mangweth et al., 2001; Murray et al., 2010; Strother et al., 2012) with the tendency it creates to over-exercise and use muscle-enhancing substances being closely associated with dysfunctional eating patterns (Riva et al., 2013). In acknowledgment of the male experience, muscle dysmorphia is considered in this thesis as a possible masculine manifestation of an eating disorder. Although currently defined in DSM-V (APA, 2013) as a subset of body dysmorphia, there is debate in the literature as to whether it would be better placed as an eating disorder (Dalglish & Nutt, 2013; Murray et al., 2010).

Paralleling the rise in numbers of muscled male bodies in visual media, the prevalence of body dysmorphia has dramatically increased in recent years (Dakanalis et al., 2015). Men who endorse traditional western masculine qualities

are more predisposed towards developing muscularity related psychopathology (Griffiths, Murray, & Touyz, 2015; Murray et al., 2013) and bodybuilding can be used to compensate for insecure gender identity (Mangweth et al., 2001). The drive for muscularity can be considered as a measure of how much the individual has internalised society's muscular mesomorphic masculine body and the characteristics associated with it.

Eating disorders in men often go unrecognised as they can be hidden on the spectrum of good health and athleticism. Muscularity and the lean body are often equated with good health and consequently, especially situated in current cultural discourses of health and fitness, potentially harmful muscle enhancing behaviours may be erroneously viewed as health promoting (Neumark-Sztainer & Eisenberg, 2014). The association between dieting and sports activity is stronger amongst males in order to achieve a lean body mass and attain a masculine body (McCormack et al., 2014). Exercise is recognised as a more masculine form of weight control than dieting and hence over-exercising pathology is often overlooked (Strother et al., 2012).

3.7.1 The marginalisation of eating disorders in males

As a consequence of the cultural positioning of eating disorders and body image difficulties within feminine discourses discussed in chapter two, the conditions have been identified as largely female phenomena in western society (Botha, 2010; Bunnell, 2016; DeFeciani, 2016; Räisänen & Hunt, 2013). Consequently, males experiencing eating disorders have been overlooked clinically (Forbush et al., 2007; McCormack et al., 2014; Strother et al., 2012; Warren & Rios, 2013), culturally (Botha, 2010) and in the literature (Dalglish & Nutt, 2013; Murray et al., 2010). Eating disorders and body image issues in men are inadequately researched, resulting in a limited understanding of the male experience (McCormack et al., 2014; Ousley et al., 2008; Räisänen & Hunt, 2013). There is an underrepresentation of men in research studies (Shingleton, Thompson-Brenner, Thompson, Pratt, & Franko, 2015) and only a handful of papers reporting on the male experience of an eating disorder (Robinson et al., 2013). Much of the professional literature, training material and therapeutic resources are aimed towards women, further reinforcing their female positioning (Greenberg & Schoen, 2008; Räisänen & Hunt, 2013). Consequently, professionals overlook the

possibility of men experiencing eating disorders (Maine & Bunnell, 2008) and are less likely to consider giving a diagnosis to a male (MacLean et al., 2015; Neumark-Sztainer & Eisenberg, 2014; Räisänen & Hunt, 2013). Men themselves, tend to dismiss their eating disordered symptoms as they fail to view themselves as being at risk due to their perception of the disorders as female conditions (Räisänen & Hunt, 2013; Woodside, 2004).

It has been suggested that some of the discrepancy between the numbers of males and females within the eating disorders' literature may be accounted for by the reluctance of men to seek treatment or participate in research for perceived women's problems (Greenberg & Schoen, 2008; Rikani et al., 2013). Males may be reluctant to seek help due to a sense of shame (Dalglish & Nutt, 2013; Maine & Bunnell, 2008) and young men especially, can be embarrassed to talk about their issues for fear of appearing "wimpy" or "girlish" (Olivardia et al., 2000). Disclosing the presence of an eating disorder may conflict with the male gender role and masculine ideologies regarding emotional expression or mental health difficulties as a sign of weakness (Currin et al., 2007). The historical, cultural and socially constructed nature of eating disorders as a female problem makes it difficult for men to understand their own eating disordered experience (Botha, 2010). Additionally, mass media sources, which are an important source of health knowledge (Sweeting et al., 2015) convey ambiguous messages, representing men with eating disorders as atypical of men and also as atypical of people with eating disorders (MacLean et al., 2015).

3.8 Conclusion

Despite being exposed to similar discourses regarding food, eating and the body, not everyone within contemporary western consumerist society develops an eating disorder (Riva et al., 2013; Ty & Francis, 2013). This chapter therefore, progressed beyond the social constructionist influences to take account of individual psychological and subjective factors. This highlights the interplay of internal and external influences upon embodied experiencing in relation to eating disorders. Person-centred, cognitive-behavioural and psychodynamic therapeutic approaches to working with clients experiencing eating disorders were discussed in order to illustrate the therapeutic approaches employed by the therapists within this study which have informed the findings and discussion chapters. Recognising the

postmodern notion of multiple realities, these different approaches to therapeutic work illustrate how the therapist's knowledge base will inevitably influence their client work and their interpretation of it. The psychological approaches were potentially problematic for this thesis as they posited the existence of pathologised essentialist inner selves rather than situating the problem externally in sociocultural discourses as narrative therapy advocates. However, these selves are recognised as being influenced by sociocultural discourses and the influential people of their attachment narratives were recognised as culturally and historically situated.

In contrast to the sociocultural discourses inscribed upon the body discussed in chapter two, this chapter introduced the eating disorders' phenomenological symbolic language to illustrate how clients' subjective experiences are enacted through the conditions. This also suggested ways in which clients might present and engage in therapy which has implications for the therapist's experience therein. In the following chapter the focus becomes more specific and the literature relating to professionals' experiences of working with this client group in relation to their affective, subjective and somatic experiencing is reviewed.

Chapter 4

Therapists' Experiences of Working with Clients with Eating Disorders

4.1 Introduction

As a consequence of the multifactorial aetiology (Hamburg & Herzog, 1990; NICE, 2017; Tasca & Balfour, 2014) of eating disorders and the complex way in which subjectivity is created through them, individuals experiencing the conditions are recognised as challenging for clinicians to treat (Burket & Schramm, 1995; Kaplan & Garfinkel, 1999; Sansone & Sansone, 2007; Warren et al., 2009). The previous two chapters introduced the history of eating practices and the changing gender roles in western culture to illustrate the meanings which have become inscribed not only onto the experiences of clients experiencing eating disorders, but also onto the therapists treating them. This narrative also illustrated how eating disorders have been positioned as essentially female conditions (Botha, 2010; Dalglish & Nutt, 2013; Morgan, 2008) and as a consequence, how the male experience has been marginalised in the literature, clinical practice and society (Forbush et al., 2007; McCormack et al., 2014). Psychological theories relevant to this study in understanding and treating eating disorders were also discussed and the significance of the two bodies in the therapeutic encounter introduced. In this chapter, the focus moves specifically onto the experiences of therapists working with clients presenting with eating disorders to illustrate the challenges which this work can afford; challenges which arise as a consequence of the sociocultural, psychological, interpersonal and physiological factors discussed in the previous two chapters.

Despite the recognition of the challenges involved in the work (Satir, 2013; Warren et al., 2009), the body of research dedicated to the treatment provider experiences of working with clients presenting with eating disorders is currently limited, and although these limitations were noted back in 1996, (Franko & Rolfe) they continue to be a concern (Satir et al., 2009; Thompson-Brenner et al., 2012; Warren et al., 2009). Many of the studies are now dated (Satir et al., 2009) and understandings of eating disorders and their treatment have advanced since their publication;

hence their ongoing legitimacy needs to be questioned. A 2012 literature review of studies pertaining to clinicians' reactions to individuals presenting with eating disorders, (Thompson-Brenner et al.) found only 20 studies published between 1984 and 2010 and concluded that it was "difficult to draw solid conclusions" as "the existing studies are scattered across a number of related topics, have utilized disparate methods with significant limitations and were published across three decades" (ibid., p. 77).

Section 4.2 introduces the clinician's experience within the therapy room of working with clients presenting with eating disorders. Maintaining the cultural positioning of eating disorders as essentially feminine conditions (Botha, 2010; Bunnell, 2016; Dalgliesh & Nutt, 2013), the literature is heavily weighted on the female therapist's experience of working with female clients. Most of the current literature is written in relation to the experiences of therapists working with clients presenting with anorexia or bulimia, thus failing to consider the potential effects of clients experiencing binge eating disorder, those captured within the EDNOS (Eating Disorder Not Otherwise Specified) category (DSM-V, 2013) or those with muscle dysmorphia. Section 4.3 suggests that some of the feelings experienced may be understood as arising from the psychodynamic concepts of countertransference and projective identification, before then considering, in section 4.4, how therapists' therapeutic orientation can affect their experience. The potential of the work to influence therapists' personal relationships with food, eating and their body is illustrated in section 4.5 (Franko & Rolfe, 1996; Shisslak et al., 1989; Warren et al., 2009). This leads into a discussion in section 4.6, regarding the presence of the therapist's body within the therapy room and the roles that it plays within the therapeutic encounter; physically, symbolically and somatically. Psychodynamic theory posits that individuals with eating disorders tend to dissociate from their affective and corporeal experience (Barth, 2016; Zerbe, 1993) projecting it onto their therapists (Hughes, 1997). As a consequence of these psychodynamic concepts, the possibility of somatic or embodied countertransference (Barth, 2001; Pacifici, 2008; Petrucelli, 2001) becomes evident, and is discussed in section 4.7. To ensure that the work remains ethical, the chapter concludes, in section 4.8, with a discussion of the implications for therapist training, self-awareness and supervision.

4.2 The clinician's experience

General consensus in the literature pertaining to eating disorders is that clients presenting with the conditions are experienced as difficult to treat (Burket & Schramm, 1995; Kaplan & Garfinkel, 1999; Matz & Frankel, 2005; Williams & Leichner, 2006) and that the therapeutic relationship is a particularly challenging one (Hughes, 1997; Rance et al., 2010). As a result of these challenges, it is recommended that therapists limit the number of clients diagnosed with eating disorders on their case load to prevent burnout (Warren et al., 2009). These are clients who typically arouse strong emotions within their therapists, including helplessness, frustration, hopelessness, fear, anger, and anxiety (Burket & Schramm, 1995). Contributing to the “unique challenges” (Warren et al., 2009, p. 27) which clients experiencing eating disorders present to their treatment providers is the shared sociocultural situation (Daly, 2016) of client and therapist and the implications of the theories of self and body discussed in chapters two and three. Other challenges arise more directly from the consequences of the subjective experiences of the client and their eating disordered experience. These include clients' interpersonal difficulties (Kaplan & Garfinkel, 1999), their hyperawareness of treatment providers' appearance (Daly, 2016; Fairburn, 2008; Lowell & Meader, 2005; Rance et al., 2014; Warren et al., 2009), the physiological consequences of the eating behaviours (Furstand et al., 2012; Kaplan & Garfinkel, 1999; Satir, 2013; Tasca & Balfour, 2014), and the disorders' high co-morbidity, high mortality rates and high incidence of relapse (Kaplan & Garfinkel, 1999; Warren et al., 2009).

Although written almost two decades ago, Kaplan and Garfinkel's (1999) paper describes in some detail clinical and therapist factors which contribute to the challenges inherent in working with clients presenting with eating disorders. Difficulties defined as being initiated within clients include interpersonal deficiencies, high levels of co-morbidity and the physiological effects of the disordered eating behaviours. Kaplan and Garfinkel (1999) also acknowledge that symptoms are typically entrenched before individuals seek treatment and as their disorder serves an adaptive, organising function reflecting deficits in their self and affect regulation, clients are reluctant to abandon their behaviours. Personal challenges for therapists noted within the study include the strong negative feelings evoked within clinicians, including hostility, hopelessness, anger and stress. Kaplan and Garfinkel also note that “anxious and demanding relatives” (ibid., p. 668) who may

accompany clients to appointments can induce a sense of desperation within the therapist. The review recognises the importance of employing a range of therapeutic interventions including behavioural and cognitive strategies, exploration of the existential and personal meanings of the disorder for the client, examination of the adaptive role of the symptoms and provision of psycho-educational material. Kaplan and Garfinkel (1999) mention gender issues in relation to the therapist, describing female clinicians as more likely to react negatively to the client's typical scrutiny of their body and to experience a sense of envy or competition towards their clients' typically thin bodies. As an example of the literature's focus on the female perspective (Greenberg & Schoen, 2008) the authors imply that eating disordered clients are female, thus ignoring the male experience. The study does acknowledge that male therapists might work with clients, but only to note that they may be idealised in their female clients' perceptions as the absent father.

In a more recent study (Warren et al., 2009), treatment providers' personal experiences were explored through the collection of data from 43 self-selected participants at the annual meeting of an eating disorders organisation. Both qualitative and quantitative questions were asked, investigating the tendency of clients to comment on their therapist's appearance, personal changes in the therapist's experience of their own body and eating behaviours and their recommendations for working with clients presenting with eating disorders. The majority of respondents were female (n=39; 91%) with between 6 months' and 31 years' experience of working with the client group. Most of the respondents noted adherence to more than one treatment modality, but the most common primary approaches were CBT (n=17; 40%) and psychodynamic therapy (n=15; 35%). The client group were recognised as being challenging to work with as a result of the nature of the conditions and the feelings evoked in therapists. The study concluded that individuals experiencing eating disorders are likely to scrutinise their therapists' appearance and possibly make comments in relation to their observations which can cause clinicians to become more aware of their own, and others', physical appearance. With only 43 participants, the study was of small size, limiting its potential for generalisability. There was no role differentiation of respondents and hence its application in relation to this study's concentration on psychotherapeutic therapists, needs to be treated with caution.

The typical resistance of eating disordered symptoms to treatment (Barth, 2008; Hamburg & Herzog, 1990; Kaplan & Garfinkel, 1999) and the subsequent length of time required for recovery (Barth, 2016; Strober, 2004) can create frustration for the therapist and cause them to doubt the efficacy of therapy, or themselves as practitioners (Hamburg & Herzog, 1990). In their study of therapists' attitudes towards this client group, Burket and Schramm (1995) found that 87% of their respondents reported feeling frustrated and described how the typically slow progress of the work can result in clinicians experiencing boredom. Strober (2004) more descriptively writes of the work as "maddeningly slow, grinding and boring" (ibid., p. 253), leaving the therapist with a sense of "[p]ity, irritation, frustration, annoyance, the desire to be free of the patient" (ibid., p. 254).

Satir (2013) claims that, especially with clients experiencing anorexia, practitioners have a tendency to want to problem solve as the boredom and frustration drives them towards more directive cognitive or behavioural interventions which the client is not necessarily in a position to accept (Zerbe, 1998). In finding a helpful balance, Delucia-Waack (1999, p. 384) claims that therapists "need to know enough to intervene but should not be intrusive without reason" as this can leave the client feeling engulfed or controlled (Hamburg & Herzog, 1990), reminiscent of earlier inadequately attuned relationships with primary caregivers. Recognising the ego-syntonic (Toman, 2002; Wooldridge, 2016; Zerbe, 1998) element of the disorders, the client can feel consciously, or unconsciously, that they are in emotional danger at the threat of their symptoms being removed (Barth, 2008).

Frustration can be manifested as a consequence of the ways in which clients' typical alexithymia (Barth, 2016; Mathiesen et al., 2015), lack of sense of self (Duker & Slade, 1988; Tasca & Balfour, 2014) and interpersonal difficulties impact on their ability to engage in therapy, as discussed in chapter three. Understanding how the form and content of their client's language is reflective of both their relationship with food and eating (Burke, 1991) and their interpersonal life can help the therapist appreciate the client's difficulties and struggle to work through their feelings. Attempting to move beyond the superficial world of food can also be frustrating with clients who find it difficult to discuss more affective and personal issues (Jabobs & Nye, 2010).

Again maintaining the professional and cultural bias towards eating disorders as female conditions (Bunnell, 2016; Burket & Schramm, 1995; Greenberg & Schoen, 2008), the literature pertaining to therapist experiences pays limited attention to the different experiences of male and female therapists. In some studies, therapists' gender is noted and minimal discussion afforded to general differences (Burket & Schramm, 1995; Satir et al., 2009; Thompson-Brenner et al., 2012), but qualitative studies focusing on the therapist's subjective experiences are typically explored from the female perspective, with the exception of a case study account written by Yalom (1991). Much of the literature relating to the therapist's experience identifies clients as female (Franko & Rolfe, 1996; Hughes, 1997; Kaplan & Garfinkel, 1999; Lowell & Meader, 2005; Satir, 2013) or suggests that female therapists will potentially over-identify with their female clients as a result of their shared sociocultural experience (Bilker, 1993; DeLucia-Waack, 1999; Hamburg & Herzog, 1990; Sands, 2016; Satir, 2013). The male experience of eating disorders is not considered sufficiently within the literature (Dalgliesh & Nutt, 2013; Strother et al., 2012), with only limited recognition afforded to potential sociocultural influences on male therapists. Reflection on the dates of much of the published literature means that the changing gender roles and increasing sociocultural pressures on men to achieve an idealised body (Greenberg & Schoen, 2008), discussed in chapter two, are not given adequate consideration. From this, the need for further recognition of the male therapists' experience of working with male and female clients with eating disorders and the male experience of the conditions becomes apparent.

4.3 Countertransference and projective identification

Furthering the utility of psychodynamic thought in understanding eating disorders introduced in chapter three, this section illustrates how the concepts of countertransference and projective identification can be interpreted as both aiding the therapeutic encounter (Franko & Rolfe, 1996; Hughes, 1997) and initiating powerful feelings within therapists (Marsden & Knight-Evans, 2009; Russell & Marsden, 1998). Professionals with no psychodynamic training would arguably not be aware of these concepts nor of their possible effects, which, as will be seen in chapters six and eight, was borne out by the person-centred counsellors interviewed for this study. This may explain why many of the published studies, which are conducted across a range of professional disciplines, do not recognise or discuss clinicians' feelings as countertransference. As acknowledged in chapter

one however, within this project a “totalist definition of countertransference” (Wooley, 1991, pg 255) is employed, defining the concept as ‘all of the reactions which a clinician experiences towards a client’; a definition which is consistent with that used by other researchers in the field (Franko & Rolfe, 1996; Kernberg, 1965; Satir et al., 2009). This allows for the recognition that many of the feelings experienced by therapists will be the practitioner’s responses to the therapeutic work, either in direct relation to their client experience or in terms of how the work causes them to question their own subjective experience. Advancing this further, the broad definition also encompasses the acknowledgement that some of the feelings may be those evoked through the psychodynamic concept of projective identification. This is defined as the client projection of their dissociated feelings onto the therapist in an unconscious attempt to evoke the thoughts and feelings they are denying to themselves (Hughes, 1997; Russell & Marsden, 1998).

As a result of the typical disconnection experienced between their bodies and subjective feelings (Barth, 2016; DeLucia-Waack, 1999; Zerbe, 1993), clients experiencing eating disorders have significant potential to induce powerful feelings within their therapists as a result of countertransference and projective identification (Franko & Rolfe, 1996; Marsden & Knight-Evans, 2009). For therapists who ascribe to psychodynamic concepts, it is important for them to reflect upon their countertransference feelings as their ability to recognise and interpret them may be essential in gaining an adequate understanding of clients’ experiences (Hughes, 1997). Illustrating the importance of accurate interpretation of feelings, Hamburg and Herzog (1990) describe how rage can be masked with boredom, despair or depression within the therapist. They claim that individuals experiencing eating disorders often have a suppressed element of primitive rage which can be frightening for therapists who feel a need to “walk on eggshells” (Hamburg & Herzog, 1990, p. 373) for fear of making their clients angry. This requires self-awareness and knowledge on the part of the therapist, alongside an understanding of the psychodynamic concepts. Farrell (1995) recognised that despite the propensity for intense countertransference reactions with this client group, the phenomenon had not been researched at depth; and more than two decades later, this is still the case. Recognising it as a psychodynamic concept, it is unlikely that it would be researched outside of the psychotherapeutic literature and hence it needs to be recognised as only one way of conceptualising eating disorders and the therapist’s experience.

In one of the few studies focusing specifically on countertransference reactions to clients experiencing eating disorders, Franko and Rolfe (1996, p. 108) recognise that they “are an important means of enhancing the therapist’s understanding of the patient and the process of psychotherapy.” Their study was conducted using anonymous questionnaires sent to specialist eating disorders’ therapists who were asked to rate their responses to clients experiencing anorexia, bulimia and depression. Although the study provides valuable quantitative results, it affords little attention to the more subjective qualitative experiences explored within this study. In part, this could possibly be explained by the fact that the majority of therapists interviewed (62.5%) were not psychological therapists, and were instead medically trained psychiatrists (n=10) and social workers (n=10). Only 12 of the participants (37.5%) were psychologists and therefore, consideration arguably should be afforded to the level of awareness that non-psychologically trained clinicians would have of psychotherapeutic concepts such as countertransference.

Common feelings experienced by the therapists in Franko and Rolfe’s (1996) study were a sense of connection, frustration, hopelessness, helplessness, engagement and success. Clients experiencing anorexia were recognised as being more likely to evoke negative feelings in the practitioner than those presenting with bulimic symptoms. There were also differences between therapists depending on how long they had worked with the client group, with less experienced therapists reporting higher levels of negative reactions. Although the study recognises that 10 of its 32 participants were male (32.25%), no distinction is made between the countertransference reactions of male or female clinicians. Nor is any consideration given as to whether male or female clients evoke differing responses within male or female therapists. The study is also limited to clients experiencing anorexia and bulimia, thus overlooking the therapist experience of working with clients with binge eating disorder or muscle dysmorphia.

A more recent study published in 2009 (Satir et al.) concentrated on countertransference reactions towards female adolescents with eating disorders. This study failed to include detailed subjective experiences, but six countertransference dimensions were identified: angry / frustrated, warm / competent, aggressive / sexual, failing / incompetent, bored / angry and overinvested / worried. As this study focused on work with adolescents, there is no indication as to whether different reactions are experienced by clinicians towards

adolescent and adult clients. Again furthering the literature's focus on the female perspective (Greenberg & Schoen, 2008), the therapists were interviewed in relation to female clients; hence there is no discussion as to whether male clients would evoke different reactions or affects.

Satir et al.'s (2009) study did however afford limited consideration to therapist gender, agreeing with Burkett and Schramm (1995) that male therapists are more likely to voice reluctance towards treating clients experiencing eating disorders. Both studies concentrated on female clients and neither considered therefore whether male clinicians would feel the same reluctance in relation to treating male clients. Although the potential impact of gendered sociocultural factors is evident within Satir et al.'s (ibid.2009) study they attribute problematic body image to the feminine experience and describe male therapists as more likely than their female counterparts to "express feelings of ineffectiveness when dealing with body image" (ibid.2009, p. 512) due to their lack of shared experience with clients. The study seems to accept gendered stereotypes as it questions whether the increased levels of anger and frustration male therapists identified are a consequence of cultural norms which make it more acceptable for males to express these feelings. They also raised the possibility that male therapists' higher feelings of competence were a consequence of the sociocultural acceptability of men feeling more able than women to admit to experiences of competency.

From the literature searches, only one study was found focusing specifically on the therapist's reactions in relation to body image, food and weight and it should be recognised that the paper was written almost two decades ago. Unlike the individual therapists questioned in this research, DeLucia-Waack's (1999) study explored the experiences of group facilitators working with clients presenting with eating disorders. Although it could be assumed that their experiences would be similar, group facilitators arguably would not be engaging with participants at the empathic depth available to individual therapists, which could potentially affect their experience. In her presentation of a supervision model for group facilitators, DeLucia-Waack (ibid.) recognises that this work can impact on clinicians' perceptions of themselves and she describes specific ways in which professionals may be caused to question their own eating habits and bodies. She also notes the importance of workers in this field feeling at ease within their own bodies and having an awareness of the sociocultural pressures influencing themselves and

their perceptions of body size. Again, however, the study is based purely on the experiences of female clinicians working with female clients.

Illustrating how the early attachment experiences of clients, discussed in chapter three, are brought into the therapeutic relationship, Russell and Marsden (1998), through a psychodynamic approach, explain that clients tend to re-enact their early interpersonal relationships within the therapeutic one. They describe how the client typically projects an internal image of her mother onto the therapist. The study is limited in that it considers only females experiencing bulimia who also have a co-morbid borderline personality disorder diagnosis. Their discussion of early attachment experiences is therefore written in relation towards the female infant's experience of mother and although borderline personality disorder is present in many clients with bulimia, it is not universal. The use of diagnoses also indicates an individualised pathological understanding of the client's experience with no reference to sociocultural factors (Maisel et al., 2004; White & Epston, 1990). The early paternal relationship or the developmental experiences of male clients with bulimia or other forms of eating disorder are also neglected. Russell and Marsden (1998) recognise that by using their countertransference feelings to inform their understanding of their clients' attachment patterns, the therapist can contain the client and provide a corrective nurturing experience. This is possible as the effective therapeutic relationship uses "the same processes that occur between parents and infants in secure attachments (Petrucci, 2015b, p. 47). Russell and Marsden describe a wide range of countertransference feelings evoked by clients and recognise how challenging and often painful these can be for the therapist. This lengthy quote is included here to illustrate the range of feelings to which therapists are subjected:

"inadequate, useless, helpless, rejected, rejecting, angry, overwhelmed, stifled, swallowed up, out of control, controlling, anxious, punitive, sadistic, frustrated, anxious, panicky, unable to think, at breaking point and vomited upon! On the other hand she may also feel omnipotent or perfect"
(ibid. Russell & Marsden, 1998, p. 32).

A common feeling experienced by the therapist, claimed in the literature as a result of projective identification is anxiety (Hughes, 1997; Zerbe, 1993). Due to their typical disconnection from their own affective experience, Zerbe (1993) claims that clients presenting with eating disorders have an ability to deny any anxiety that they might feel about their condition or their physiological wellbeing, and project it

instead onto those who care for them, including the therapist (Hughes, 1997). Mirroring the inadequate empathic attunement experienced in infancy (Hamburg & Herzog, 1990; Zerbe, 1993), they have little, if any, empathy towards their body (Sands, 1991) and are hence able to disconnect from the pain and potential damage they inflict upon it through their behaviours (Hughes, 1997; Petrucelli, 2015b). As a consequence, therapists can experience the fear and anxiety around their client's physical well-being which the client is denying, as well as the very real fear that the physiologically ill client might die during the course of their work (Hamburg & Herzog, 1990).

Acknowledging therapist affective experiences in this way arguably implies that therapists have some understanding of the psychodynamic concepts of countertransference and projective identification. Therapists practicing from a different therapeutic background and without these understandings are likely to interpret their experiences differently and hence the impact of the therapist's therapeutic orientation upon their experiences needs to be considered.

4.4 Therapeutic orientation

There is some evidence that the professional discipline of the treatment provider affects how clients experiencing eating disorders are viewed, but research in this area is again limited (Jarman et al., 1997; Satir et al., 2009; Thompson-Brenner et al., 2012). Studies tend to focus across medical, psychiatric and social work disciplines and there are no studies specifically exploring the effect of the therapeutic orientation of psychotherapists working with clients presenting with eating disorders upon their experiences.

Only one study (Burket & Schramm, 1995) looked specifically at psychological therapists' attitudes towards clients presenting with eating disorders, and within it, a distinction was evident between therapists who enjoyed working with the client group and those who did not. Of those who did not like treating the client group a preference was indicated towards employing cognitive-behavioural treatment approaches. Conversely, those therapists who described enjoying the work more typically addressed the underlying psychodynamic issues. Although the study showed that all therapists were prone to feeling frustration, anger, helplessness, anxiety and satisfaction, it found that those who favoured this client group, and were thus more likely to be working with the psychodynamic elements, also

experienced greater levels of empathy towards their clients. Recognising the shared sociocultural discourses of clients and therapists, Burkett and Schramm (ibid.) were mindful of the possibility that empathy could be indicative of therapists over-identifying with their clients, especially for female clinicians. This identification between female therapists and clients again maintains the positioning of eating disorders as essentially feminine conditions (Botha, 2010; Bunnell, 2016; Dalglish & Nutt, 2013; Robinson et al., 2013). The age of the study also needs to be borne in mind as sociocultural pressures around the male aesthetic have increased (Martins et al., 2007) since its publication.

4.5 Effects on therapists' relationships with food and their appearance

Having considered the range of feelings evoked for therapists within the therapy room, the chapter now turns towards the more personal level to illustrate how therapists' own relationships with food, eating and their bodies (DeLucia-Waack, 1999; Franko & Rolfe, 1996; Holbrook, 2013; Kaplan & Garfinkel, 1999; Warren et al., 2009) can be affected by the work. The potential for identification with their client's sociocultural situation, can cause therapists to recognise eating and appearance related preoccupations within themselves (Zerbe, 1992). Consequently, and also considering the interrelatedness of the individual's subjective self with their relationships with food, eating and their body, as discussed in chapter two, the need for ongoing therapist self-reflection is essential (Daly, 2016; DeLucia-Waack, 1999; Satir, 2013). An individual's identity and self-image can be challenged by the body image they hold about themselves (Polivy & Herman, 2007) and hence, if this work causes the therapist to re-examine their sense of their own body, the significance of any challenge to long held self beliefs becomes apparent. This can be particularly pertinent for therapists who have their own eating disordered history. Although the literature is unequivocal that individuals living with active eating disorders should not work with clients experiencing the conditions there is debate as to whether those with historical experience should due to the potential for past issues to re-emerge (Johnston, Smethurst, & Gowers, 2005; Rance et al., 2010).

4.5.1 Effects on therapists' eating behaviours

Returning to Warren et al.'s (2009) study first discussed in section 4.2, the paper confirmed the findings of earlier studies (DeLucia-Waack, 1999; Franko & Rolfe, 1996; Kaplan & Garfinkel, 1999; Shisslak et al., 1989) concluding that clinician's personal relationships with food, eating and their body can be affected by the work. The study (ibid.) investigated professionals from a range of backgrounds and hence its generalisability for the therapists studied in this thesis needs to be treated with caution. The majority of respondents (91%) were female and no discussion was provided as to whether therapist or client gender affected their responses. Within Warren et al.'s (2009) study, 70% (n=298) of respondents reported that their view of food changed, whilst 54% found that their eating behaviours altered, in both positive and negative ways. In contrast to their clients' emotionally driven relationships with food, the study described therapists developing healthier attitudes towards food or increasingly seeing their own food more simply as a source of nutrition. Conversely however, it found that the work caused some clinicians to engage in problematic eating practices, as was reported by eight respondents, with three admitting to having engaged in eating disordered behaviour following a client session. Clinicians interpreted this as their personal over-compensating behaviours in relation to clients' restrictive ones. What the study failed to establish in this instance was whether these workers had a history of their own eating disordered practices which were potentially resurfacing or whether these were new behaviours initiated through the work. In relation to their own physical appearance, 72% of Warren et al.'s (2009) respondents reported feeling self-conscious during treatment and 71% experienced increased awareness and hyper vigilance, especially in relation to their weight. They also found that professionals' awareness of the personal and sociocultural meanings attached to food was raised, both in relation to themselves and for understanding their clients' experiences.

Similarly, an earlier survey by Shisslak et al. (1989) exploring the reactions of 71 healthcare professionals' (58 females and 13 males) showed that 28% (n=20) of respondents reported being moderately to greatly affected by their work. This group, encompassing 18 females and 2 males, perceived themselves as having become more aware of their appearance, their feelings toward their body and the food that they were eating. However, 70% (n=14) also reported having had their own past or ongoing difficulties around food, which could have influenced the

results. This raises further questions for people working in this field that experience their own difficulties, whether that be eating disorder symptoms or the more common dieting and disordered eating practices engaged in by many people in western society. As with many other papers, the participants in Shisslak et al.'s (1989) study comprised of a range of professional disciplines and hence the transfer of its findings into this thesis needs to be treated with caution.

Therapists' individual subjective experiences within the therapy room are perhaps more difficult to research and collate, but illustrative examples are evident within a small number of studies. For example, Zerbe (1993) writes of finding herself unconsciously engaging in dieting and exercise practices after having over-identified with two patients she was working with. A third patient had also been critical of overweight staff and had made comments about Zerbe's physical appearance. Illustrating the importance of regular supervision or consultation with peers, Zerbe (ibid.) describes only becoming aware of these changes after a colleague enquired if she was being affected by her work. Similarly, Derenne (2006) found herself feeling self-conscious following comments made to her about her body by a client experiencing an eating disorder and she described going home and running five miles as a consequence. DeLucia-Waack (1999) describes a group facilitator questioning if her own self weighing habits were dysfunctional after listening to a participant talk about how often she weighed herself. When a clinician's self-experience is brought into question in such a way, it can cause them to feel ashamed, isolated or overwhelmed and reluctant to disclose their experiences to colleagues or supervisors (DeLucia-Waack, 1999; Holbrook, 2013).

This section has introduced the idea that work with clients with eating disorders can affect the therapist's sense of their own appearance and how they feel about their body. The following section develops this to consider in more depth the visibility and role of the therapist's body within the therapeutic relationship with clients experiencing eating disorders.

4.6 The therapist's body

The body as a symbolic representation of the individual's subjective self in relation to eating disorders was discussed in chapters two and three, illustrating the importance of therapists recognising the symbolic language of their clients' bodies.

Within this chapter, the therapist's body becomes prominent with an acknowledgement that it is an always present and significant feature within the therapeutic relationship (Jabobs & Nye, 2010). Burka (1996), in describing her own experience, acknowledges that every therapist has a body whose physical presence will inform the therapeutic relationship. Although the bodies of client and therapist are clearly present in all therapeutic encounters, their presence is arguably afforded greater significance within this work. The body becomes a concrete means of constructing identity for people experiencing eating disorders (Polivy & Herman, 2007) and hence they are likely to attach their own narratives regarding body size to the physicality of their therapist (Lowell & Meader, 2005). A notion which became important during this research was that of therapists experiencing an adequate awareness of their own embodied self, feeling at ease within their own bodies, and presenting themselves physically as such within the therapy room (Daly, 2016; DeLucia-Waack, 1999; Orbach, 2003). When working with clients presenting with eating disorders, who tend to experience distressing or disconnected relationships with their own bodies, it is imperative that the therapist is able to model this kind of congruent embodied presentation as an alternative (Orbach, 2003).

Despite the significance of the two bodies in the therapy room, the physical body is often left out of psychotherapeutic training and literature regarding talking therapies, with the therapist's body in particular being neglected (Burka, 1996; Fairburn, 2008; Shaw, 2003). This is beginning to change as therapists and authors recognise the value of the physical body as an instrument of engagement and understanding, especially with clients experiencing eating disorders (Barth, 2016; Beresin, Gordon, & Herzog, 1989; Crisp, 1997; Daly, 2016; Newman, 2008; Orbach, 2003, 2004, 2009; Petrucelli, 2008; Rance et al., 2014; Sands, 2016).

By failing to observe the physicality and somatic experiences of the two bodies in the therapy room, an important source of therapeutic communication and understanding is potentially missed (Petrucelli, 2015b). Shaw (2003, p. 33) claims that therapists' somatic feelings should be considered as therapeutic guidance and asserts that the "therapist's body is inextricably involved in the therapeutic process". This study suggests that this omission could be due in part, to the therapist's limited awareness of their own somatic experiences or their discomfort within their own physical body. Confronting such issues within themselves can be challenging for

therapists and it has been suggested that practitioners are “too scared” or “don’t want to face” (Rance et al., 2010, p. 387) their own experiences. There are currently only four studies (Rance et al., 2010) featuring subjective accounts referring specifically to counsellors’ perception of their body image, weight and relationship with food (Derenne & Beresin, 2006; Lowell & Meader, 2005; Shisslak et al., 1989; Warren et al., 2009).

In their work with clients experiencing eating disorders therapists are exposed to a range of body sizes, including the overly thin anorexic body, the potentially obese and the over-muscled. This sustained exposure and therapeutic focus on the clients’ physicality, leaves therapists vulnerable to alterations in their personal perceptions of how a body should look (Hummel, Rudolf, Untch, Grabhorn, & Mohr, 2012), potentially normalising the size of eating disordered bodies. Visual exposure to thin female body shapes or muscular male physiques may result in therapists identifying with those body shapes and as a consequence, measuring their body against those of their clients and potentially feeling inadequate if they perceive their own body to be lacking.

The next part of the discussion begins with a consideration of the presence of the therapist’s physical body within the therapy room before moving on to consider its role as a very visible and always present form of self-disclosure (Daly, 2016; Jabobs & Nye, 2010; Orbach, 2006).

4.6.1 The physical presence of the therapist’s body

Despite the recognition that individuals experiencing eating disorders tend to be hyper aware of other peoples’ bodies, including that of their therapist (Fairburn, 2008; Lowell & Meader, 2005; Warren et al., 2009), the appearance of the clinician is rarely discussed in relation to the client group (Burka, 1996; Fairburn, 2008). The studies in which the therapist’s body are considered tend to be written from the perspective of the female body in relation to female clients, maintaining the cultural and clinical positioning of eating disorders as feminine conditions (Bunnell, 2016; Dalgliesh & Nutt, 2013; Robinson et al., 2013). The literature pertaining to therapists’ experiences of their bodies also tends to have been written in relation to anorexia and bulimia, with more limited attention afforded to binge eating disorder, and again in relation to female clients and therapists. As discussed in chapter two,

increasing numbers of males are presenting with eating disorders (Dakanalis et al., 2015; Locker, Heesacker, et al., 2012) and greater consideration needs to be afforded to the male experience and the presentation of the over-muscular body as a possible manifestation of eating disordered subjectivity (Murray et al., 2010).

Clients experiencing eating disorders typically have a disturbed body image (Dakanalis et al., 2014) and compare their bodies and body parts to those of other people (Daly, 2016; Fairburn, 2008); when this scrutiny is directed towards the body of their therapist, it has implications for both the therapist's experience of their body and the therapeutic encounter (Daly, 2016; DeLucia-Waack, 1999; Lowell & Meader, 2005). A therapist who has a stable and accurate perception of their own body image will be more able to accommodate this scrutiny and to discuss the client's reactions and observations towards their body (Daly, 2016; DeLucia-Waack, 1999). Practitioners who do not have such a robust sense of their own body image may find the scrutiny unsettling (Orbach, 2004) and that it can interfere with the quality of their therapeutic work (Burka, 1996). Although these studies are written from the female perspective male clients experiencing eating disorders share the tendency towards scrutiny and thus male therapists are subjected to similar experiences as their female counterparts.

Despite the recognition of this tendency towards scrutiny (Daly, 2016; Fairburn, 2008; Kaplan & Garfinkel, 1999; Rance et al., 2010; Warren et al., 2009), only limited research exists exploring the effect of the therapist's body upon therapy with clients experiencing eating disorders (Petrucci, 2008; Rance et al., 2014). Clients will observe their therapist's body and, furthering the cultural inclination towards the correlation of body size with personality characteristics and personal and professional success (Lanzieri & Hildebrandt, 2016; Lupton, 1996, 2013), discussed in chapter two, will create assumptions about the therapist's identity, their professional effectiveness and personal relationship with food (Lowell & Meader, 2005). Clinicians thus need to be aware of this and to reflect upon how their body may be being perceived (Rance et al., 2014) and how it may be affecting the client's therapeutic engagement.

In one of the few studies exploring the influence of the therapist's body upon the experience of clients presenting with eating disorders, Lowell and Meader (2005, p. 241) assert that the therapist's body can have "an appreciable impact" on treatment

and recognise that talking about the bodies in the therapy room can enrich the therapeutic encounter. Their study acknowledges the importance of exploring transference and countertransference feelings, disclosure and the use of the therapist's self, including their body, within the therapy. Within this, clients' use of their therapists' bodies to evidence their distorted beliefs, as a target of envy or as a container for projections and fantasies is also discussed. Lowell and Meader's (ibid.) study is limited however in that it only explores the effects of female therapists with thin bodies working with females experiencing eating disorders. The influence of sociocultural factors on clients' beliefs and narratives are acknowledged as they describe individuals projecting the assumption of a thin body equating with a happy, successful life onto their therapist. Discussing the tendency of clients to project their beliefs about bodies onto their therapists and thus make assumptions about them also illustrates their proclivity to create identities for themselves and others through sociocultural discourses and body size. Illustrating the assumptions clients might form regarding their therapist based on their body size, Lowell and Meader (ibid.) discuss clients' presumptions that a thin clinician has had an eating disorder themselves or alternatively, that she is naturally thin and thus can have no appreciation of their experiences. The importance of the therapist being aware of these projections and of being able to discuss them openly with the client is acknowledged before considering the potential consequences of these assumptions for the therapists' own experience. As a consequence of these projections Lowell and Meader (ibid.) claim that thin therapists can be left with ambivalent feelings about their own body; proud that it is culturally acceptable and yet also feeling vulnerably aware of the potential for clients to feel envy, anger or hatred towards it (ibid.), and consequently, themselves. Thinking alternatively about the therapist with an overweight body, clients with eating disorders may be reluctant to work with them for fear of their body becoming like the therapists (Burka, 1996) or because they hold negative attitudes towards overweight people (Daly, 2016; Fairburn, 2008).

4.6.2 The therapist's body as self-disclosure

As a consequence of its visibility and clients' tendencies towards scrutiny, the therapist's body is an always present means of self-disclosure (Daly, 2016; Jabobs & Nye, 2010; Orbach, 2006) in terms of its size, shape, presentation, how at ease the therapist appears within it and the sociocultural discourses clients project onto

it. Acknowledging this therefore it is essential that therapists working with eating disordered clients are comfortable within their own bodies (Daly, 2016; Orbach, 1986, 2003; Zerbe, 1993) and have a healthy relationship with food (DeLucia-Waack, 1999). However, due to the impossibility of being completely immune to the sociocultural pressures (Halsted, 2015) discussed in chapter two, it can be difficult for therapists to achieve this (Daly, 2016; Zerbe, 1993). What is therefore important is that therapists are aware of their beliefs and values around body shape and size and how these might affect their experiencing of both their own and their clients' bodies (DeLucia-Waack, 1999; Orbach, 1986, 1998).

Empathic therapeutic dialogue and clients' scrutiny of their bodies, leaves therapists open to experiencing a heightened awareness of their own physicality. As Warren et al.'s (2009, p. 38) study showed, for some clinicians, this is "uncomfortable and intrusive," whilst for others it is simply recognised as an unavoidable effect of working with clients experiencing eating disorders. Within this context, the need for fastidious therapist reflection upon their own relationships with food, eating and their body is paramount (Daly, 2016; DeLucia-Waack, 1999; Satir, 2013). As one respondent within Warren et al.'s study notes, it is critical to "feel confident about your own eating behaviors [sic] and body image" (ibid. 2009, p. 40) and to "directly address your own food, body image issues, judgments and feelings" (ibid. 2009, p. 40). It could be conjectured that the differences in how therapists experience the heightened awareness of their own body may be related to how at ease they feel within it.

The hyper vigilance which clients experiencing eating disorders afford other peoples' physical presentations (Fairburn, 2008; Lowell & Meader, 2005; Warren et al., 2009) ensures that they will be very aware of their therapist's body and will at times, make comments, both positive and negative, about it (Warren et al., 2009). In their study, Warren et al. found that 86% of their respondents had been subjected to such comments and 83% felt that their bodies were being monitored and evaluated even if no direct comments were made. Such comments can arouse powerful feelings within therapists (Burket & Schramm, 1995; Lowell & Meader, 2005; Warren et al., 2009) and as a consequence therapists may experience a client's sense of disgust towards their body, may question their existing body image or be left feeling physically inadequate. Despite this though, Lowell and Meader (2005) acknowledge the therapeutic benefit of discussing the

two bodies within the therapy room. Similarly, Burka (1996) describes the importance of being able to tolerate having her body used as a conversational subject within therapy and how this enhances her understanding around the countertransference affects she experiences in relation to her clients.

Being aware that clients are likely to be scrutinising their body can cause therapists to feel self-conscious (Derenne, 2006; Zerbe, 1998) which may have implications for their ability to engage in therapy. DeLucia-Waack (1999) describes an example of an eating disorders' group facilitator becoming aware that her legs were being judged by her client. The facilitator engages in an inner dialogue about the size of her legs, wondering what the client is thinking of them and questioning what messages she is projecting about herself through the size of her body. When therapists engage in this inner awareness and dialogue they are no longer able to be fully present in their client's process (Kaplan & Garfinkel, 1999). Derenne (2006), a child psychiatrist in training, described her confidence crumbling as she experienced how vocal her eating disordered clients were about her body. As well as causing her to feel insecure about her ability as a therapist, she was left feeling self-conscious about her body within the sessions.

In an example of how a therapist's body image can fluctuate throughout the course of therapy one of the respondents in Warren et al.'s (2009) study described finding herself experiencing her body as big in relation to her clients: "I am sometimes self-conscious of being robust and curvy when I'm sitting with anorexic teenagers" (ibid., p. 39). From the other side of the spectrum, another respondent found her own thinness problematic:

"I sometimes feel self-conscious about my weight (thinness). Makes me feel like an imposter. Makes me doubt my ability to empathize [sic] with clients, makes me feel hypocritical and doubt myself as a professional" (ibid., p. 39).

4.7 Embodied countertransference

From the psychodynamic perspective discussed in chapter three, embodied countertransference has been recognised as a useful concept in understanding clients' experiences (Kearney-Cooke, 2001; Pacifici, 2008; Petrucelli, 2015b). Due to the power of the examples in the literature, the concept is afforded attention in this current section. As illustrated through the examples below, embodied

countertransference can be powerful for the therapist as therapeutic processes are interpreted as being somatically experienced within their body (Petrucci, 2015a). Again, the literature is written by female therapists in relation to female clients with the exception of Yalom (1991) further highlighting the research gaps pertaining to the experiences of male therapists. These studies tend to be presented in the form of case studies, which provide detailed narratives of the therapist's experience which is helpful for describing powerful individual subjective experiences, but provide only limited opportunity for generalisability or comparative analysis.

Due to their disconnection from their bodies and emotional experience (Barth, 2016; DeLucia-Waack, 1999; Zerbe, 1993) the embodied experience of individuals presenting with eating disorders tends to be more palpable in the therapy room than that of other psychological presentations (Pacifci, 2008). The literature however is limited in its depiction of such embodied countertransference phenomena or their value within the therapeutic relationship and its role in creating a more effective sense of self for clients. Arguably this is due to its being a psychodynamic concept and therefore not subscribed to by authors or therapists working from other approaches.

Through the perception of embodied countertransference experiences, the therapist's body can be viewed as a therapeutic tool for understanding client experience (Aron, 1998; Kearney-Cooke, 2001; Pacifci, 2008; Petrucci, 2015b). From the psychodynamic perspective these phenomena can be subtle and hence the therapist needs to be sufficiently attuned to their own body in order to experience them (Sands, 2016). These psychosomatic reactions can be interpreted as primitive countertransference responses in which the body of the clinician expresses the client's conflict which has arisen through pathological early care-giving relationships (Field, 1989; Zerbe, 1992, 1993). In treatment, Zerbe (1992) describes the importance of the therapist containing and tolerating the client's powerful emotions to enable her to begin recognising and owning them for herself. In another paper, she describes therapists "feeling their own heart palpitate, stomach rumble, head hurt" (1998, p. 48) as clients project their preverbal experiences onto them. She extols the virtue of reflecting upon these "psychophysiological countertransference reactions" (1998, p. 48) in understanding the client further.

A small number of authors have described their embodied countertransference experiences in some depth (Barth, 2001; Burka, 1996; Orbach, 1994, 2003, 2004; Pacifici, 2008; Petrucelli, 2001, 2015b), but the examples have not been collated and are found in a diverse range of articles and published books. The personal nature of such embodied experiences arguably makes them more difficult to research as they cannot be easily measured and their reporting relies on the ability of therapists to effectively language their subjective affect. From the examples included below it can be seen how informative these embodied experiences can be for client understanding if the therapist is able to interpret them accurately.

Petrucelli (2015a, p. 47) describes working with a compulsive binge eating client and feeling “pushed down, physically stiff, palpably stifled” and that she is her client’s “personal dumpster.” Reflecting on her somatic experiences, she was able to recognise that she was feeling how her client felt in relation to her domineering mother. She then talks of feeling “bogged down; my legs are heavy” (Petrucelli, 2015b, p. 48) and understands this as her client’s attempt to insulate herself from her feelings. On offering these examples and her interpretation back to the client, she is able to confirm that her conceptualisations are accurate.

Considering the therapist’s body as an analytic object, Burka (1996) recognises that during the course of treatment her body takes on different meanings in response to her clients’ processes. In the early stages of therapy, she describes the therapist’s body as the “embodiment of the symbolic mother” (ibid., p. 260) for the client and claims that this representation changes as therapy progresses. Recognising that her experience adapts in response to different clients she illustrates the ways in which her embodied self within the therapy room alters as she feels:

“sometimes dumpy and self conscious, sometimes voluptuous and racy, sometimes motherly and nurturing, sometimes shrivelled and empty. My same body can seem frail in relation to a large man or monumental in relation to a petite woman” (ibid., p. 263).

Therapists who do not experience a robust sense of their own embodiment are at risk of having their own subjectivity challenged (Burka, 1996; DeLucia-Waack, 1999) when considering the inter-relatedness of self and body, as discussed in chapter two. Writing of her own experience of working with a client experiencing an

eating disorder, Barth (2001) posits that therapists need to recognise their own dissociated experiences around food, eating and bodies as well as those of their clients. In describing her experience of working with her client Mathilde, Barth (2001) illustrates how the therapist's sense of themselves in their own body can fluctuate:

“no matter how I was feeling about myself before Mathilde entered my office, when she left I almost always felt inept, unattractive, stupid – and twenty pounds heavier than I had at the beginning of that session.”

Despite the visible fragility of the emaciated anorexic body it still has potential to instil countertransferential feelings into the therapist's. Pacifici (2008, pp. 115-116) remembers feeling as if she could “see inside” her client and describes how she felt “physically pushed into a space of immobility where breathing was difficult and even “dangerous”. At times, she experienced herself as “a heavy, but powerless giant” and her body became “a hindrance”. In an example of the therapist's embodied experience of the client enabling the therapist to connect with her client's experience of self, Pacifici (2008, p. 116) reports a sensation of:

“float[ing] through initially cryptic and unintelligible bodily states, which, over time allows me to find a pathway through Evelyn's different self states.”

The therapeutic value of exploring such countertransferential feelings is illustrated by Petrucelli's description of “feeling sleepy, dazed, disconnected, or on “cruise control” (2001, p. 105) whilst working with a client experiencing bulimia. Having initially decided not to voice this experience in the therapy session, a chance encounter with the patient in a nail salon, and her concomitant experience of the client there, caused Petrucelli to address her countertransference reactions in the session, leading the client to disclose in greater depth the true extent of her bulimia. Following the client's disclosure, Petrucelli (ibid.) admits to feeling “foolish” for having not recognised it sooner, acknowledging how adept individuals experiencing eating disorders can be at hiding things even from experienced practitioners. She then admits to feeling “betrayed” that the client had not felt able to disclose sooner but also “excited” at the opportunities for exploration now open to them.

In another example of the power of the countertransference feelings with clients experiencing eating disorders, a therapist writes of feeling “enraged” and “exposed” and so “out of control of the treatment” that she experienced herself as “literally

falling apart in front of [the] patient” (Kuriloff, 2001, p. 130). Illustrating the intensity of the countertransference feelings experienced she describes clenching her jaw so tightly that she broke a tooth.

Orbach is a vocal advocate for the use of the therapist’s embodied countertransference and she describes a range of such experiences with her clients (Orbach, 1994, 2003, 2004, 2009). Recognising the value of the physical sensations she experiences Orbach describes embodied countertransference as “a window into understanding aspects of the physical development of the individual” (Orbach, 1999, p. 109). As discussed in chapter three, the body’s corporeal development is as important for Orbach as that of the emotional and she posits the value of clinicians allowing their clients to use their bodies as a therapeutic container in the same way as they would traditionally use their therapists’ psyches. In her experiencing of this, Orbach (2003, p. 8) describes her clients with their troubled bodies using her body as a “temporary external body” which has instilled within her a parallel sense of having a reliable and steady body.

To illustrate the power and usefulness of such embodied experiencing, some of the somatic communications which Orbach has experienced with her clients are presented in this paragraph. When working with Edgar, Orbach (1999) describes feeling her body expanding and growing bigger within their sessions despite his physical body becoming smaller as he lost weight. After initial uncertainty about voicing this experience, she disclosed it and found that she had been unconsciously embodying his Grandma, and her disclosure allowed productive exploration of this relationship (ibid.1999). In relation to her client Herta, Orbach (1994, 2004) describes a “purring contentment” which she recognised as a sense of her own body’s reliability and stability as Herta projected her need for a strong, stable body of her own. With another client, Jane, (2009) Orbach describes a confusing urge to stick her tongue out following one of their sessions. Reflecting on this, she recognised a sense of disgust and revulsion which, when reflected back to Jane, the client was able to own as her personal disgust and revulsion towards both her disabled brother’s body and her own (Orbach, 2004).

Yalom’s (1989) account of working with an obese female client, Betty, is the only detailed narrative I have been able to find written from a male therapist’s perspective, and one in which the potential for clients to affect their therapist’s

personal eating behaviours beyond the therapeutic relationship is seen. Yalom acknowledges his repulsion of fat female bodies from both his familial experiences and constant “[c]ultural reinforcement” (ibid., pg 88) of the overweight stereotype. At the outset of Betty’s therapy, he describes being “revolted” by her, feeling “irritated and bored” (ibid., pg 91) and questioning if he could relate to her. He considers her as representing “the ultimate countertransference challenge” (ibid., pg 91) and describes experiencing her social interactions as “primitive and superficial” (ibid., pg 92) until he was able to establish the therapeutic relationship and engage in her process. As Betty embarked on a diet, Yalom found himself feeling guilty outside of the therapy if he ate treats and he describes how he sometimes “passed up seconds in her honor” [sic] (ibid., pg 104).

Although powerful and arguably useful therapeutic communications for the therapists experiencing them, embodied countertransference responses have to be recognised as psychodynamic constructs and therefore, their experience and interpretations will only be available to therapists practising in this way. They are discussed here due to the specialist therapists’ stated inclinations towards integrating psychodynamic conceptualisations into their client work. Chapter four concludes in section 4.8 with a discussion of relevant professional practice issues pertaining to training, supervision and therapist personal development.

4.8 Professional practice issues

Professional competency is paramount to safe and effective therapy for clients and therapists alike. As the counselling and psychotherapy fields move towards more rigorous levels of regulation and public accountability, it is becoming increasingly vital that therapists work within their competence levels (Bond, 2015; NICE, 2017). This is especially important when working with vulnerable clients, including those experiencing eating disorders (Williams & Haverkamp, 2010). Working from an inadequate understanding leaves therapists susceptible to unintentionally colluding with the disordered behaviours or negatively affecting the wellbeing of clients (Williams & Haverkamp, 2010). Due to their complexity, some authors claim that specialist skills and knowledge are necessary for therapists to work effectively with clients experiencing eating disorders (Natenshon, 2012; Spotts-De-Lazzer & Muhlheim, 2016 ; Williams & Haverkamp, 2010; Williams & Leichner, 2006).

This chapter has already illustrated how demanding therapy with clients presenting with eating disorders can be and therapists with limited experience can find the work particularly challenging (Jarman et al., 1997). Inexperienced therapists are more likely to experience increased negative affects towards their clients (Franko & Rolfe, 1996; Satir, 2013; Thompson-Brenner et al., 2012), especially higher levels of frustration, fear and anger (Franko & Rolfe, 1996; Zerbe, 1992). It has also been claimed that less experienced therapists may try to fix the client at the expense of their being fully present within the relationship (Satir, 2013). To reduce these negative effects, adequate training would be beneficial for all therapists who may work with clients presenting with eating disorders (Bannatyne & Stapleton, 2014; Thompson-Brenner et al., 2012; Williams & Leichner, 2006). Issues relating to training are discussed below in section 4.8.1 before the discussion turns to self-awareness in section 4.8.2 and the necessity of appropriate supervision in section 4.8.3.

4.8.1 Therapist training and knowledge

As implied in chapter three, with its presentation of four different therapeutic approaches to working with clients experiencing eating disorders, there is no definitive treatment protocol which all therapists follow (Jarman et al., 1997). The disorders' multifactorial aetiology (Delvecchio et al., 2014; NICE, 2017; Petrucelli, 2015a; Starkman, 2016a; Tasca & Balfour, 2014) suggests numerous factors for therapists to consider in relation to client treatment and recovery. The influence of sociocultural discourses (Daly, 2016; Matz & Frankel, 2005; Zerbe, 1992) needs to be considered alongside clients' personal narratives in relation to their bodies, their histories and their subjectivities. Attachment narratives, from either a psychodynamic perspective (Tasca & Balfour, 2014; Tasca et al., 2011) or a narrative therapy model (Dallos, 2004, 2014) can facilitate understanding of clients' interpersonal development and thus therapeutic engagement. The symbolic meanings of clients' embodied and subjective presentations (Farrell, 1995, 2015) can be informative in relation to each of the disorders. Cognitive-behavioural strategies or narrative therapy's externalisation technique can be employed to manage and challenge eating behaviours and dysmorphic body beliefs (Burket & Schramm, 1995; Fairburn, 2008; Petrucelli, 2016). And finally, an element not usually covered in psychotherapy training (Spotts-De-Lazzer & Muhlheim, 2016),

the nutritional and physiological effects of the disorders (Gottlieb, 2015; NICE, 2017; Tasca & Balfour, 2014) need consideration.

From the discussion in chapter three, it became evident that therapists working from different therapeutic approaches may place different emphases on the areas upon which they focus and how they conceptualise eating disorders. There appears to be a movement within some research circles to resolve this, with an increasing propensity towards integrative thinking around eating disorders and a more multi-disciplinary approach (Barth, 2016; Petrucelli, 2015a; Satir, 2013; Tasca & Balfour, 2014; Tasca et al., 2011). However, this becomes problematic as therapists can only work from the knowledge base acquired through their therapeutic training. Integrative working necessarily requires clinicians to seek out further training from alternative approaches. In chapter eight, suggestions will be made as to specific concepts and areas of knowledge which may be most pertinent for therapists to appreciate when working with clients experiencing eating disorders.

A study in 1997 explored the subjective understandings and experiences of a multi-disciplinary team of clinicians working with young people experiencing anorexic symptoms (Jarman et al.). Using semi-structured interviews and interpretive phenomenological analysis, the study suggested that client and clinician experiences of therapy are affected by the understandings and opinions of healthcare professionals. No consensus was reached as to how best to work with clients experiencing eating disorders as participants felt that there was too much conflicting information. Similar to other studies however, Jarman et al. recognised the multifactorial aetiology of eating disorders and the need to address "biological, behavioural, cognitive, feminist, psychoeducational, familial and sociocultural" elements (ibid., p. 138). The study concluded that a balance needed to be reached as non-directive approaches typically instilled anxiety within clinicians whilst stringent behavioural interventions were not always effective as they threatened the anorexic need to feel in control. They did however recognise that sometimes, "more directive, and disempowering, interventions" (ibid. Jarman et al., 1997, p. 139) were necessary, and through a case example of a social worker who took a pragmatic and directive approach to his work, it was shown how this less empathic style resulted in the professional being less personally affected by the work.

In their study of the sufficiency of providing the core conditions in psychotherapy with clients presenting with anorexia, Marchant and Payne (2002) concluded that, on its own, person-centred counselling was not an adequate treatment modality. The therapist described a fear of doing harm and feeling that “my way of working was not enough” (ibid., p. 128). Similarly, the focus on symptom reduction and challenging eating disordered thinking afforded by cognitive-behavioural therapy shows only limited success rates (Tasca & Balfour, 2014), as presented in chapter three, and can leave the therapist feeling restricted (Gottlieb, 2015). Past research has indicated that therapists report greatest satisfaction in their work when they use a combination of cognitive-behavioural therapy and psychodynamic psychotherapy as this allows them to address relevant dynamic issues as well as symptomatic behaviours (Burket & Schramm, 1995; Hamburg & Herzog, 1990; Zerbe, 1992). Despite the recently published NICE guidelines (2017) suggesting eating disorder focused CBT or a manualised focal psychodynamic model, a number of writers advocate the benefit of integrating the psychodynamic elements with behavioural changes (Barth, 2016; Natenshon, 2012; Petrucelli, 2015a; Satir, 2013; Tasca et al., 2011).

Natenshon (2012) takes integrative working a step further to profess that successful treatment requires the therapist to adapt their approach to suit each individual client. Satir (2013) similarly advocates that therapists rely less on manualised treatment programmes and instead, combine a range of techniques into their work. However, to work effectively in this way therapists need to have an understanding of a range of theories relevant to eating disorders. This could be problematic as there is currently a general lack of knowledge in relation to the conditions (Williams & Haverkamp, 2010) and conflicting advice for professionals treating them (Williams & Leichner, 2006). Inadequate training and knowledge has been shown to contribute to practitioners’ low levels of confidence and competence in treating the disorders and hence a need for more comprehensive training is evident (Bannatyne & Stapleton, 2014). Williams and Leichner (2006, p. 323) conclude that “[t]he complexity of EDs [sic] necessitates that the professionals who treat them possess a specialized [sic] and comprehensive knowledge and skill base” and that training pertaining to eating disorders should be mandatory.

A therapist working beyond their knowledge or competency levels has ethical implications in relation to non-maleficent and beneficent practice (Bond, 2015) and

yet despite this, there are no systematic criteria from which to assess psychotherapeutic competence to work with clients experiencing eating disorders (Williams & Haverkamp, 2010). In their Delphi study, Williams and Haverkamp (ibid., p. 105) identified five domains of competency for therapists to ensure “minimally ethical eating disorders psychotherapy.” These are listed as “Core Knowledge and Skills, Interdisciplinary Teamwork, Specialized [sic] Therapeutic Relationship Skills, Professional Responsibility and Therapist Characteristics” (ibid., p. 105). This study was carried out in Canada and hence it is necessary to add some caution when generalising the findings to other countries as psychotherapeutic trainings may differ.

An understanding of the physiological consequences of eating disorders (NICE, 2017; Tasca & Balfour, 2014) is also essential to ensure that therapists are aware of how such changes may affect client engagement in therapy (Gottlieb, 2015; Satir et al., 2009) as well as the potentially life-threatening medical complications (Furstand et al., 2012). Their reluctance to relinquish the eating disorder means that clients may defend or minimise their behaviours and health issues. The risk of therapists with inadequate knowledge unintentionally colluding with clients to avoid deeper exploration and more accurate disclosure is consequently high (Jabobs & Nye, 2010). As discussed in chapter 3, clinicians who are unaware of the biopsychosocial effects of starvation may overlook the nutritional element of treatment and attribute clients’ poor progress to their simply being difficult (Kaplan & Garfinkel, 1999).

As will be discussed in chapter eight, lower levels of understanding appeared to have implications for the therapist experience of working with clients experiencing eating disorders. The specific areas in which this thesis claims that knowledge would be beneficial will also be presented.

4.8.2 Therapist self-awareness

Alongside knowledge of the aetiology and presentation of the conditions, therapist self-awareness of their own relationships with food, eating, body image and embodied experience is essential for effective client work and clinician well-being (Daly, 2016; DeLucia-Waack, 1999; Williams & Haverkamp, 2010). Self-awareness is an integral element of the psychotherapist’s reflective practice (Bond,

2015) and although it is recognised that all clients have the potential to affect their therapists, clients experiencing eating disorders present some unique challenges (Satir, 2013; Warren et al., 2009). Acknowledging the shared sociocultural positioning between clients and therapists (Daly, 2016; Derenne, 2006; Matz & Frankel, 2005) the interrelatedness of the individual's subjectivity with their sense of embodiment and the notion of selves created within relationship, discussed in chapter two, the significance of the therapist's self-awareness becomes apparent.

Appreciating the potential for empathic dialogue with clients to affect the therapist's own experience (Holbrook, 2013; Shisslak et al., 1989; Warren et al., 2009), as discussed in section 4.5, there is a need for therapists to examine their own beliefs around their bodies, food, and eating (DeLucia-Waack, 1999; Williams & Haverkamp, 2010). It is recommended that therapists have an in-depth awareness of the effects of sociocultural influences upon their own beliefs about weight, body image and self-worth (Daly, 2016; DeLucia-Waack, 1999; Orbach, 1986, 1998). Failing to explore their personal beliefs regarding cultural body norms, therapists may inadvertently communicate or reinforce unhelpful or unrealistic beliefs and values to their clients (DeLucia-Waack, 1999).

With an inadequately developed level of self-awareness therapists are at risk of having their own issues around eating and their body highlighted. The therapist's ability to facilitate change within the eating disordered experience is claimed to be based upon the degree to which their own issues have been addressed (Daly, 2016; DeLucia-Waack, 1999; Satir, 2013). In her recognition of the potential for therapist identification with clients, Satir (2013) advises that those working with individuals experiencing eating disorders should engage in personal therapy to enable them to tolerate better both their own feelings and distress and the projections of their clients. Writing of her own experience, Satir (2013) describes the pain of her clients' self-critical feelings forcing her to confront her own such feelings and by attending to these in personal therapy she felt able to access greater levels of empathy for her clients.

As discussed in section 4.6, the therapist's body is prominent in the therapeutic relationship with clients experiencing eating disorders and it is important that the therapist has a comfortable relationship within their own body (Daly, 2016; DeLucia-Waack, 1999; Zerbe, 1993). It is suggested that it is only through their ability to

present a robust and congruent embodied experience within the therapy room that the therapist can bring their body into the therapeutic dialogue to encourage client exploration of their own body related beliefs (Lowell & Meader, 2005). Writing exclusively about female therapists, Daly (2016) observes the difficulty for the therapist of modelling a secure attachment to her body in a culture which promotes body insecurity and acknowledges that she would not have been in a position to do so had she not worked through her own issues with her body.

4.8.3 Supervision

To maintain effective and safe practice, counsellors and psychotherapists are required to engage in regular clinical supervision in which they discuss their client work and its impact upon themselves (Bond, 2015). Supervision can provide a space for the therapist to explore their own beliefs and values around food, eating and body image. This ensures that they maintain a realistic sense of their own body and eating related behaviours which benefits both themselves and their clients (DeLucia-Waack, 1999). It is also the relationship in which the therapist's self-awareness can be encouraged as a means of more fully understanding their clients' experiences (Satir, 2013). The necessity of appropriate supervision in relation to work with clients experiencing eating disorders is recognised in the literature (DeLucia-Waack, 1999; Franko & Rolfe, 1996; Satir et al., 2009; Shipton, 2004; Warren et al., 2009) and yet there are currently no empirical studies examining the efficacy of its provision (Thompson-Brenner et al., 2012). As a result of the unique complexities of clients experiencing eating disorders (Satir, 2013; Warren et al., 2009), the value of supervision with a supervisor with knowledge of the complexities of the conditions is recommended (Hamburg & Herzog, 1990). Recognising how the feelings experienced within the therapeutic dyad can be transferred into the supervisory relationship, it is claimed that supervisors can play an important role in facilitating supervisees' discussion and expression of their reactions to their clients (Franko & Rolfe, 1996; Hamburg & Herzog, 1990).

Despite the recognised value of supervision, many therapists are reluctant to disclose their feelings in relation to eating disordered clients to their supervisor (Hamburg & Herzog, 1990; Jarman et al., 1997). In her commentary on Warren et al.'s (2012) study, Satir (2013) writes that therapists who feel competent working with clients with other presentations, may be hesitant about divulging feelings of

insecurity in relation to clients with eating disorders. She acknowledges that the material presented by clients in therapy can be experienced by therapists as provocative and unappealing, and clinicians may be reluctant to admit to such feelings. Writing from personal experience, Satir (2013) claims that through clinical supervision, she began to understand eating disorders as being about more than food, eating and body image and learned to appreciate them as the individuals' best attempts at coping with life.

4.9 Conclusion

In this chapter, the current literature relating to therapists' experiences of working with clients presenting with eating disorders has been reviewed. Although the research is currently limited, this client group have been shown to have the potential to instil powerful and potentially unsettling experiences, emotions and thoughts in their therapist (Burket & Schramm, 1995; Warren et al., 2009). These were shown to occur at the subjective level when therapists find their own relationships with food, eating and their bodies challenged (Warren et al., 2009), and also at the corporeal level through powerful somatic countertransference reactions (Burka, 1996; Pacifici, 2008; Petrucelli, 2015b).

In order to understand and most effectively use these experiences, therapists need to have a clear understanding of the aetiological and maintenance factors of eating disorders, discussed in chapters two and three. Due to the complexities of the conditions and therapists' differing orientations, a definitive treatment protocol has been difficult to devise (Barth, 2016; Starkman, 2016a). The psychodynamic concepts of countertransference, projective identification and embodied countertransference were invoked within this chapter to illustrate their use as interpretive tools of client and therapist experience (Kearney-Cooke, 2001; Pacifici, 2008; Petrucelli, 2015b). However, the validity of these concepts was questioned, especially as much of the extant literature focuses on multidisciplinary professionals who may have no knowledge of psychodynamic theory.

The benefits of therapists having a clear understanding of their own relationships with food, eating and their body before working with this client group (Daly, 2016; DeLucia-Waack, 1999; Satir, 2013; Williams & Haverkamp, 2010) were also discussed. Working empathically with clients and challenging their beliefs regarding

food, eating and their body can leave the therapist open to having their own narratives changed (Warren et al., 2009) and hence the importance of continual self-reflection was highlighted. The chapter concluded with a discussion of pertinent training and supervision issues to ensure ethical and effective practice.

The thesis up until now has reviewed the relevant literature in order to ground this particular study. In the following chapter, the methodological journey the research followed will be presented.

Chapter 5 Methodology

5.1 Introduction

The previous three literature review chapters introduced the sociocultural and psychological positioning and experiencing of eating disorders and the therapist's experience of working with this client group. The focus in this current chapter shifts to the methodological aspects of the study, beginning in section 5.2 with a reminder of the research question initially presented in chapter one. There then follows a discussion in sections 5.3 and 5.4 of the initial methodological intention of following a constructivist grounded theory (Charmaz, 2006) approach. The necessity of expanding the methodology to more fully encompass the needs of the research topic and my place, as researcher, within it are then presented in sections 5.9 and 5.10.

As a consequence of the initial recruitment strategy for participants, the preliminary study, discussed in section 5.7, comprised of five person-centred counsellors working in general practice settings. Analysis of their findings suggested a more targeted strategy was needed to recruit therapists with specialist experience of clients presenting with eating disorders. This resulted in the creation of a second data set for the main study, described in section 5.8, incorporating thirteen therapists who largely described themselves as integrative practitioners.

My initial commitment to grounded theory stemmed from a determination to produce as objective a study as possible within a qualitative approach whilst maintaining a separation between my researcher, practitioner and private selves. However, as a consequence of my personal connection with the topic and my ontological positioning as a practising counsellor throughout the study, it became apparent during the preliminary study that this approach was flawed and potentially detrimental. The impossibility of separating my researcher self from my therapist and personal subjectivities became evident and it thus became necessary to find a way of incorporating these into the methodology. Thus, as discussed in sections 5.10 and 5.11, reflexivity was afforded increased significance and employed

alongside the integration of heuristic research principles with the established grounded theory processes of constant comparison, theoretical sensitivity and theoretical sampling (Corbin & Strauss, 1988, 2008; Glaser & Strauss, 1967). Maintaining a clinical practice over the duration of the research process meant that I could not fully 'bracket off' (Rennie, 2000) my counsellor self to the extent necessary to maintain the objectivity I had initially sought. Bracketing is being defined as a process of putting aside one's beliefs, not making judgements and remaining open to the data (Jootun et al., 2009).

This researcher experience suggests that, especially within an exploratory qualitative approach, methodology should remain flexible to ensure on-going fit with the research (McLeod, 2001). Working from grounded theory's open-minded exploratory position (Charmaz, 2006), and mirroring my therapeutic ontology of approaching clients with an open mind, it was impossible to predict what the research would present. Flexibility was therefore required to accommodate the changing methodological needs as a result of evolving participant data, emerging findings and researcher experience. The research is then led by the findings, giving a sense of the topic suggesting its own preferred methodology, or as Moustakas (1990) posits, of learning which has a path of its own and is open to changes of direction. This necessarily adds to the importance of reflexivity to ensure that assumptions regarding methodology are questioned and made transparent throughout (Engward & Davis, 2015). The researcher's history and influence upon the data should also be made clear (Mills, Bonner, & Francis, 2006a) and for added transparency, an extended monologue of reflexive writing is included in section 5.12. As a reflexive practitioner interested in researching the effects of client work upon therapists, a parallel emerges when considering how this particular research topic impacted upon myself as researcher. The experience also illustrates the sociocultural leanings of the study, showing the inseparability and mutual influence of selves and culture, or researcher and research.

From a postmodern systemic approach, methodology is fluid and evolves in response to the research, inspired by reflexive considerations between emergent theory and practice (Simon, 2014). This methodological expansion shifted the research further from a more positivist approach of choosing a research method and remaining true to it, towards a more emergent process of actively engaging and shaping the process of inquiry (Simon, 2014). Adopting a flexible approach to

methodology and creating a 'bricolage' mirrors the pluralist approach to therapy (West, 2001) adopted by the specialist therapists for effective working with clients experiencing eating disorders, illustrated in chapters seven and eight.

5.2 Revisiting the research question

As discussed in chapter one, the aim of the research was to explore and conceptualise an understanding of the potential ways in which counsellors and other psychological therapists can be affected by their work with clients experiencing eating disorders. To achieve this, therapists working with the client group were interviewed in order to gather personal accounts of their experiences which would then be analysed to construct an interpretive account of the affects upon clinicians.

The initial intention was to assemble any shared narratives into a cogent descriptive theory which could be used to inform practitioners of what to expect in relation to psychotherapeutic work with clients experiencing eating disorders. However, this initial intention of constructing a grounded theory was acknowledged to be unrealistic as the early findings were more conducive to the production of a "constructed interpretation" (Fassinger, 2005, p. 158) of the data and the study's emerging categories.

The research sought to explore two potential areas in which therapists could be affected by their work. The first of these was the professional subjective experience of the counsellor within the therapy room to establish any specific affects which emerged as a direct consequence of engaging in the therapeutic relationship. The second was to examine any impact upon the therapist's own personal relationships with food, eating and their own body; an area of particular significance due to the inseparable nature of the body, eating practices, subjectivity and sociocultural influences discussed in chapters two and three. As the research progressed the significance of the two bodies within the therapeutic encounter emerged as an area of interest. This included, as discussed in chapter four, consideration of both the physical bodies present in the room and the therapists' somatic experiences, including those of embodied countertransference.

5.3 A qualitative approach

Recognising that the phenomenological experiences of counsellors could not easily be reduced to quantitative measures, and in consideration of the study's postmodern and social constructionist leanings, it was decided that this study required a qualitative approach. With its focus on individual voices and subjective experiences, qualitative research aligns itself with the open style of psychotherapy (Bager-Charleson, 2014) and is recognised as being particularly well suited to studying clinical practice as it reflects the complexity of psychological phenomena (Silverstein et al., 2006). In qualitative research the aim is to capture individuals' experiences (Hallberg, 2006) in order to enable understanding of phenomena and the world (McLeod, 2001) and evoke interpretation through the researcher's analysis of their narratives. Recognising the researcher's personal influence upon the analysis, the findings of qualitative research are reflexively contextualised and report only one possible truth (McLeod, 2001).

Qualitative research encompasses the ideas of postmodernism and social constructionism which, as introduced in chapter one, underpin this study. Rejecting the idea of an objective reality which can be studied without bias (Silverstein et al., 2006; Todres, 2007), postmodernism challenges the notion of one truth to discover and argues instead for multiple realities and methods of interpretation and exploration (Epston, White, & Murray, 1992; McNamee, 2014). The qualitative approach recognises that the social locations and subjective experiences and histories of both researcher and the researched influence the construction of knowledge (Silverstein et al., 2006) and thus, data collection and analysis. The researcher is encouraged to transparently disclose their social situation and theoretical framework in order to acknowledge any potential biases (Silverstein et al., 2006).

In contrast to quantitative research's objectivity and disembodied statistical focus, qualitative research allows for the inclusion of participant voices and positions the researcher as a reflexive research participant (Etherington, 2004a) to varying degrees depending upon the methodology employed. Allowing for a more collaborative approach to knowledge creation, qualitative research is relational and fluid and can be considered as "an interactive interpretative dialogic process" (Anderson, 2014, p. 63). The researcher is more visible within qualitative studies

and there is a recognition that it is impossible for them to be value free (Anderson, 2014), therefore advocating the need for continuous reflexive practice.

Recognising its parallels with therapy, the reflexivity required of the qualitative approach reflects counsellors' use of their 'internal supervisor' in relation to monitoring themselves within the therapeutic relationship (Silverstein et al., 2006).

A qualitative research approach was also appropriate considering therapy as a subjective field with multiple therapist and client realities. The role of the researcher in qualitative research can be considered similar to that of the counsellor in that they both use their selves in their attempt to understand the other (Foster, McAllister, & O'Brien, 2006). The self-reflexivity of qualitative research mirrors the self-awareness of the therapist when attending to transference and countertransference within the therapeutic relationship (Silverstein et al., 2006). Both therapy and qualitative research share a focus on language and behaviour, providing the "rich description of subjective experience" (2006, p. 351) which this study sought. The inclusion of detailed narratives and participant voices was necessary to ensure accurate representation of therapists' experiences. Not only would this allow for transparency in relation to the findings, but "grounding the findings" (Elliott, Fischer, & Rennie, 1999, p. 222) in the data through the inclusion of verbatim quotes is recognised as a means of ensuring the quality of qualitative research.

In contrast, quantitative research sits within a modernist, positivist frame and claims that with the proper tools and techniques, and through objective observation, a single truth can be discovered (Bager-Charleson, 2014; McNamee, 2014). Its focus is one of discovering how the world is and building on deductive reasoning in order to "measure real things" (Bager-Charleson, 2014, p. 22). Positioned within Descartes' objective, analytic and dualistic epistemology, it separates the researcher from the phenomena or participants being researched (Gergen, 2015) and considers the inquirer as a rational and primary organising factor (McNamee, 1992). The researcher is understood to be objective and value free and through their process of deductive reasoning, facts are ordered to reach a definitive conclusion (Bager-Charleson, 2014). The objectivity of quantitative research also assumes that the researcher will neither be affected by the research nor influence it. Quantitative research is understood to discover essences that reveal natural universal laws of 'truth' and is used for studies which intend to predict or control

phenomena. The statistical language of quantitative methodologies can be considered as an “expert language” (Gergen, 2015, p. 65) which was inappropriate for my personal therapeutic ontological beliefs and social constructionist claims towards equality within relationships,

5.4 The methodological journey

Having ascertained the study’s position as a qualitative inquiry, its methodological course within that approach will be considered in section 5.4. The methodological approach shifted from its original intention as my engagement with the research developed and I became increasingly aware of the inseparability of my researcher, therapist and personal subjectivities. This process is described below to make this trajectory and the thought processes behind it transparent.

5.4.1 Considering a phenomenological approach

With its epistemological focus on experience and narrative (Bager-Charleson, 2014), a phenomenological approach was initially considered as it satisfied the aim of exploring the lived experiences of therapists. Phenomenology is also the underpinning philosophy of the person-centred counselling approach (Tudor, Keemer, Tudor, Valentine, & Worrall, 2004) from which I was working therapeutically at the outset of the study. Implicitly rejecting Cartesian dualism, phenomenology developed from the writings of Husserl who established the phenomenological school in the early twentieth century as a means of examining human experiences in order to discover its ‘essence’ or essential qualities (Finlay, 2011). His student, Heidegger challenged Husserl’s work to take greater account of the nature of being; essentially what this research was striving to explore in relation to therapists’ accounts of working with clients experiencing eating disorders. Heidegger posited that any human experience is necessarily situated within a contemporary and cultural backdrop and linked his phenomenology with hermeneutics, recognising the importance of language in giving meaning to experience. Allowing for the consideration of therapist experiences through the influence of contemporary sociocultural discourses, as discussed in chapter two, phenomenology’s position seemed suitable for this study.

However, although acknowledging an element of phenomenological influence, the initial aim was to advance the study beyond the descriptive outcome of a phenomenological account and move it towards a conceptual understanding of the process experienced by therapists (Rungapadiachy, Madill, & Gough, 2006).

Taking my established interest in the field, and personal history of eating disorders into consideration, it was important to employ a methodology which would enable systematic analysis of the data, in as objective and rigorous a way as possible, so as to minimise researcher bias. Emerging from this position, a grounded theory approach with its focus on theory development and methodical data analysis, whilst still accommodating qualitative research principles, was chosen. The deliberations which informed this decision and especially which grounded theory approach to employ, are discussed below in section 5.4.2.

5.4.2 Deciding upon a grounded theory method

Although grounded theory's original aim was to facilitate the development of grounded theories, the methodology is also recognised as a systematic process of data gathering and analysis, which is how it was employed in this study. The intention for the research was to produce an 'interpretive account' (Fassinger, 2005), comprising a blend of descriptive and constructed categories (Rennie, 1998), which would explicate the ways in which therapists counselling clients experiencing eating disorders were affected by their work. Grounded theory's rigorous research procedures offered a focused means of achieving this to ensure that that data generation was led by the emerging findings. Deriving its initial descriptive categories directly from the participants' experiences minimised the imposition of personal presumptions or expectations (Grbich, 2007) upon the analysis. From this more observer type position, the later constructed coding categories would remain detached from my subjective perceptions, maintaining a degree of objectivity. Positing that the researcher's identity and perspective are secondary within the analysis, grounded theory (Glaser & Strauss, 1967) offered a way of keeping my subjective experience at a distance and thus minimising its influence upon the research.

Aiming for the development of theory, rather than hypothesis testing, grounded theory is recognised as a suitable methodology for subject areas in which little is known. As discussed in chapter 4, the experiences of psychological therapists

working with clients experiencing eating disorders is currently an under-explored area (Satir et al., 2009; Thompson-Brenner et al., 2012; Warren et al., 2009) and hence this furthered grounded theory's appeal. Originally formulated as a means of exploring social processes to clarify and explain them and their consequences, it is an approach which is popular in psychology and social sciences (Rennie & Fergus, 2006) and thus sat congruently with my therapeutic background. The humanistic, experiential counselling philosophy in which my work as a counselling practitioner sits has, as its foundation, the attempt to understand and accept the individual client's world view without forcing the therapist's, or any other prescribed position, on their unique experience. With this shared epistemology of understanding clients or research participants Rennie et al. (1988) recognise that grounded theory suits humanistic psychology, allowing the researcher insight to the covert worlds of individuals through intensive interviewing (Charmaz, 2006). To remain true to this therapeutic ontology a methodology which accommodated effective exploration and subsequent understandings of participants' individual phenomenological experiences was needed.

At the outset of the study, a grounded theory approach seemed to offer the level of objectivity I, perhaps erroneously, believed the research needed in order to produce a valid outcome (McNamee, 2014). Positing that the researcher's identity and perspective are secondary within the analysis (Glaser, 1992; Glaser & Strauss, 1967), grounded theory offered a way of keeping my subjective experience at a distance and thus minimising its influence within the research. Aware of wanting to keep participants' experiences focal, the method ensured that the findings would remain grounded within informants' data (Corbin & Strauss, 1988, 2008; Glaser & Strauss, 1967).

Having decided upon a grounded theory approach, the decision as to which of its differing versions was most appropriate had to be made based upon my ontological and epistemological positions (Mills et al., 2006a). Taking these into account, alongside the ways in which grounded theory evolved from its original conception by Glaser and Strauss (1967), led to the adoption of the constructivist grounded theory methodology espoused by Charmaz (2006). The thought process which led to this conclusion is discussed below.

5.4.3 Adopting constructivist grounded theory

Since its introduction, grounded theory has evolved in a number of different ways, beginning with the divergence of Glaser and Strauss (1967) themselves who, following their individual epistemological leanings, developed their own versions of the methodology. Arguably, these developments could be interpreted as evidence of the importance of researchers ensuring that their methodological thinking remains compatible with their ontological and epistemological values and the necessity of adapting methods to ensure congruency; a phenomenon which will be shown in sections 5.9, 5.10 and 5.12 to be of significance within this study.

As well as providing a systematic means of gathering and analysing data, traditional grounded theory (Glaser & Strauss, 1967), with its inductive approach towards generating findings and knowledge seemed to offer the objectivity I initially sought. The researcher's role in this model is to gather data from participants as an objective analyst rather than as an active participant in data analysis and knowledge construction. The social phenomenon being explored is considered as external to the researcher and there is an assertion that a 'truth' exists within the topic of exploration, just waiting to be discovered by the researcher. From the researcher's position as 'distant expert' (Mills et al., 2006a), there is an assumption that, given the same data, another researcher would arrive at the same conclusion (West, 2001). This more positivist approach appealed for its ability to ensure that my subjectivity, influence and perceptions were as far removed from the study as possible.

However, the ontological counselling position I held meant that it was important for me to acknowledge the impossibility of my being an 'expert' on the phenomenological experiencing of other people. From this perspective, subjectivity is considered as unique to the individual experiencing it and this research aimed to gather a variety of these different experiences which could be analysed through systematic grounded theory processes in order to develop an understanding of a general picture. Although this would suggest the possibility of an objective truth waiting to be discovered within the data as Glaser and Strauss (1967) suggest, this ultimately felt problematic for this study as it contradicted its postmodern and social constructionist paradigm assumptions, within which individual subjective experiences are actively sought and sociocultural influences acknowledged.

I then considered Glaser's (1992) version, with its emergent approach allowing for the findings to arise from within the data. Although its objective researcher position had value for this study, its epistemological objectivity was in conflict with the study's relativist stance. Glaser (1992) declared that the researcher would 'discover' their theory from within the data, taking minimal account of the social context and individual world view of each research participant and researcher. The approach was thus rejected because, as discussed in the literature review chapters, this study acknowledges the impossibility of separating sociocultural influences from the individual's subjective experience; both that of the researcher and the researched. The phenomenological experiences of counsellors and their clients are not objective truths and hence cannot be measured or discovered as such. The individual therapist's experience arises within them in relation to each client and each encounter is inevitably influenced by the history, intra- and inter-personal experiences, and sociocultural position of both therapist and client. It also removed the researcher from the analysis, viewing them in a position of "distant expert" (Mills et al., 2006a) which contradicted both the study's social constructionist leanings and my therapeutic ontology.

Corbin and Strauss's (1998, 2008) evolved portrayal thus appeared more relevant with their favouring of pragmatism and symbolic interactionism. Especially in their later version (Corbin & Strauss, 2008), which moved increasingly towards an interpretive stance (Merry & Levers, 2013), the approach fitted more congruently within the study's ontological and epistemological beliefs. Corbin and Strauss (2008) recognised the importance of understanding peoples' lived experiences and their individual interpretations of those, thus allowing for the detailed analysis of the individual therapist's experiences. Relying upon symbolic meanings and language during social interactions (Engward, 2013) individuals interpret their social situation through their personal understandings of the cultural symbols used, deriving meaning that affects their behaviours (Hall, Griffiths, & McKenna, 2013). The psychotherapeutic language inevitably employed by myself and the research participants has to be acknowledged as having informed the data and its subsequent analysis as we engaged in theoretical conversations which non-therapists may not have interpreted in the same way. In relation to the embodied subjectivities considered within this study, the symbolic meanings attached to bodies, which were discussed in chapters two and three, are a significant

component of how individuals create their individual subjectivities and behaviours and interpret those of others.

Corbin and Strauss (1998, 2008) shifted grounded theory away from dualistic positivism and towards ontological relativism within a constructionist paradigm, recognising reality as a product of interpretation and constructionism. Their recognition of the influence of the researcher in data gathering and analysis allowed for greater visibility of the inquirer which seemed more appropriate for this study. However, Corbin and Strauss's (1998, 2008) approach was rejected due to its reliance on detailed formulaic methods of coding which, as Glaser (1992) criticises, become prescriptive and run the risk of forcing the data into preconceived categories rather than allowing for their organic emergence. Such structured coding also retains post-positivist leanings (Hall et al., 2013). Rennie (1988) views this approach as introducing hypothetico-deductivism to grounded theory and it was important to ensure that this research remained within the inductive, emergent paradigm so that the interpreted findings arose directly from participants' experiences. As a therapist, I aim to maintain an open attitude towards my clients, trusting that relevant issues and conclusions will arise from within them; hence this inductive, emergent stance sat well with my therapeutic ontology.

Further reading of the literature then led to Charmaz (2006), who established a version of the method which she termed 'constructivist grounded theory'. Evident within this rendering of the theory is the possibility of following a structured methodology, ensuring rigour and minimising researcher bias, whilst also allowing the researcher's subjectivity to be present within the analysis. Charmaz (2006) subsumed the principles of social constructionism and acknowledged the role of the researcher within the interpretation of the data and its subsequent theoretical development. From constructivist grounded theory's perspective, "social realities are inseparable from the researcher" (Ghezeljeh & Emami, 2009, p. 17) as data and theories are not discovered, but are instead socially constructed (West, 2001) through experience, research practices and interactions with others (Charmaz, 2006). The research therefore offers an interpretation rather than unveiling an absolute truth (Charmaz, 2006; Hall et al., 2013) and therefore, despite my initial aim for objectivity, I recognised that the findings would be my individual construction arrived at through my personal knowledge base, as researchers cannot be totally objective (Charmaz, 2006) or value free, especially when researching people

(West, 2001). Constructivist grounded theory is ontologically relativist in its recognition that concepts such as reality and truth can only be understood within a broader framework contextually positioned in a particular time, place and culture (Charmaz, 2006). Similar to the ways in which bodies and eating disordered behaviours have been interpreted differently throughout time, discussed in chapter two, this study can only be acknowledged as my interpretation of the findings through the knowledge base I hold at this time.

Highlighting the reciprocal nature of the research relationship, Mills et al. (2006a; 2006b) more explicitly state that a constructivist grounded theory is grounded in both researchers' and participants' experiences and thus brings the researcher as author to the methodological forefront. Acknowledging also that meaning is created through the interactions of the researcher with the participants and their subsequent data (Mills et al., 2006a), it also recognises the significance of knowledge being co-created within relationship (Mills et al., 2006b). Findings are thus a construct produced by the interaction between the interpreter and the interpreted as situated in society (Merry & Levers, 2013) and the resultant interpretation is co-constructed from a combination of the researcher and participants' narratives (Gardner, Fedoruk, & McCutcheon, 2012). Within this, the psychotherapeutic language which myself and participants will have used as a matter of course due to our therapeutic backgrounds will have contributed to the construction and interpretation of the therapists' experiences, and my subsequent hearing of them.

The reflexive and transparent nature of Charmaz's (2006) constructivist approach allows the researcher's voice to be heard within the analysis, enabling the emergence of a transparent theory or interpretation whereby the researcher's person and influence upon its development can be clearly seen. In agreement with the pragmatist underpinnings of Strauss and Corbin (1988), Charmaz posits that "any theoretical rendering offers an *interpretive* portrayal of the studied world, not an exact picture of it" (Charmaz, 2006, pp. 10, italics in original). The constructivist approach recognises that researchers cannot be totally objective and that an inter-relationship necessarily exists between researcher and participants. Much as the researcher can attempt to 'bracket off' (Rennie, 2000) their own attitudes, it is impossible to achieve this completely (West, 2009). The researcher's values must be acknowledged as "an inevitable part of the outcome" (Mills et al., 2006b, p. 2) and therefore, to ensure validity and rigour, any analysis must clearly acknowledge

the role and person of the researcher in its interpretation (Waite-Jones & Madill, 2008a, 2008b). To achieve this, constant reflexive practices were employed throughout this study, and the inclusion of reflexive writing in section 5.12 seeks to make my experiences transparent.

Ontologically relativist, constructivist grounded theory identifies reality and truth as being contextually positioned within a particular time, place and culture, with individuals making sense of their world through their social interactions (Charmaz, 2000). It also acknowledges that researchers are a part of the world which they study and the data collected, and hence theories can only be constructed through the researcher's past and present interactions with people, perspectives and research practices. Ghezeljeh and Emami (2009) claim that ontology and epistemology merge, whereby the knower is inseparable from what can be known in construction of a particular reality. Constructionist ontology denies an objective reality and instead views realities as constructions of individual minds (Ghezeljeh & Emami, 2009). Knowledge is created through the interactions of the researcher, the empirical data and the literature, and the researcher is acknowledged as being inseparable from whatever can be known in the overall construction of the theory or interpretive account.

5.4.4 Considering the literature review within grounded theory

The positioning of the literature review is debatable within grounded theory and hence had to be considered for this study. Glaser (1992) remained true to the original view that it should be avoided until the grounded theory has been discovered to ensure that the researcher maintains an open mind, allowing categories to emerge naturally from the empirical data and to prevent the theory becoming contaminated or stifled by the literature and existing theories (Charmaz, 2006; Hoare, Mills, & Francis, 2012). Reading the literature too early can leave the researcher feeling over-awed and deskilled by published studies (Glaser, 1992) which could detrimentally affect their self-worth and self-belief in relation to their theory development (Bager-Charleson, 2014). Charmaz (2006) also argues that delaying the literature review can help avoid the imposition of preconceived ideas in the theory and instead, encourage the researcher to articulate their own ideas.

However, taking into account that researchers often choose topics which have personal significance to themselves (Etherington, 2004a), they are likely to bring prior knowledge of the subject to the study. For this study, my prior knowledge of both psychotherapy and eating disorders ensured that awareness of some of the relevant literature at the outset was unavoidable. The research questions arose from my awareness of relevant gaps in the literature which also meant that I had some sensitisation to the topic (Corbin & Strauss, 1988, 2008).

In contrast to Glaser's (1992) approach others, including Corbin and Strauss (1988, 2008), Charmaz (2006) and Clarke (2005), consider the literature as an important element of the data and suggest that it "should be theoretically sampled along with other emergent data" (McGhee, Marland, & Atkinson, 2007, p. 336). Used reflexively, the literature review can be seen as fluid and additive throughout the research process (Lo, 2016). Reading substantive areas early in the study can increase the researcher's theoretical sensitivity to their accumulating data (Walls, Parahoo, & Fleming, 2010). The extant literature can be considered as secondary data and used concurrently with the empirical data in order to formulate the emerging findings (Lo, 2016). As coding continues and concepts are recognised, the emerging findings and interpretation directs the literature review (Walls et al., 2010) in much the same way as theoretical sampling drives the data gathering. As illustrated by the discussion of psychodynamic theories in chapter three, the findings emerging from the specialist therapists led my literature review towards psychodynamic studies.

In line with the approach taken in this study, McGhee, et al. (2007, p. 334) concur that what is more important than the positioning of the literature review is to adhere carefully to the process of reflexivity and to remain inductive throughout the study. Ongoing reflexive engagement with the literature through the use of memoing, research journals, supervision and personal therapy, enabled continuous development and reflection upon my own theoretical and personal understandings which increasingly informed the interviews and on-going analysis. Indeed, it was my ongoing practice of reflexive reading of the literature, in conjunction with the data gathering process, which deepened my understanding of the subject area, broadening its scope and suggesting its methodological progression. As was later experienced, reflexive engagement with the literature and accumulating data shifted the focus from therapist relationships with food and eating more fully towards their

subjective experience and an acknowledgement of the significance of the two bodies in the therapy room. From this it can be argued that the original grounded theory idea of engaging with the literature and writing the literature review after the research has been completed can prove limiting and detrimental to a research study. In relation to this study, the literature review chapters were continuously developing entities throughout the research process, evolving in response to the data and my expanding understanding of both.

Having established my intention of conducting a constructivist grounded theory approach to the study, its ethical considerations are presented in section 5.5 before a description of the methodological procedures follows in section 5.6.

5.5 Ethical considerations

Before discussing the preliminary study, which is detailed below in section 5.7, the ethical practices pertaining to this research will be noted to illustrate the ethical considerations that underpinned the rigour and safety of the study and its participants. These practices were applied identically in both the preliminary and main studies.

Before any participant recruitment commenced, the research proposal was submitted to, and gained the approval of York St. John University's Health and Life Sciences Faculty Research Ethics Committee. As a practising counsellor intending to research other counsellors' experiences, the research was also designed to satisfy the BACP's (British Association for Counselling and Psychotherapy) Ethical Guidelines for Researching Counselling and Psychotherapy (Bond, 2004). The research was planned to comply with both the university's and BACP's ethical guidelines so as to ensure the academic integrity of the study and also the well-being of participants and any clients with whom they were working.

Throughout the design and conduct of this research priority was afforded to the therapeutic ethical principle of non-maleficence (Bond, 2015) to ensure that participants would experience no harm as a result of participating in the study; specifically that it would have no detrimental effect on their emotional well-being or that of any clients with whom they were working. Due to the nature of the interview questions and the typically self-reflective characteristics of therapists I was aware of

the potential for participants to query their own relationships with food or their individual subjectivity. Remaining mindful of any sensitive issues which could emerge I offered the opportunity of a debriefing session to participants, immediately following the interview or at a later date, if they felt the need to engage in further discussion. Acknowledging that one of the measures of an effective research interview is that participants learn something through the process, all of the therapists stated that they had found the conversation valuable and informative in furthering their own awareness around the issues discussed. None of the interviewees accepted the offer of a debriefing conversation or reported being negatively affected by their participation.

Due to my personal interest and historic experience of the subject area, I was aware that I had also to consider my own psychological well-being and that of any clients with whom I was working clinically. At the start of the study, my personal engagement in eating disordered behaviours was many years in the past, but as a counsellor, I was aware that reading the literature and listening to other therapists' experiences could have the potential to arouse unexpected thoughts and feelings that paralleled earlier personal experiences. Memoing, keeping a reflective research journal, supervision and personal therapy were consistently used as a way of monitoring any potential effects upon myself.

5.6 Methodological procedure

Although the findings are distinguished between the person-centred counsellors of the preliminary study and the later engagement with specialist therapists, the same methodological procedure was followed for all interviewees. Participants for the preliminary study were recruited through advertisements at counselling agencies and colleges in the North East of England. In order to recruit the specialist therapists, advertisements were placed with national eating disorders' services and a mail shot was sent via e-mail to all of the dedicated eating disorder clinics within the UK.

Potential participants were provided with an information sheet (appendix A) detailing the study and their role within it and a consent form to consider (appendix B) before taking part. Semi-structured interviews, anticipated lasting between sixty and ninety minutes, were planned to gather relevant data. At the outset of each

interview, participants were given the opportunity to raise any questions or concerns they may have had before signing the consent form and granting their final acceptance to take part.

5.6.1 Data generation

Interviews are a well-documented source of data for qualitative studies as they elicit first-hand accounts of the phenomenon under scrutiny (Waite-Jones & Madill, 2008a). Recognising that there is no objective reality to discern, interviews should be recognised as a process of data generation and mutually created knowledge, rather than data collection (Mills et al., 2006a). Recognising the paradoxical nature and process of qualitative inquiry whilst drawing a parallel between intensive interviewing and grounded theory methods, Charmaz (2006) describes them both as “open-ended yet directed, shaped yet emergent, and paced yet unrestricted” (Charmaz, 2006, p. 28). Bringing the paradox into this study, a balance needed to be achieved between generating appropriate data and providing some direction to the interview whilst also ensuring that questioning did not overly influence participants’ responses. To satisfy this, semi-structured interviews were chosen to ensure that pertinent topics were discussed, whilst also allowing both interviewer and interviewee the freedom and flexibility to explore any spontaneously arising issues. A sense of equality is also injected into the discussion by ensuring that participants have a degree of power over its direction (Mills et al., 2006a). Semi-structured interviews provide the opportunity for interviewees to ask questions or to introduce their own topics in a way that rigidly structured interviews do not allow (Mills et al., 2006b). Remaining congruently within my non-directive humanistic therapeutic stance, open ended participant questions were devised which are illustrated in the interview schedule (appendix D).

Participants were informed that although it would be unlikely that any hidden issues would emerge during the interviews, there was a possibility that the content could cause them to re-evaluate some of their ideas around their own relationships with food and their bodies. Recognising research in psychotherapy as a moral activity (McLeod, 2001) and being mindful of counselling ethics regarding sensitive personal information, participants were assured that if they felt uncomfortable at any stage of the process, they were free to withdraw from the study and have all of their data removed at no consequence to themselves. Although this could have

been detrimental to the data gathering process, from an ethical therapeutic position (Bond, 2004), it was important to value participants' rights to ownership of their personal material, especially when appreciating the potentially delicate nature of its content in respect of both the therapists and any clients they might have spoken about.

As practising therapists, it seemed reasonable to assume that participants would be self-reflective as counsellors are encouraged throughout their training and by their governing bodies to engage in continuous self-awareness and personal development activities (Bond, 2015; UKCP, 2009). I envisaged that their interview responses would reflect both pre-existing levels of knowledge and personal awareness around the topic and also provide an opportunity for further self-reflection. Because of this, it was important to ensure that participants were aware that the interviews were data generating exercises and not designed as therapeutic devices, whilst simultaneously acknowledging that some personal development insights could occur.

During the process of interviewing, the notion that "[r]esearchers have several 'selves'" (Mills et al., 2006a, p. 10) became apparent. The impossibility of keeping my identities as counsellor and researcher completely distinct emerged as similarities between the therapeutic relationship and the researcher-participant conversation (Kvale & Brinkmann, 2009) became evident. My therapeutic listening and questioning skills were inevitably employed during the interviews as they formed an integral part of my subjectivity and relating style. Potentially beneficial in facilitating participants' explorations, I also had to remain aware of the possibility of over-stepping the boundary into the counsellor position and "fall[ing] into quasi-therapeutic" (Fassinger, 2005, p. 159) responses and conversation. To manage this, the reflexive 'internal supervisor' (Silverstein et al., 2006) skills I employ in the therapy room, when inwardly observing my experience of my client and considering my responses, were used.

As the participants were counsellors too, this reflective style of conversing was not unusual and we were able to relate as two therapists engaging in personal exploration. To remain open and transparent with interviewees, I disclosed my personal history of eating disorders to them alongside my academic interest in the topic. This was done in a very brief, descriptive manner, but its sharing encouraged

participants to share more of their own personal experiences and allowed them to ask any questions they had of me (Mills et al., 2006b). I recognised the privileged position this afforded me as such reflexive relationships can create a level of intimacy that encourages people to share deeply personal stories (Etherington, 2004a; Foster et al., 2006). Recognising the ways in which individuals' subjectivities affect interpersonal interactions and thus the type of data gathered, if workers from a different professional background had been interviewed, this might not have been the case. Additionally, if the interviews had been conducted by a researcher from a different professional background they may have been conducted in a different way and yielded very different data.

All interviews were held at an appropriate venue of each participant's choice, again affording equality into the process (Mills et al., 2006a). They were recorded on a digital voice recorder to ensure accurate representation of their content. The recordings were downloaded onto my personal computer for transcription as soon as possible and deleted from the portable recording device. They were saved into password protected files on my personal computer and transcribed verbatim by myself. Printed copies of the transcriptions, used for the purposes of my analysis and note taking, were stored in a locked filing cabinet to which only I had access. For the purposes of any future publications arising from this study, the files will remain password protected on my computer and the transcriptions securely stored in this cabinet.

To ensure reciprocity within the study the completed transcriptions were sent to the participants for their verification and further comment, if appropriate. Participants were also offered the opportunity to have removed from the transcript anything which they did not feel comfortable having included. In line with the narrative emphasis advocated in grounded theory, and to ensure the on-going presence of participant voices within the findings, therapists were made aware that the study would include their verbatim anonymised quotes.

Further illustrating the difficulty in separating my researcher and counsellor selves, I believed it ethical to allow participants the opportunity to verify the accuracy of the transcribed data from their memory of the interview (Fassinger, 2005). BACP Ethical Guidelines for Researching Counselling and Psychotherapy (Bond, 2004) claim that best practice "approaches consent as a process" and hence a form of

'process consent' (Arthur & Usher, 1998), was used to ensure that participants remained happy with their ongoing involvement in the study (Nichols, 2015). A second consent form (appendix C) was thus sent to participants with their transcription to gain specific permission for the inclusion of transcribed information within any written work, published material or oral presentations arising from this research study. Providing transcripts to participants shows respect to the interviewee for offering their time and experiences and protects their well-being (Mero-Jaffe, 2011), especially in relation to sensitive topics. It also enables them to make a more informed choice as to their ongoing inclusion in the study (Hagens, Dobrow, & Chafe, 2009); due to the potentially sensitive nature of the experiences they were sharing in relation to themselves and their clients, therapists might have had second thoughts about allowing such information to enter the public domain and it was appropriate to allow them the opportunity to remove any comments they were uncomfortable with. It also enhances trustworthiness (Bond, 2004; Mero-Jaffe, 2011) and helps maintain a more equal power balance (Mero-Jaffe, 2011) in the researcher-participant relationship.

However, the disadvantages of 'interview transcript review' (Hagens et al., 2009) need to be considered. As per the right to withdraw from the study at any time posited in section 5.6.1, this could have proved detrimental for the study if anyone had chosen to remove any significant data as this can introduce bias (Hagens et al., 2009) and it also affords power over the research to the participant. This was a possibility as participants can react negatively to seeing their words on paper, especially in relation to personal or sensitive topics, and may wish to alter them in ways which could have negatively impacted the research (Fassinger, 2005). This would also have been challenging for me to manage as a researcher as, having been given the knowledge or experience, it would have been difficult to remove it from my awareness. In relation to participants themselves, interview transcript review requires time and effort (Hagens et al., 2009), and reading their responses can sometimes cause shame or embarrassment (Mero-Jaffe, 2011). It also adds time into the analysis process for researchers as they have to wait for participants' responses and additional consent forms (Hagens et al., 2009), which there is no guarantee will be returned.

However, despite the disadvantages, the influence of my counselling self upon my researcher subjectivity could not be ignored as my sense of ethical responsibility

(Bond, 2004) remained high, as within any therapeutic relationship. Fortunately this was not a dilemma I had to navigate as each participant gave consent for their interviews to be used in their entirety within the documented confines of confidentiality. The therapists were all keen to have their transcripts sent to them so that they could be reminded of the things they had shared and perhaps learned about themselves during the process of the interview.

In order to ensure rigour and validity, I attended regular supervision sessions with my academic supervisors throughout the research process. These meetings became a forum in which my ongoing analysis and interpretation of the data was verified in order to reduce the possibility of researcher bias and ensure that the emerging findings remained grounded in the data (Corbin & Strauss, 1988, 2008; Glaser & Strauss, 1967). My reflexive ontological positioning as a counsellor meant that I already had an established practice of reflective journal writing in relation to my therapeutic work. I extended this to include a similar approach to my research work which became a form of self-supervision (Simon, 2014) and reflexive inquiry.

5.6.2 Methods of analysis

To ensure the grounded theory process of constant comparison (Glaser & Strauss, 1967) was effectively employed, the transcript of each interview was coded immediately upon its completion and before conducting the next. The process of grounded theory comprises an on-going procedure of 'comparative analysis' (Glaser & Strauss, 1967) as a means of constantly comparing, for both similarities and differences, data incident with incident and emerging categories and concepts against each other to ensure continuous fit as the findings develop. This process begins from the very start of data collection and ensures that the researcher remains close to the data at all times, thus keeping the emerging findings grounded in that data. As the data is gathered and analysed, the researcher 'codes' it to advance it from the pure description of participants' experience and to raise it to the conceptual level. The researcher's theoretical sensitivity is invoked as analysis includes the level of insight they are able to bring to the study (Mills et al., 2006b).

Rather than the word by word, or line by line analysis originally recommended by Glaser and Strauss (1967), the data in this study was broken into 'meaning units' of phrases and sentences (Rennie et al., 1988; Waite-Jones & Madill, 2008b). This

allowed for more accurate understanding and analysis of the participants' narratives and ensured that meaning would not be lost through erroneous breaking up of their experiences. As Rennie (2000) recognises, the process of interviewing participants and then being emerged in the transcription of their responses, gives the researcher an overall sense of the interviewee's experience which could be lost through the fragmentation of their narratives. Understanding the context of each response inevitably influences the understanding of individual phrases and statements (Rennie, 2000) and hence improves the validity of the researcher's analysis. Many of the participants' responses are included in their entirety in the findings chapters in order to ensure accurate representation of the therapists' narratives and to make explicit from where the final analysis emerged.

Although, as presented in the findings chapters, the emergent coding categories were similar between the person-centred counsellors and the specialist therapists, theoretical coding illuminated a number of differences between the two data sets. This meant that not only was each interview being compared against all others, but also that themes between the two data sets were compared to ascertain both similarities and differences.

When the analysis first began, the qualitative software package, 'n-Vivo', was used as it claimed to provide a systematic means of collecting, collating and analysing the growing data. However, this computerised recording method began to feel increasingly detached. Echoing the disconnected psyche-soma experience of clients presenting with eating disorders (Barth, 2016; Zerbe, 1993) or the increasingly disembodied western way of living (Soth, 2006) I was reading about in the literature, it became more appropriate to connect with the data in a more direct manner. The meaning units and their subsequent coding categories were written on note cards and post-it notes with different coloured pens, and, sitting on the floor amongst them, I was able to gain a clearer vision of the study's development. Through this more hands-on approach to analysis I felt physically closer to the data, ensuring a more intimate connection to it.

5.6.3 The research sample

As a result of the richness and quantity of data gathered from interviews, qualitative studies tend not to be of vast sample size. McLeod (2001) proposes a sample of

between 8 and 15 whilst Charmaz (2006) suggests that twenty-five participants form a sufficient study size. I therefore envisaged interviewing between twenty and twenty-five counsellors which seemed an adequate sample size to enable saturation of categories to occur, whilst not creating unmanageable superfluous data. The time constraints of the study and the practicalities of acquiring appropriate participants also needed to be considered. In line with grounded theory, the interviewing process was planned to cease once 'saturation point' was achieved; a point when "gathering data no longer sparks theoretical insights, nor reveals new properties of these core theoretical categories" (Charmaz, 2006, p. 113). Due to the limited number of participants who came forward for inclusion in the study, the final sample comprised of eighteen therapists; five person-centred counsellors who formed the preliminary study and an additional thirteen specialist eating disorders' therapists within the main study. Their specific details are presented in tables 5.1 and 5.2 below.

5.7 The preliminary study

Encompassing the inquisitive and exploratory nature of the research question, the preliminary study was embarked upon from a place of curiosity rather than from one with predetermined hypotheses in mind (Charmaz, 2006). It was conducted to ensure feasibility and to verify that the research questions would yield relevant and appropriate information (Leon, Davis, & Kraemer, 2011). It was important to ensure that interview questions facilitated participants' thinking around their experiences without being too directive or inappropriately challenging. The questions asked were open-ended to facilitate honest discussion and disclosure of therapists' experiences. Interviews were conducted in a non-directive manner as per my therapeutic approach so as not to prejudice participant thought and disclosure. Clarification of points was sought through additional open-ended questions, in a manner similar to that which would be employed in the therapeutic relationship, encouraging participants to further expand their narratives. Charmaz (2006, p. 25) discusses this process of "intensive interviewing" as it fits with grounded theory's directive, yet emergent nature, and creates an effective balance between asking relevant questions and allowing participants' instinctive responses to emerge.

Within the preliminary study the research sample was defined simply as counsellors who had current or recent experience of working with clients presenting with eating

disorders; either clinically diagnosed or self-recognised. These participants were recruited through advertisements at counselling agencies in the North East of England and through personal contacts. The five counsellors who presented as participants are detailed in Table 5.1 below. Although experience levels of counsellors were not specified during the recruitment process, as evidenced in the table, all five participants had been working as therapists for a number of years and thus could be considered experienced practitioners. However, as the findings in chapter six will illustrate, this level of experience did not necessarily translate into confidence regarding working with individuals experiencing eating disorders.

None of these participants had accessed any specialist eating disorders' training other than one counsellor who had attended awareness raising courses and workshops. Four of the five counsellors who participated in the study were female. Gender had not been specified as the initial research aim was to ascertain a general experience, but as will be discussed in chapter six, gender did have some impact on the experiences of these particular counsellors. The recruitment material did not specify therapeutic orientation neither, although as also evidenced in table 5.1, all five participants identified themselves as person-centred counsellors. As discussed in chapter eight, this provided an opportunity for the analysis and discussion regarding the role of therapeutic orientation and knowledge upon therapists' interpretations of their experiences.

Table 5.1 Preliminary study participants

This table details the participants who were recruited for the preliminary study. The identity tag used to label each participant in the table is used to attribute their comments in the following findings chapter.

ID Tag	Gender	Age	Years' experience	Therapeutic orientation	Counselling venue
C1	Female	41-50	11	Person-centred	University student counselling service
C2	Female	41-50	15	Person-centred	Organisation working with survivors of sexual abuse

C3	Female	51-60	9	Person-centred	Private practice
C4	Male	41-50	14	Person-centred	NHS (counsellor in GP surgeries)
C5	Female	31-40	9	Person-centred	Private practice

5.7.1 Methodological implications of the preliminary study

The conclusions which it was possible to draw from the preliminary study had clear implications for the future direction of the research. Following the interviews with the five counsellors, a natural saturation point was reached whereby no new information was being generated through the coding process (Corbin & Strauss, 1988; Glaser & Strauss, 1967). The preliminary study was useful and informative in terms of a specific group of non-specialist counsellors, but it did not fully capture the essence of the study. From this I concluded that these initial participants were not sufficiently experienced in working with the client group to offer the depth of experiential narrative I had hoped to acquire. It could be argued that this indicated preconceptions about the kind of data sought, which potentially suggests researcher bias. However, it could also be viewed as an illustration of the impossibility of the researcher completely removing themselves and their knowledge from the research. Referring back to the discussion in section 5.4.4 regarding the place of the literature review in grounded theory, the prior knowledge I had of the literature meant that I had an awareness that therapists were vulnerable to additional experiences than those discussed by the person-centred counsellors.

Adding to this conclusion, I had experienced a sense of imbalance within the power structure of the interviews. The participants appeared to expect that I would have more knowledge and experience of eating disorders than they did by virtue of the fact that I was researching the topic at doctorate level. As a result of this, I felt a sense of their expectation and servitude pushing me towards the position of 'expert;' a position which contradicted both my researcher and therapist ontological positioning. However, it also caused me to recognise that in relation to many counsellors who do not have the same experience as myself, I did embark on this research from a place of advanced knowledge

Additionally, this participant group, by virtue of their therapeutic environments tended to have come into contact with clients at the less severe end of the eating disorders' spectrum. This may have had implications for their experiences and hence potential limitations for the data they were able to give for the study.

Following the grounded theory concept of theoretical sampling (Charmaz, 2006; Glaser & Strauss, 1967), a change in recruitment tactics was adopted. The data sample for the main study was refined towards therapists with more dedicated practice of working with clients presenting with eating disorders to discover if additional experience and specialised knowledge altered the therapist encounter.

5.8 The Main Study

To recruit therapists with more specialist experience, all of the dedicated eating disorders' organisations and clinics I was able to find contact information for within the United Kingdom were written to, and interested therapists invited to contact me. Advertisements for participants were also placed in the research section of the classified adverts in the professional BACP (British Association for Counselling and Psychotherapy) journal, 'Therapy Today'. Two of the psychoanalytic therapists interviewed were personally recruited during my attendance at workshops, and the final participant was introduced by one of these. Through this process, I was able to recruit a further thirteen therapists, whose experience and therapeutic orientation are detailed in table 5.2 below.

The recruitment of participants proved to be more difficult than anticipated and hence it can be argued that grounded theory's theoretical sampling (Charmaz, 2006; Glaser & Strauss, 1967) was not fully employed as it was not possible to achieve saturation points (Charmaz, 2006; Glaser & Strauss, 1967) beyond the initial one of the counsellors within the preliminary study. As a consequence of having only limited control over the therapists who responded, the research was driven to a large extent by those who did show an interest. The first six specialist therapists interviewed had all developed their therapeutic approaches beyond their original training orientation to become integrative practitioners as a result of working with the client group. They all discussed the benefit of including psychodynamic elements into their way of working and understanding clients which directed the research toward the psychoanalytic literature. Remaining with grounded theory's theoretical sampling led to my attendance at psychodynamic workshops and to the

seeking out of psychoanalytic therapists as a way of further verifying this developing understanding. The two psychologists, who worked from a cognitive-behavioural perspective, presented together from the same clinic providing an opportunity for comparison between their way of working and the six integrative therapists previously interviewed. Once the therapists had indicated their interest, they were subjected to the same interview schedule and analysis procedure as that detailed in section 5.6.2 for the non-specialist counsellors of the preliminary study.

Table 5.2 Specialist eating disorders' therapists

This table details the specialist therapists who were recruited for the main study. The therapeutic orientation is stated as the therapists themselves described their training and style of working. The number of years' experience for these therapists relates to the number of years they have worked with this specific client group and does not include previous therapeutic experience. The identity tag used to label each participant in the table is used to identify their comments in chapter seven.

ID Tag	Gender	Age	Years' experience	Therapeutic orientation	Counselling venue
T1	Female	41-50	4	Integrative (Initially trained as systemic psychotherapist)	NHS specialist ED service (inpatient and outpatient)
T2	Male	41-50	17	Integrative (Person-centred, CBT, psychodynamic, systemic)	NHS specialist ED service (inpatient and outpatient)
T3	Female	61-70	20	Integrative Hypno-psychotherapist	Private practice
T4	Male	41-50	4	Integrative therapist with training in somatic psychology	ED inpatient clinic
T5	Female	41-50	15	Integrative	Private practice

T6	Female	61-70	10+	Psychodynamic / integrative	ED inpatient clinic
T7	Female	51-60	22	Psychologist; CBT	ED clinic (non-residential)
T8	Female	41-50	10	Psychologist; CBT	ED clinic (non-residential)
T9	Female	51-60	2	Integrative	Private practice
T10	Female	51-60	6	Integrative	ED clinic (non-residential)
T11	Female	51-60	30+	Psychoanalytic therapist	Private practice
T12	Female	51-50	30+	Psychoanalytic therapist	Private practice
T13	Female	51-60	15+	Psychoanalytic therapist with training in body psychotherapy	Private practice

5.8.1 The specialist therapists' interview experience

There was a greater sense of equality within the researcher-participant relationship in the interviews with the specialist therapists. They presented confidently in their identities as specialists and hence afforded me none of the reverence experienced with the person-centred counsellors. This led to a more open, sharing experience in which I found myself disclosing more of my personal history as participants shared their own intimate thoughts and experiences, further reinforcing the equality of the exchange (Douglass & Moustakas, 1985; Etherington, 2004a; Mills et al., 2006b). This would prove to be significant in terms of the methodological shift towards incorporating increasing reflexivity and heuristic research principles as documented in sections 5.9 – 5.11. This depth of sharing produced two distinct personal consequences which are discussed further in section 5.9. The first was one of being able to connect more closely with the data and the literature in order to further both the analysis and my knowledge. The second was of a much more personal nature in that it caused me to make unanticipated connections with my own personal history, causing my own subjectivity, self-understanding and

therapeutic practice to change. This process demonstrates the study's epistemological assumptions of the inseparability of self from culture or research, and subjectivities being challenged and created through relationship and experience.

As will be illustrated in the following two findings chapters and the discussion chapter, despite showing some similarities, the coding categories which emerged from this set of participants proved to be different in some significant ways from those of the person-centred counsellors. Each of the specialist therapist's interviews was coded against all others to develop conceptual codes pertinent for this part of the research. By also returning to the data and coding categories from the preliminary study it was possible to compare the similarities and differences between the two groups. From this, and as discussed in chapter eight, training suggestions for trainee and non-specialist therapists emerged.

5.9 Unanticipated impact on myself and hence the methodology

In ways that had not been anticipated, the data generating experience, on-going engagement with the literature, and use of reflexivity led to an increasing awareness of my related past and present experiences and of bringing some of these into question. This process was ignited early in the research whilst I was still interviewing the person-centred counsellors. During discussion involving counsellors' awareness of their body in their therapeutic relationships, participants occasionally commented about the presentation of my body in terms of its shape and size, which caused my attention to turn inward to my own experience and embodied subjectivity in that moment. Considering the sociocultural inscriptions written upon bodies (Malson, 1998) discussed in chapter two, it is necessary to contemplate the potential conscious and unconscious assumptions being made by interviewer and interviewee about each other's body. Comments relating to my body reflected its slimness and it seems prudent to reflect if, considering the conflation of personality traits with body size (Daly, 2016; Lowell & Meader, 2005) discussed in chapter two, participants would have felt as relaxed talking about my body if it had been an overweight one with western culture's typically negative connotations (Yalom, 1991).

Reflecting upon these comments informed my thinking regarding potential effects of the physical body upon the interaction between two people. Not only was this relevant for me personally, but it also brought the increasing significance of the embodied experience into the data gathering process and interview setting. Burns (2006) describes interviewing as an embodied interaction and acknowledges the importance of recognising how both researchers' and participants' embodied subjectivities influence the data gathering experience. Echoing Shaw's (2003) words in relation to psychotherapy, Burns (2006) recognises that little attention is paid to the role of the physical bodies within research activities and acknowledges the inter-subjective exchanges which take place between the two bodies in interview settings, much as between those of therapists and clients in the therapy room.

My deepening understanding of the literature pertaining to eating disorders was also forcing me to re-examine not only myself and my previously established understanding of my eating disordered history, but also my current therapeutic style; a summary of these experiences is documented below in a reflexive monologue in section 5.12. Recognising the social constructionist stance employed, these effects on my subjectivity are not surprising when the relational nature of self is considered. It was perhaps inevitable that my engagement with the research would change me, in a similar way to how the therapists being researched were potentially affected by their empathic relational engagement with their clients.

It became apparent that my initial attempt to remain at a distance from the data in order to maintain an objective stance had been unrealistic and that that approach had the potential to "limit and hinder" the research process (Jootun et al., 2009, p. 46). It also became evident that the phenomenological technique of 'bracketing' is flawed due to the inseparability of subjectivity, knowledge and culture (Heath & Cowley, 2004). Recognising that researchers are inherently part of the social world and intrinsically become part of this system when observing it (Simon, 2014), I instead sought to achieve a position of "critical subjectivity" (West, 2009, p. 192). This position acknowledges that qualitative researchers tend to research topics which they are passionate about (Etherington, 2004c; West, 2009) and which therefore have the potential to create strong reactions within them. The impossibility of the researcher completely bracketing their personal assumptions is acknowledged (West, 2009) and it is recognised that the researcher's world view

will inevitably influence the analysis and as such, should be transparently stated. Confirming this, Etherington (2004c) claims that even the most objective observer will bring their own prior knowledge and personal or cultural narratives to the research. Illustrating the inseparability of my ontological therapeutic position with my subjectivity and researcher experience I found myself engaging with the data in a similar way to that which I would with client material. To protect the integrity of the research it therefore felt important to find a way to encompass this experience and congruently acknowledge my involvement in the research process.

Consequently, although grounded theory continued to satisfy many of the objectives for the research, in terms of facilitating a constructed interpretive analysis and providing a systematic methodology, it became evident that it had limitations for this particular study with myself as researcher. Hence, it became necessary to adapt the methodology to satisfy the changing needs of the study (Meekums, 2008; Nuttall, 2006). The inductive nature of grounded theory and the rigour advocated by the constant comparison method remained appropriate, but the approach to analysis needed to be broadened to take more account of my reflexive experiencing which was affording greater understanding of the literature and data. It was thus concluded to “stretch” (West, 2001, p. 128) grounded theory, accepting that:

“the role of qualitative researcher involves becoming a bricoleur, resourcefully weaving together whatever tools and methods might be necessary in order to achieve an insightful and comprehensive understanding of the topic being investigated.”

From a postmodern perspective, methodology can be considered fluid and a “messy, chaotic process with surprises that requires one to improvise during the process” (Bava, 2014, p. 157). As a consequence, new methodological practices are created which may move away from the status quo and become “innovative and possibly disruptive of the traditional” (ibid., p. 169), allowing researchers to become “designers of methodology” (ibid., p. 169). Charmaz (2006) acknowledges that grounded theory provides guidelines that can be adapted to suit diverse studies and that its methods can be used to complement other approaches to qualitative analysis. Hence taking this and the issues discussed above into account, alongside West’s assertion that grounded theory “is a research tool that can be used creatively” (2001, p. 128), the original methodological approach was

revised to more fully encompass the needs of the study whilst retaining its rigour and structured analysis.

5.10 Combining heuristic research principles

Engaging with the data from the specialist therapists and my subsequent immersion in the psychodynamic literature, led to me becoming increasingly embedded in the subject and engaging in something akin to 'immersion', the second phase of heuristic research (Moustakas, 1990). Much of my lived experience was being subsumed by the research topic and the process of conducting the research was affecting me in ways that I had not anticipated; as a researcher, therapist, and on a more personal level, which could not be fully accommodated within the grounded theory approach. Previously established understandings of myself, my eating disordered history and my therapeutic approach were brought into question on numerous occasions, and it became necessary to find a way of legitimately acknowledging this process within myself and how it was furthering my understanding of the data. As my personal understanding of the eating disorders' field deepened, I was able to understand texts and participant interviews on a deeper theoretical and conceptual level (Defrancisco, Kuderer, & Chatham-Carpenter, 2007) resulting in more detailed and precise analysis (Moustakas, 1990).

As the study progressed it became evident that my reflexive reading of the literature and interview transcripts was opening up old wounds in a way which had not been anticipated. I was aware at times of feeling "swamped" and of experiencing a sense of "fragmentation" of myself during the process as a result of its being so intimately connected with my own personal narrative (Savin-Baden, 2004) which was consistently being rewritten. Using my therapeutic knowledge, I became aware of this depth of engagement occurring within myself at various times as my current personal and professional subjectivities were challenged and consequently altered. I recognised the need to incorporate this experience within the research whilst also protecting both the integrity of the study and my own psychological well-being. This involved more intensive personal engagement with my research journal alongside conversations with both my academic and clinical supervisors. At appropriate stages, I also engaged in personal therapy sessions to enable me to make sense of the ways in which the research was affecting me.

Heuristic research, unlike grounded theory, anticipates this process of self-transformation and acknowledges the use of the researcher's tacit and personal knowledge in the development of the analysis. It posits that "the investigator must have had a direct, personal encounter with the phenomenon being investigated" (Moustakas, 1990, p. 14), which made legitimate my positions as a counsellor working with the client group and a woman in western society with a history of eating disorders, alongside my identity as a researcher.

This approach also took greater account of the ontological positioning I held as a humanistic counsellor in which I engage in a constant process of self-reflection and personal development throughout the course of my client work. From this perspective I had an appreciation that such a *modus operandi* had the potential to instigate sometimes painful realisations and personal transitions for the therapist, but I also understood how beneficial such experiences could be if the therapist could immerse themselves in it and allow themselves and their work to be enhanced through it. Following this train of thought, the potential benefits for the research of a similar kind of immersion in the data and literature by myself as researcher became apparent. Etherington (2004b) recognises that heuristic research attracts researchers in the fields of counselling and psychotherapy and those who value using themselves in their work. The process of heuristic research appeared to mirror this reflexive therapeutic endeavour for understanding, demanding:

"the total presence, honesty, maturity, and integrity of a researcher who not only strongly desires to know and understand but is willing to commit endless hours of sustained immersion and focused concentration on one central question, to risk the opening of wounds and passionate concerns, and to undergo the personal transformations that exists as a possibility in every heuristic journey" (Moustakas, 1990, p. 14).

As my interest in the role of the body and the embodied experiences within the therapeutic encounters had grown, I was also drawn to embodied theories of knowledge. As I understood myself to be using these ways of creating knowledge, heuristic research, with its increased focus on the self of the researcher, offered the opportunity for me to dwell in these theories. Gendlin's (1996) notion of 'focusing' offered a theory of experiential phenomenology emphasising the role of feeling in cognition. Used within the therapeutic relationship, the therapist employs focusing

techniques to encourage the clients to pay attention to their somatic experiences to allow meaning to emerge. Focusing recognises that experience and knowledge can be pre-conceptual and felt within the embodied experience. I was already using focusing within my therapeutic relationships to encourage clients to concentrate upon their somatic experiences and allow meaning to emerge. It was therefore a natural progression to extend this way of creating understanding into my research work, allowing recognition of the notion that knowledge can be pre-conceptual and felt within my own embodied experience (Gendlin, 1996). This more embodied acknowledgement of knowledge production fits also with the study's recognition of a need to move beyond Cartesian dualism and recognise the indivisibility of mind and body, self and world.

As discussed in chapter three regarding the marginalised position of the body in the talking therapies, involvement of the body has become "a minority voice in postmodern dialogue" (Todres, 2007, p. 33). Paralleling the embodied nature of empathic attunement within the therapeutic relationship and the co-creation of new narratives through this for clients, the role of the researcher's body within data analysis and interview conversations needs to be considered (Burns, 2003, 2006). As illustrated throughout the literature review chapters, embodiment is inextricably linked with being and knowing (Todres, 2007) and therefore, knowledge creation. Gendlin (1996) challenges the body's marginalisation, claiming that it is always implicated in creating meaning through its physical and sensorial participation in the world. He claims that knowledge creation is a bodily inclusive hermeneutic cycle and that developing meaning happens, not just on the cognitive level, but also on the embodied, as a 'felt sense'. In considering Gendlin's 'felt sense', knowledge creation becomes "not just a personal cognitive process" (Todres, 2007, p. 3) but rather one involving the sensorial experiences of the 'lived body' (Bager-Charleson, 2014; Todres, 2007). Aristotle's concept of phronesis allowed the use of Gendlin's (1996) 'felt sense' to be employed as an "intuitive reference" (Todres, 2007, p. 40) through which I was able to confirm my perceptions and developing understanding; again, mirroring my ontological therapeutic position.

Aristotle's view of knowledge was three dimensional, encompassing phronesis, epistme and techne (Nieminen et al., 2011). Epistme aligned with the scientific and inductive and deductive nature of quantitative research and techne related to technical skills and production. The developing methodology within this study

draws upon the third dimension of phronesis as my theoretical knowledge of both research and the therapeutic eating disorders' field became more integrated and implicit (Colman, 2013). Employing critical self-reflection from an inner state of professionalism, I was able to draw upon my personal and therapeutic knowledge in order to decide what constitutes good practice (Tyreman, 2000) and understanding within the field of therapy. As phronesis is based upon feelings and recognised as having capacities associated with empathy (Svenaesus, 2014) this kind of knowledge is one encompassed within my counsellor subjectivity. Once I recognised the impossibility of separating myself from the research and adapting the methodology to encompass this, the concept of phronesis enabled me to draw more upon my embodied, intuitive subjectivity in the research process and accept this as a legitimate source of knowledge.

5.10.1 Methodological adaptation

In order to successfully accommodate the study's inclusion of heuristic research principles with the already established grounded theory methodology of the preliminary study, potential similarities between the two approaches needed to be considered, especially as West (2001, p. 128) claims them to be at "opposite end[s] of the pole." He claims that grounded theory is based in researcher objectivity, whilst heuristic research "actively and deeply" (ibid., p. 130) involves the self of the inquirer. He also recognised that understanding within grounded theory comes from the people researched, whilst the findings in heuristic research are "found within the researcher and elucidated by an intuitive and tacit process of knowing" (ibid., p. 130). Although his first point echoes my experience and illustrates the need for my methodological shift, the latter point is more difficult to reconcile. My intention was to combine both aspects of analysis and knowing; keeping the findings grounded in the experiences of the people researched, whilst also allowing for a deeper involvement of myself. The adaption was necessary however, because as West (2001) recognises, grounded theory can promote objectivity and non-reflexivity, which "can lead, especially for those of us researching the world of therapy, to a denial of inter-subjectivity (ibid., p. 127).

In consideration of West's (2001) comments, the remainder of this section discusses the ways in which I was able to reconcile the two methodologies for this study. From a shared base, both approaches sat within the qualitative field and are exploratory approaches towards research aiming "to discover the nature and

meaning of the phenomenon itself" (Moustakas, 1990, p. 42). The data generating and analysis strategies remained consistent as arguably, similarities exist between the methods employed within grounded theory and heuristic research. Both methodologies use the intensive interviews (Charmaz, 2006) utilised within this study and advocate that the interpretations and theory being developed remain grounded within the words and experiences of participants rather than from any preconceived researcher assumptions (McGhee et al., 2007; Moustakas, 1990). The constant comparison procedure within grounded theory which ensures this validation of the data arguably mirrors the process of constantly returning to the data within heuristic research (Moustakas, 1990).

Although reflexivity is a significant element of both methodologies, and indeed, qualitative research in general, heuristic research allows for greater acknowledgement of the researcher's self as a tool within the research process, especially in relation to psychological studies (Etherington, 2004a; Moustakas, 1990). Due to the unexpectedly powerful ways in which this study challenged both my personal and professional subjectivities and understanding of my personal history, adding heuristic research principles seemed the most transparent and effective way to include this within the study, whilst maintaining its integrity. Reflexivity is discussed further in section 5.11 below, but it in relation to the accommodation of the two methodologies, grounded theory's notion of memo writing as a way of exploring emerging themes and categories can be considered as a reflective and reflexive practice (Fassinger, 2005).

Following this shift in methodological thinking, the data gathering and coding protocols remained fixed in their already established grounded theory format, maintaining consistency in methodological procedures. The adaptation occurred rather within the analysis as my personal submersion in the data deepened, encompassing the principles of heuristic research and acknowledging the legitimacy of phronesis and embodied knowledge as discussed above in section 5.10. Periods of incubation and illumination (Moustakas, 1990) were engaged in to allow for internal processing of the data, literature and personal experience. From this place of emerging knowledge it was possible to return to the data and further deepen the analysis through the heuristic phase of explication (Moustakas, 1990). This process was continued until the interview transcripts of all thirteen specialist

therapists had been analysed, comparing them both to each other and to the findings of the person-centred counsellors.

5.11 Using reflexivity

Using Etherington's (2004a, pp. 31-32) definition, reflexivity is "the capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid and changing) inform the process and outcomes of inquiry." It was a skill I brought with me from my counselling practice (Bager-Charleson, 2014; Etherington, 2004a) and hence reflexive practice and writing were employed from the outset of the research study. Its value became of increasing relevance as the effects of the research on myself as a researcher, therapist and individual were recognised. Engaging reflexively ensures an on-going awareness of pertinent issues which could beneficially or detrimentally affect either the researcher or the research. Recognising the potential effects of any arising issues allows for conscious reflection on their value or relevance for the research (Etherington, 2004a). Being able to distinguish between those affects which were pertaining to the research and those specific to personal experiencing allowed for a cleaner analysis of the data. This level of awareness can heighten perceptions and sharpen observations as the researcher is free to focus more exclusively on the data without being unconsciously influenced by personal issues (Etherington, 2001a).

Recognising that qualitative studies are prone to a degree of subjectivity, reflexive practice allows for constant reflection on the work being undertaken which has the potential to add to the richness and depth of the research. Including the researcher's reflexive voice in the analysis must also add to its rigour; by being transparent and openly reflexive it is possible to make explicit how the researcher's positioning within the study influences its interpretation (Etherington, 2004a; Jootun et al., 2009).

Reflexive practice occurred in various ways throughout the study; within the reading of the literature, during the interviews, and most significantly during data analysis. Reflexivity was achieved during interviews through continuous self-reflection enabling the tracking of subjective responses to participants' reflections and presentations in a way similar to that employed by my therapist self with client material in the therapy room. From this place of awareness, it was possible to

decide which personal experiences were relevant for disclosure within the interview or which were impacting on engagement with, and understanding of, each participant (Etherington, 2004a). Being able to actively choose which elements of personal experience to disclose enabled deeper and more congruent engagement with participants than a more detached position would have allowed. This also facilitated greater depth of questioning as the semi-structured interviews could be constructed fluidly to keep pace with the movement within each interview (Mills et al., 2006a, 2006b). Again, this illustrated a crossover with a therapeutic way of being and another example of the difficulty of separating this ontological aspect of myself to maintain objectivity. This practice was also engaged with throughout the transcription process, although outside of the interview setting it was possible to immediately write down and reflect upon any personal reactions and subjective experiencing. These reflective writings continuously stimulated thinking around the data and the literature.

The possibility of the effects experienced as a result of conducting this research having similarities to some of the effects being discussed with participants was also recognised. It therefore seemed imperative to find a way of including some of my more pertinent research journal reflections in the thesis, to make transparent any such similarities and illustrate how these informed my analysis of the data. To make explicit the depth of reflexivity I have engaged with, I present below a summarised retrospective account taken from my journals and memos.

5.12 A reflexive account of the research

The final section of this chapter is a reflexive account of my experiences of conducting this research. Reinforcing the claim that researchers often have to defend themselves against accusations of self-indulgence when including their own stories for research purposes (Bager-Charleson, 2014; Etherington, 2001b), I assert that I include it not as a narcissistic endeavour, but to retain transparency and protect the academic integrity of the thesis. I also hope that through it, the reader's own personal insights may be triggered, adding to the authenticity of qualitative interpretive description (Todres, 2007). By documenting a visible separation of myself as an individual and myself as a researcher, my intention is to make clear where my subjectivity and its influence starts and ends. This will provide the reader with the opportunity to judge for themselves how my person has

impacted the data (Jootun et al., 2009). It also illustrates how informative personal subjectivity and experiencing can be within a research study and how the research engaged with inevitably changes the person of the researcher.

Through my reflexive writing I was able to see how my original intention of employing grounded theory was not based purely on methodological reasoning. Reminiscent of the eating disordered experience of gaining others' approval, I set out to follow a well-established methodology which I knew had already gained respect within the academy for researching qualitative studies. But as has been discussed previously in this chapter, I soon began to realise that grounded theory was not entirely appropriate for this study. And that was a difficult thing to admit; both to myself and to my academic supervisors. Part of me, the 'good little girl', felt that 'I must have gotten it wrong'; and yet 'good little girls do not get things wrong'. Another part of me felt like a rebel; who was I to say that such a well-established methodology was not enough for me and my research? I worried about being accused of arrogance. I wondered if it was my fault; was I missing something within the methodology? As for many individuals, these self-doubts and self-blame were common features of my eating disordered self and it was interesting to see them still in evidence despite my years of recovery.

I worried that taking the less conventional route would be fraught with danger and uncertainty; that it would not be so readily accepted within academia. I could not get away from my sense that, as already discussed, this study, with myself as researcher, needed more than grounded theory could give. It felt that I was taking a huge risk in adapting my methodology part way through the study, but I was also aware of a sense of welcoming myself into it as my confidence as a researcher grew. Used to relying on other peoples' approval, just knowing that this way of working could elicit disapproval from some quarters was challenging. And yet it was also empowering. I had a strong sense of what was right, both for myself and for the study, and felt that I had to follow that tacit sense of knowing. The acceptance that I consequently experienced from my supervisors, colleagues and other interested parties was invaluable in encouraging me to take this methodology forward.

As the methodology progressed I found myself taking a more visible role within it, mirroring the way in which I have allowed my self to grow and become more visible

and audible in life. The rest of this chapter will make visible to the reader the inseparability of my academic and personal journeys throughout the course of this research.

5.12.1 At the beginning of the journey

The story of how this thesis came into being is one of serendipity and of taking unexpected opportunities. During an annual appraisal at work, my manager suggested funding a PhD to complete some research which would benefit my organisation. I was successful in my application and I soon, began my work-related research. I was enjoying the process of learning and the philosophical thinking which the PhD involved, and so was hugely disappointed when a new manager came into the organisation nine months later and refused to continue the funding. Left with the choice of abandoning the PhD or changing my research direction, with the support of my academic supervisors, I decided to change track.

In hindsight, if I had continued with the original research topic I would have still been travelling along my old track; doing what other people decided for me and metaphorically living a life defined by external expectations. But needing to decide upon a new topic relatively quickly meant that I had to listen to my intuition and make the decision on my own. Because of my experience and long-held interest in the subject, eating disorders seemed to be the obvious choice.

And so almost exactly one year after originally starting work on my PhD, I began the 'real' research. And from the beginning I felt a much greater sense of ownership; it felt very much more me, much more mine. It felt like an echo of my life experience; the alternative research question mirroring my step into counselling training as, like many other eating disordered individuals in recovery I began to establish my own sense of self, connecting to my embodied experience (Sands, 2016) and turning my back on others' expectations and external discourses.

5.12.2 Adapting the research methodology

From this starting point, I believed that I had a wide knowledge of eating disorders; and compared to most people, I did. But I was not prepared for the ways in which my understanding of the disorders, and consequently myself, would shift and

change over the course of the research. At this point I was anticipating that my findings would focus on counsellors' thoughts, beliefs and behaviours around food, weight and body shape. I had no appreciation at this stage of the significance that the embodied aspect of the work would take in the research. Indeed, at my upgrade meeting it was queried as to whether the word 'embodied' needed to be included in the title. Although I had no evidence at the time, my intuition or developing tacit knowledge told me to leave it in which proved serendipitous bearing in mind how much more visible the body was to become.

As discussed earlier in the chapter, the initial five interviewees were person-centred counsellors. I found these interviews interesting and felt that they confirmed some of the things I had expected to hear. But I was also left feeling disappointed because I felt that I had not discovered anything which was not already evident in the literature; an experience which caused me to doubt my own self-worth and the value of the research. This self-doubt and sense of not being good enough is a common experience within the eating disordered population. It was interesting to note that despite being in recovery for many years, I was still prone to the old self-doubts given the right circumstances.

Interviewing participants proved to be a surprisingly exposing experience for me. As with this thesis, I found myself disclosing more of my history than I had anticipated. This felt authentic and valuable as I experienced the interest and acceptance of the interviewees. It also encouraged interviewees to talk more openly about their own experiences, further confirming the relational and cyclical nature of information gathering and knowledge evolution. It was also through the interviews that I began to appreciate the presence and influence of the bodies in the room. As we discussed our own bodies, I began to recognise how this same process could potentially be mirrored in the therapy room between client and therapist. This helped me recognise the importance of the therapist being able to talk openly about their own body when appropriate.

Another element which I had not adequately prepared for was the way in which engaging at depth with the literature would begin to challenge my understanding of my own eating disorders, and hence my understanding and experiencing of my self. As I reflected upon the articles and books I was reading, I began to turn

everything back upon myself in a way which had not been anticipated. It began to feel as if there were five different parts of me participating:

1. Academic researcher - gathering knowledge for the research.
2. Practitioner researcher - using the reading to reflect upon, and inform the interviews I was conducting. This is the part of me that straddled the academic researcher and the therapist parts.
3. Therapist – challenging my current way of working therapeutically and taking my learning back into the therapy room with clients.
4. Myself the woman (with an eating disordered history) - reflecting on my own historic experiences and thinking within the sociocultural influences discussed in chapter two. Alongside this, many of the psychodynamic influences on my development and current phenomenological experiencing, as presented in chapter three, were ignited.
5. My embodied self – experiencing new learnings within my body and learning to listen to my body's knowledge.

I had expected to find the first three parts, but the intensity of the latter two proved to be a surprise. And yet in hindsight, it seems inevitable that I would be affected in some way. Embarking on the study from the perspective of 'the good little girl' I believed that effective research needed to be objective and disconnected from the self of the researcher. And yet on reflection, this disconnection seems suggestive of the mind-body split which this thesis recognises as a factor in the development of eating disorders (Zerbe, 1993). To remain true to myself and to the knowledge being generated, it therefore followed that I needed to allow myself a more participative and visible role.

5.12.3 Accommodating myself within the research

As discussed in sections 5.9 and 5.10, I found myself needing to adapt the methodological approach in order to accommodate these voices which refused to be silenced. Historically, I would have silenced my voice, believing it, and myself, to be wrong and not worthy of being heard. But it was too powerful in this instance and I found myself wanting it to be heard; I found *myself* wanting to have a voice. I felt a strong need to be seen and to be heard in order to be congruent and accept an authentic place within the research.

At times, this caused a lot of self-doubt, but I had a hugely empowering experience whilst presenting a paper at the 2012 BACP Research Conference in Edinburgh (Cox, 2012). A section of the paper focused on my methodology and in particular the introduction of myself into the research through reflexivity and heuristic research. I had been expecting challenge, even condemnation, towards this methodological movement and hence had presented this section from an overly defensive position. I was surprised and empowered by the positive feedback I received affirming that my methodological shift seemed appropriate for this piece of research. The only negative feedback I received was towards my defensive position, which it had been felt was not necessary. This experience also taught me the importance of believing in myself and allowing myself to break away from established rules and methods in order to do the right thing for myself and my research.

5.12.4 Research mirroring the eating disordered experience

Entering the thesis writing stage of this study, I became aware of feeling as if I was back in the process of a bulimic binge-purge cycle. Over the six years in which I had engaged with the research, I recognised how much information and knowledge I had taken in and gobbled down. As with the food in a bulimic binge, I wanted to take in as much as I could, greed for increasing knowledge and understanding increasing my appetite. Stepping back into memories of the bulimic experience, there was a pressing need to get rid of the food, to purge it from my body; a feeling mirrored as I attempted to expel my words onto paper and metaphorically purge everything taken in. Feeling overwhelmed by the amount of knowledge ingested and needing to get it out. Yet also feeling held back, resistant, reluctant, fearful, even unable to at times; very reminiscent of my historic experiences of purging.

In the bulimic experience, the food had to be expelled before it was digested so that it did not become part of me. This time though there was a difference; there was no quick purging solution. I had to sit with the metaphorical full stomach, with the sense of chaos and excess of having too much undigested information in my brain and embodied self. I had to allow and encourage myself to digest the knowledge and data ingested, to take from it the intellectual nurturance on offer, to allow it to change me and become part of me and turn it into something useful before I

expelled it. These metaphorical images have echoes of the symbolic nature of the eating disordered experiences discussed in chapter three.

5.12.5 Eating disordered ontology as a way of being

The academic endeavour enabled me to reach a deeper understanding of how my eating disorder symbolised my way of being in the world, as discussed in chapter three. Reaching this depth of knowledge for myself then further confirmed my theoretical understanding of the symbolic conversation of eating behaviours for others. Recognising the bulimic aspect of my PhD experience resulted in my understanding that phenomenologically, I still tend to have a bulimic approach to life; illustrating how my historic relationship with food and eating mirrored my relating style and way of being in the world. Whenever I become interested in anything, I want to learn as much about it as possible; wanting to binge and ingest as much information and experience as is available to me. Consequently, I hit points at which I become overwhelmed and freeze; a kind of saturation point. This would be the point at which in a bulimic cycle I would have made myself sick; "I have too much inside of me, I need to get rid of it, I need to get it out." This cannot happen with knowledge and experience. And so I freeze. I find myself unable to take in any more and yet also unable to purge. And hence I find myself stuck at a frustrating impasse until I have had time to digest everything and integrate it as part of my continuously changing self.

This has happened on a number of occasions throughout the course of my PhD; both during the research gathering experience but especially whilst writing up the thesis. I feel a sense of urgency, a high level of motivation, enthusiasm and excitement; at which point I can readily gather the research, read the literature, analyse the data or write the words of the thesis. And then I hit my saturation point. And everything becomes a struggle, a chore, an impossibility. I then fall into the typically eating disordered trait of metaphorically beating myself up about it. I feel frustrated with myself. Angry with myself for 'just not doing it.' The anger intensifies, but I do not know what to do with it. And so it gets turned in upon myself in a form of depression which stifles and defeats my creativity, and ultimately, myself. At this point it becomes easy to give up and stay stuck in the impasse, but the need and determination to complete this study took that option away.

In a way in which I was unable to during my bulimic days, I had to engage with the anger, depression and frustration in order to work through it and rediscover my sense of motivation and self-belief. On reflection, I am now able to understand this experience as being where the processes of digestion and assimilation, reminiscent of Moustakas' (1990) incubation phase, were occurring. Although I felt guilty at the time, I now appreciate that by withdrawing from the research during these times I was enabling this necessary process to occur. As per the 'typical' eating disordered personality, I struggled with being kind to myself in allowing this to take place, feeling I had to continuously push forward and constantly engage at full depth. And this is a cycle I see mirrored throughout my life; and it is only through the reflexive engagement with this research that I have been able to reach this understanding about myself and my way of being.

The most difficult aspect of the research was producing the thesis. I recognised, during the writing phase, how much the alexithymia of the eating disordered individual is still very much a part of me, especially when I feel under pressure. I struggled at time to articulate my thoughts, which often made writing a slow, frustrating and difficult time; much like the therapeutic experience with the eating disordered client.

A final significant self understanding which I have achieved through the process of completing this PhD has been recognising how my life is forming a complete gestalt; my previous experiences have informed my research, my research continues to inform my self understanding and I am enabled to combine all of this to create my career in helping others understand and recover from eating disorders. This reflects my holistic experience of completing this study; my self and my therapy work informing the research, which in turn informs myself and my therapy work. The process of completing this research has been a continuous cycle of professional and personal advancement.

5.13 Conclusion

This chapter began by establishing the study within a qualitative approach, before discussing my decision to apply a constructivist grounded theory approach (Charmaz, 2006) to the production of a 'constructed interpretation' (Fassinger, 2005) of the experiences of therapists working with clients presenting with eating

disorders. It then documented the progression of the methodology employed to complete this research study. This needed to be adapted part way through the research in order to better accommodate the changing needs of the study alongside my own development as a researcher. I have made clear the reasons behind this methodological shift and how it was possible to accommodate heuristic research (Moustakas, 1990) principles alongside established grounded theory protocols. The latter part of the chapter provided a reflexive account of the inevitable reciprocal relationship which developed between myself and the research, illustrating the inseparable nature of qualitative research from the researcher. Mirroring the affects upon therapists which I was exploring, it became apparent that researching the field generated numerous affects for myself as a researcher.

Having made explicit how the data was gathered and analysed, the following two chapters present the findings that emerged. As discussed above, the participants of the pilot study and those recruited following it formed two data sets. In order to illustrate this distinction, the findings from the preliminary study with the person-centred counsellors are presented in chapter six and those of the specialist therapists in chapter seven. The implications of the similarities and differences between the two groups will then be discussed in chapter eight.

Chapter 6

Findings from the Non-Specialist Counsellors

6.1 Introduction

As discussed in the methodology chapter, the data gathered in the preliminary study from the person-centred counsellors did not deliver the detailed narratives suggested by the extant literature. This then suggested a specific focus on specialist therapists for the remainder of the study. The data from these more experienced clinicians both enhanced, and contrasted with, that of the person-centred counsellors which had implications for the findings. To allow clear illustration of the evident similarities and differences, the findings are organised into two separate chapters. In this, the first of these, findings from the preliminary study with the non-specialist person-centred counsellors are presented.

Table 6.1 on the following page summarises the main themes and their concomitant sub-themes which emerged during the preliminary study and directs the reader to the chapter sections in which they are recounted and evidenced in verbatim quotes from the participants. As will be illustrated in chapter seven, similar themes arose between the two groups of therapists but different emphases and interpretations were apparent. The significance of this for clinicians and professional practice will be discussed in chapter eight. The use of italics within the quotes illustrates emphases within the counsellors' speech during their interviews. Throughout this chapter, the identity tag Cx is used to identify the counsellor to whom the quotes can be attributed. The corresponding counsellor details can be found within Table 5.1 in the methodology chapter on page 144.

Table 6.1 Themes arising from the preliminary study

Main theme	Sub theme	Chapter section
Feelings elicited by client work	Frustration	6.3 6.3.1
	Feelings initiated by sociocultural influences	6.3.2
	Fear and uncertainty	6.3.3
	Inadequacy	6.3.4
	Admiration	6.3.5
	Nurturance	6.3.6
Counsellors' experiences in relation to their own bodies and eating behaviours	Questioning own eating behaviours	6.4 6.4.1
	Self-consciousness around own body	6.4.2
	Positive reactions	6.4.3
	Self-disclosure	6.4.4
Self awareness in relation to counsellors' own personal histories and relationships with food, eating and their bodies	Discoveries made during research interviews	6.5 6.5.1
The bodies in the therapy room	The client's body	6.6 6.6.1
	The counsellor's body	6.6.2
	Lack of somatic experiencing	6.6.3
Professional practice issues	Understanding the eating disorders	6.7 6.7.1
	Use of clinical supervision	6.7.2
	Training	6.7.3

6.2 Gender considerations

Before presenting the findings in detail, the gender bias within this preliminary study should be noted as only one of the five counsellors interviewed, was male (20%). A visible difference between the experiences of the male and female counsellors became evident, but from such a small sample size, it would be naïve to generalise.

All four female participants described elements of a socioculturally influenced and emotionally attached relationship to food, eating and their body and were able to identify in some way with their clients' eating disordered thoughts and behaviours. The male counsellor (C4) in contrast, claimed to have experienced no personal problems with food or his body image and when speaking of problematic eating, stated:

“I don't identify with that at all ... I don't think I think about it [food] in any other way other than a kind of joyful, association ... It's kind of a by-product, you know, of nutrition and kind of keeping your body working.”

From this experiential position he admitted finding it difficult to understand how anyone could view food in a problematic way as it was “so completely removed” from his experience.

He also recognised the lack of awareness his “ignorance” implied and the potential negative effects of this for his empathic understanding of client experience:

“There's a process that's going on that I'm just not tuning into; it's not part of my, it's not part of my being, it's not a part of the way that I am, and erm, I would miss that unless it's presented fairly directly.”

It is impossible to verify if this can be attributed to the counsellor's gender and his possible internalised gendered role, although it is interesting to note that he was the only participant in this group who felt unable to “tun[e] into” his clients' emotional processes in relation to food.

6.3 Feelings elicited by client work

Having highlighted the gender bias, section 6.3 presents the feelings experienced by the person-centred counsellors in relation to their work with clients presenting with eating disorders which were summarised above in table 6.1.

6.3.1 Frustration

Three of the female counsellors (C1, C2 and C5) described experiencing frustration towards their clients. Illustrating a potential lack in the counsellors' understanding of the deeper psychological aspects of the eating disordered experience, the frustration was felt towards the ways in which clients could not redirect the willpower they appeared to show in relation to their food restriction or excessive exercising towards recovery. C2 for example, said that she wished that she "could take their determination and target it somewhere else."

Frustration towards themselves and their own relationships with food was also experienced by two participants. When seeing her clients successfully losing weight whilst she was struggling to do so, C1 voiced that "this work can lead to me feeling frustrated." Similarly, C2 described feeling "frustrated, disappointed, erm, fed up," when questioning the congruence of her working with clients experiencing eating disorders whilst feeling that her own relationship with food and eating was not ideal.

6.3.2 Feelings initiated by sociocultural influences

All five of the person-centred counsellors were aware of images in the media promoting the aesthetically ideal body shape and of western society's equation of thinness with happiness and success. The male counsellor was the only one who described a neutral relationship towards media representations of body shape and clothing sizes. He described having "always had a cynicism about what we're told" by the media and of his tendency to consider adverts as "hysterically funny." In contrast, the female counsellors (n=4) felt that they were affected by the images in some way. C1 recognised this gender difference when she said that "women in society certainly have a strange relationship with the media." Discussion regarding media influences was all directed towards female representations, implying that the counsellors had considered this only in relation to female clients experiencing

eating disorders, thus evidencing the condition's current female-centric position in the clinical literature.

The power of sociocultural discourses, through the fashion industry and media in creating idealised small body sizes raised strong views from all four females. Two of the counsellors recognised the normalising effect of the representation of thin feminine bodies in advertising and the media, with C2 saying "I guess the fact that it is out there in the shops or in the magazines, is making it part of society's norm."

C1 felt that the availability of small clothing sizes contributed to the normalisation and acceptability of unrealistically thin female bodies. She found this frustrating as she felt that it encouraged young girls to strive towards these small sizes, hence giving permission for engagement with strict dieting and disordered eating behaviours:

"So people say that magazines put pressure on; I don't know if they put pressure on, I think they just give you permission. I think, when I can buy clothes that *allow* me to be unhealthy in my coping strategy, then yeah, there's some sort of, almost like permission giving. It must be okay, because otherwise why would they sell clothes in those sizes?"

Despite being aware of the manipulation of bodies in media representations, the female counsellors described feeling caught in a dilemma between their professional, rational knowledge and the influence of these images (n=3). Illustrating the power of sociocultural discourses and the difficulty in separating self from culture despite her knowledge and awareness, C5 admitted that "it's hard to not get drawn in by the glossy images." C2 described knowing that "they're all airbrushed. We *know* that and we reason with it, but I think we still struggle with it." Similarly, C1 commented that "we're all rational human beings; we all know the theories around eating disorders, dieting. But, there's *still* this pull of the magazines."

Based in a prestigious English university, C1 voiced frustration towards her institution's drive for "perfection and hard work." Recognising that this mirrored elements of the eating disordered motivation, she was aware that it was in conflict with the client beliefs and values she was attempting to challenge. C1 described these university ethics as a microcosm of the western culture described in chapter

two, in which perfection and the drive towards success and the achievement of a thin body are prized. Within this culture she discussed the difficulty in encouraging clients to move away from these sociocultural values in order to recover from the eating disordered experience when society and their peers are celebrating them.

Two of the counsellors also recognised the influence of media images on clients and how this can affect the counsellor and their client's process. C2 talked of feeling concerned and frustrated when witnessing overweight clients successfully losing weight but then comparing themselves to unrealistic images and still finding themselves lacking. Similarly C3 voiced her frustration at the indirect promotion of slimness through adverts for items as innocuous as laxatives. She described a current advert in which a woman was supposedly bloated and yet "she must be a double zero, minus one or something. And erm, the message that's giving out is, that's about slimming and being slim."

6.3.3 Fear and uncertainty regarding talking about eating disorders

The socially constructed meanings that words such as 'thin', 'fat', and 'obese' have acquired caused uncertainty or fear for all five counsellors in relation to the language that they use when talking to clients experiencing eating disorders. C4 stated that he would like to know "how to talk to different eating disordered groups about their weight." He went on to discuss being afraid to broach the topic with clients in a way in which he would not be with other issues. Part of this fear was attributed to his awareness of negative stereotypes prevalent within western society and of not wanting to risk offending a client. C4 recognised the potential detrimental effect of this upon the therapeutic process, and yet the fear of offending the client pervaded:

"I'd probably have the fear of getting it wrong and upsetting somebody, and I think, because of that, that I would be far more cautious than I normally would be. Which would probably make me less effective, because I'd be tippy-toeing."

An awareness of the words used with clients can be helpful so as to avoid reinforcing the voice of the eating disorder or sociocultural influences. C1 talked of her sensitivity towards this and of her tendency to offer no compliments relating to appearance, as she might with other client groups. However, she also recognised

that this led to her being “a lot more cautious, actually, about my interventions” which she recognised had potential implications for therapeutic efficacy.

6.3.4 Feeling inadequate as counsellors

Although all five counsellors were experienced practitioners, their sense of competency was challenged in relation to this client group. With an assumption that eating disorders were a complicated presentation which needed specialist help, four of the counsellors described feeling a sense of inadequacy or questioning of their ability to work with clients presenting with the conditions. At the more severe end of the eating disorders spectrum, when the physiological wellbeing of clients is potentially compromised, it could be argued that this would be the case, but in the venues at which these counsellors worked the presentations tended to be less severe.

For example, C3 when talking about a client she had worked with remembered thinking; “[c]an I work with this client? Do I have the skills? Do I have the knowledge?” She talked about having felt that “this is a bit beyond me” and questioning if she should “refer on to someone more specialised.” The client C3 was working with did not have a severe eating disorder and the issues were related more closely to body image difficulties, and yet still C3 questioned her competence and level of knowledge. Similarly C5 felt that “these clients bring out the inadequacy in me” and she too questioned “should I be referring on?” C2, an experienced counsellor in a sexual assault agency where eating disorders are often used by clients as coping mechanisms, admitted that “I sometimes feel out of my depth” and questioned if it was a specialist area. She went on to describe herself questioning:

“Do I have enough knowledge? Do I have enough experience? Could I know more? Could I do more? Is there something I’m missing?”

The male counsellor’s (C4) sense of inadequacy arose during the research interview as he realised how unaware of the eating disordered experience he was. As the conversation progressed he admitted that “all of a sudden, I’m feeling really inadequate.” Describing feeling “clumsy and a bit awkward” when working with clients, he could not pinpoint the cause of his discomfort. He recognised other client presentations (for example, he mentioned alcoholism and domestic violence)

that he had no personal experience of, and yet for those, he thought that he would feel more confident in simply needing “to go and read loads of books.” After further discussion, he felt that his inadequacy arose from his “ignorance” and sense of “not being tuned into it.” He went on to say that “I don’t know what to look for,” when clients are disclosing eating disordered behaviours or tendencies “and I think that for other things I know what to look for.”

C1 was the only person-centred counsellor who did not voice this sense of inadequacy. She had attended workshops exploring eating disorders and described one which had been especially helpful in enabling her to think about her own embodied relationship and focus on finding things about her body to be thankful for. Illustrating the benefits of clinicians exploring their own relationships with food, eating and their embodied experience, she talked of how these exercises “had quite a profound effect on me and my work actually, and that was something that I took into my work.”

6.3.5 Admiration

Feelings of admiration were expressed by three of the counsellors, although it was experienced in different ways. For one of the counsellors (C1) it contained an element of ambivalence which left her feeling uncomfortable. She described admiring what she perceived to be clients’ willpower, and the aesthetic results of the behaviours, but also feeling shame around this with her knowledge that such clients are “mentally unwell”. She spoke of her “admiration” and of being “almost in awe of the level of grit that it must take somebody to be able to not consume food to that level.” This sense of “admiration for the ability to be that restrained really, or that determined” was expanded upon later in the interview when she discussed the ambivalence of “knowing it’s a mental illness and they’re doing it to their detriment, and yet you still have this admiration.” In relation to clients experiencing bulimia, she confessed to thinking:

“Oh my god, that’s horrific that you do that to yourself, but actually, you *do* look really good. Awful that you feel the need to do that, but; you’re looking good on it girl!”

Recognising her sense of shame in relation to these thoughts and feelings she admitted that “it’s probably not something I would usually share.” These statements

also illustrate the effect of sociocultural body ideals on the counsellor's experience as she admires her female clients' thin bodies as well as recognising western culture's prizing of determination and control.

Further illustrating how some counsellors perceive the restricting behaviours as an act of determination, C5 described feeling "admiration of what appears to be effort on the part of the client." In a similar way to the frustration described above in section 6.4.1, this admiration of clients' determination maybe indicates a lack of understanding of the experiencing of an eating disorder.

In contrast, C2 described experiencing admiration towards clients as they begin to discover themselves and make life changes. Recognising how self-limiting the control of food can be, she talks of "just want[ing] to get up and do a dance" when her clients begin to move away from this control and start living more authentically.

6.3.6 Feeling maternal or nurturing

Despite the literature noting a tendency for therapists to feel maternal or nurturing towards clients with anorexia, only two counsellors described this experience. In response to the overly thin bodies of clients presenting with anorexia, C1 disclosed experiencing "quite maternal feelings." Towards clients experiencing bulimia, she described acquiring an additional element of sadness in relation to the violence of their behaviours as she remembered thinking "gosh, that's awful that you're so desperate that you do that." Similarly, C2 talked of feeling "really sad" that "somebody has to feel so bad about themselves that their only recourse is potentially dangerous eating disordered behaviour."

Having illustrated the range of feelings the person-centred counsellors described experiencing within the therapy room, section 6.4 emphasises a more personal focus and considers the counsellors' own relationships with food and eating.

6.4 Counsellors' experiences of their own bodies and eating behaviours

As discussed in chapter four, working empathically with clients experiencing eating disorders has the potential to affect therapists' own relationships with food, eating

and their bodies. When the inter-relationship between body and self is considered, as in chapters 2 and 3, the significance of the therapist's fluctuating experiences of their body in relationship with their client becomes apparent. The experiences of the person-centred counsellors in relation to this are presented below.

6.4.1 Counsellors' embodied experiences

All four of the female counsellors discussed examples of a client's experience leading to their questioning some of their own eating behaviours and body weight. They also described examples of wondering what clients thought of their body. Two participants disclosed a sense of incongruence between the therapy that they were providing and the actuality of their physical body in the room. The male therapist had not been affected in this way.

C5 talked of how listening to clients describing their own embodied experience had caused her to question how clients viewed her and her body:

"It does bring things out for me, because if somebody's talking about how they feel, and especially if they're very thin, but they see themselves as fat, I quite often think, 'what do they see me as?' You know, what do they see sitting before them?"

Illustrating the idea of the counsellor's body as a visible form of self-disclosure, C2 who described herself as "small and podgy," questioned the congruence of discussing positive eating behaviours with clients when her body size indicated that she was not following the same advice. She also confessed to feeling frustrated, disappointed with herself, and questioning her competence and entitlement to be counselling clients experiencing eating disorders:

"There *has* been occasion though, when I've gone away and thought, 'Oh my God; should I be doing something about myself?' It can lead to feeling, frustrated. Disappointed. Erm, fed up. Sometimes it can send me on a bit of a spiral down, and I think, you know, 'Who am I, to sit with this person. What gives me the right?'"

Similarly, C1 described experiencing psychological discomfort witnessing a client successfully losing weight whilst she was unable to lose her own. She described working with an obese individual who lost weight during the course of therapy and

despite being pleased for her client, she was left “thinking, ‘I haven’t won my battle yet.’ And that’s a hard one sometimes.”

This longer extract depicts how a counsellor’s personal embodied experience can be impacted by this work and within it, C3 recognises her inadequate levels of self-awareness. She also discloses her feelings towards the size differential between herself and her client and the effect this had on her thinking:

“This client was irritating me by their focus on their body shape. And as I’m a size 24, and them being a size 10, I thought, ‘Ooh; if I was a size 10, I’d be in ICU being treated for something. I had been accepting of my body weight and size, *but*, since this client, I’ve become very aware, I *don’t* look in full length mirrors. I never look at myself in shop windows. Something that I possibly have done, subconsciously, but this client, for whatever reason, pressed the trigger. Pressed the button on me that I didn’t realise was there. And when I think of all the training, the self awareness we do ... Prior to this client, I’ve never thought too much about it. I’m pleased it hasn’t *distressed* me, and I haven’t gone on a diet, but I *did* think about it mind. I *did* think about it.”

Counsellors’ experiences of their own body, and hence their subjective experiencing, can change depending on their feelings towards their own current weight or eating habits (n=2). The impact on the quality of their therapeutic engagement and consequent effect on the client’s experience should be considered in relation to this. Two of the counsellors (C1 and C2) spoke of this shifting perception and although they recognised its potential to affect their client work, neither of them was sure how. C1 was aware that, depending on her own feelings towards her body size, she would feel more or less self-conscious about herself and that “it must be there where I’m there with my clients.”

Similarly, C2, who admitted to a history of yo-yo dieting, felt that:

“It’s different at different times of life depending on where my kind of food journey is. I don’t know whether it has a better or a worse impact, but the impact is definitely different.”

Illustrating the potential for unconscious collusion with a client in relation to positive cultural weight loss discourses, C2 continued to say that “when I’m kind of doing

well on my diet, erm, there's almost like a kind of camaraderie element in the relationship." Conversely, and illustrating a tendency to avoid discussing physical changes, C2 described working with a client during which time she lost three stone. Despite knowing that this amount of weight change would be clearly visible to her client who was trying to gain weight, it was never talked about; "so although it wasn't openly discussed, it was clear to her, and to me."

6.4.2 Positive reactions

C1 was the only counsellor who described a positive experience in relation to her own body when working with clients experiencing eating disorders. Speaking of "an appreciation for the bits of me that are looking good and looking healthy," she experienced an affirmation of her own healthy body in comparison to the unhealthy states of some of those of her clients. However, and despite this positive reaction, the same counsellor, as quoted in section 6.4.1, found her client's weight loss difficult to experience when she was not losing weight of her own.

6.4.3 Identifying with clients' behaviours

Reinforcing the differences between the male and female participants and the possible influence of gendered norms, identification with client behaviours was experienced only by the female counsellors (n=4). Illustrating the potential for over-identification with clients discussed in chapter 4, C1 talked of "identifying some of my own behaviours" in her work with clients experiencing bulimia and binge eating disorder. She could especially relate to "their emotional connection, between emotion and food," recognising that "that's very much the same for me." She was able to use her own experiences in order to gain some understanding of her clients, feeling that:

"my own kind of relationship with food is a microcosm really, of what they're experiencing, and I empathise with that. I eat too much food for emotional reasons."

Although this kind of identification has the potential to enhance empathic understanding through shared behaviours and sociocultural identification, it also risks minimising the severity and complexity of eating disorders in relation to the use of food for satisfying psychological purposes.

Illustrating the overlap between 'normal' eating and the behaviours associated with an eating disorder C2 found that the work sometimes brought her own eating habits into question:

“And sometimes it’s like, you know, moments of when the light bulb’s going on, when somebody says they’ve done something, and I’ve thought, ‘Oh, I’ve done *that!* I didn’t think that that was a problem. Oh my goodness, that *is* a problem’.”

Similarly C5 talked of:

“the fine line between my own comfort eating, maybe eating too much chocolate, too many biscuits when I’m feeling low and hearing clients doing something similar. It does make me think about my own behaviour sometimes. And I guess, now that I’m thinking about it, dieting and restricting my own food. It’s all on a continuum isn’t it?”

The idea of eating behaviours being on a continuum and the distinction between comfort eating, disordered eating and eating disorders was illustrated in chapters one and three. Its implications for therapists, clients and therapeutic work will be discussed in greater detail in chapter eight.

6.4.4 Self-disclosure

As presented in chapter four, the therapist’s body can be considered as a visible form of self-disclosure, especially if it changes during the course of therapy. It was posited that it is helpful for clinicians to acknowledge their weight changes with their clients to ensure that the body does not become a taboo topic within the therapy room. To achieve this, it is beneficial for the therapist to feel a degree of comfort within their own embodied experience as clients may sense their clinician’s unease which may negatively impact the therapeutic relationship. Illustrating a lack of awareness regarding this, the two counsellors (C1 and C5) who talked about losing weight admitted that they had not felt comfortable in talking about it with their clients. For example, C5, who had been dieting whilst working with someone trying to gain weight, described the topic of her reducing body size being “like the pink elephant in the room” which was clearly visible but never discussed. C1 echoed

this, admitting that in her work “we never spoke openly about the fact that I was losing weight.”

Self-disclosure can also involve counsellors sharing relevant elements of their personal experience to clients when it is therapeutically beneficial. Only one of the counsellors (C1) mentioned this, but she said that despite using it regularly with other clients, she would “never” use self-disclosure “with clients around eating or food or anything.” Although never having been diagnosed with an eating disorder, she felt that she had unresolved issues of her own and hence, “[i]t doesn’t feel appropriate because of my own issues with diet and food.” As a consequence, C1 thought that she potentially engaged less fully with clients experiencing eating disorders than she would with others: “I wouldn’t say that I don’t give as much of myself, but maybe there’s something that they potentially miss out on.”

6.5 Counsellors’ own histories in relation to food

Participant interviews indicated that not all of the counsellors had given much consideration to their own relationships with food, eating and their body. They understood the notions of comfort eating and of using food in an unhealthy way, but evidenced little recognition of the interconnection between eating and embodied subjectivity. As discussed in chapter four, effective work with this client group requires the therapist to have achieved a significant degree of self-awareness around their own relationships with food, eating and their body, which appeared lacking within the participants’ interviews.

6.5.1 Research interviews as personal awareness experiences

Despite having some awareness of her personal history, C1 was shocked to realise just how erratic her eating behaviours had been for a significant proportion of her life. Although she had lived with this erratic behaviour for a number of years, she had never reflected on it, nor upon its meaning for her:

“Gosh, that’s shocking. As I’m talking about my own kind of history, I’m kind of thinking that ‘I’ve yo-yo dieted for *eighteen* years.’ That’s just dawned on me. That’s *massive*.”

In contrast, C4, the male counsellor with no history of eating issues and his self-professed “ignorance” towards the subject became aware that he had “probably missed stuff because I’m not sensitised to it. I’m not picking it up.” Although I failed to enquire during the interview, it could be questioned as to whether this ignorance in part was due to the counsellor considering eating disorders as female conditions, as much of the literature suggests. Due to his own relaxed attitude towards food, he had had no reason to reflect on his relationships with eating and his body and hence was not aware of the significance of these on an individual’s subjectivity and experiencing.

C3 began to realise during the interview just how out of touch she was with her own body and its physiological needs and signals. Describing often going all day without food or water, she had no appreciation of how this might impact her therapeutic effectiveness and sense of wellbeing. She also commented; “I’ve just realised as I’m talking now, that I do, I do deliberately not eat.” Having limited understanding of the effects of inadequate nourishment either towards oneself as a counsellor or towards clients has the potential to negatively impact on therapeutic engagement and thus outcome. The counsellor’s disconnection from her own embodied experience is also likely to make it difficult for her to enable clients to connect to theirs’.

As discussed in chapter three, the relationships which people develop with food, eating and their body begins at birth, and yet the person-centred counsellors interviewed had little awareness of this. This could potentially have a detrimental effect on their understanding of their clients’ issues and relating style in the therapeutic relationship. For C3, the interview was the first time that she had explored how both her family of origin and her current family affected how she viewed food and of the emotional significance of various family food rituals. She suddenly appreciated the significance of the Kit-Kat her husband had bought their daughters every Sunday morning when one daughter’s relationship broke down:

“Her dad bought her a Kit-Kat, without really thinking about it, and she cried, and cried and cried. And she said, ‘I’ve missed this’.”

C3 also recalled her own emotionally charged memories of childhood; her mum making soup, the men in her family being fed first and receiving the meat and other luxuries whilst the women and girls got the leftovers. During the interview she was

able to begin recognising the deeper messages implied by these behaviours regarding her own, and other peoples' places in the family. From this she began to make deeper links with the patriarchal and gendered societal discourses discussed in chapter two, which fed in to this, not only for her own family, but also potentially for clients.

Three of the five counsellors were surprised to realise how significant the role of food is in establishing a person's identity and way of being in the world. This is an important consideration when helping a client to understand how food has influenced their history and development of their sense of self as it helps them understand the power of external sociocultural discourses on identity and embodiment. The counsellors' responses also illustrate how such discourses are typically internalised without question. C4, who had not previously given this any thought said; "It is all connected isn't it? You tend not to think about it." C3, recognising the symbolism inherent in an individuals' relationship with food and eating commented; "so it's not only food. It *is* about how food relates to a lot of things in life. It's not just a separate thing." She went on to say that it was only through the experience of the research interview that she had stopped to think about this: "I'm learning that through this discussion, because it's about how much it impacts, on everything." This experience was echoed by C5 who commented that "I don't think a lot of people are aware of, until you really start to look at it, like we have today, you don't question it at all."

Having considered the effects on the person-centred counsellors' understanding of their own relationships with food, eating and their bodies, the findings below turn to their thoughts regarding the physical bodies within the room.

6.6 The physical bodies in the room

The physical bodies within the therapy room were not afforded much attention by the person-centred counsellors and hence it would seem that they lacked awareness of the inseparable nature of self and body. During the research interviews however, both my body and those of the participants were often brought into the discussion. Three of the female counsellors (C1, C3 and C5) made positive comments in relation to my body (n=3). As a relatively tall, slim, 'socially acceptable' size 10 female it is interesting to reflect if the counsellors would have

felt as comfortable talking about my body if it had been significantly smaller or larger.

6.6.1 The client's body

Despite their visible physical presence, the two bodies in the therapy room elicited very limited comment with only 2 counsellors mentioning them (C4 and C5). When specifically asked to reflect on how they viewed the physical bodies of clients, C5 commented that "I notice it, and I kind of put it to one side" suggesting a dualist approach and privileging of the mind, mirroring the disembodied nature of western society as discussed in chapter 2. C4 similarly said; "I kind of see them, in front of me and whatever their body shape, and then, I suppose I'm waiting for the, the erm, the verbal component of the relationship." As was evident within chapters three and four, and will be discussed in chapter eight, clients' bodies are potentially useful sources of therapeutic information and yet this was not alluded to by any of the person-centred counsellors.

When questioned further about the body size of his clients, C4 reflected; "I think I notice big people more. Don't know why that is. So yes, I'm aware of it, but it, it doesn't feel like that massively colours the way that I approach things." It would seem pertinent to question if this was true, or if this was an example of the counsellor having not explored in depth his attitudes and beliefs around body size or the ways in which body size is related to subjectivity. From this, the discussion led to the idea of clients possibly communicating something through the size of their body, an idea that this counsellor said that he had not given any previous thought to.

6.6.2 The counsellor's body

When the idea of clients observing their counsellor's body was introduced into the interview discussion, C1 said that she had "never thought of that. That would make me paranoid!" Not only does this quote illustrate the counsellor's potential discomfort at the thought of clients looking at her body, but it highlights a lack of knowledge around the tendency of clients to scrutinise other peoples' bodies.

As posited in chapter four, when working with individuals experiencing eating disorders, it is helpful if counsellors convey an accepting attitude towards their own body. Without this, there is potential to introduce incongruence into the therapeutic relationship. Graphically illustrating this point C1 became increasingly conscious during the interview of her embodied discomfort and postural changes when working with clients experiencing anorexia:

“I probably try to hold myself, in a way that looks a bit thinner if I’m working with a client, who’s erm, anorexic. I don’t know; maybe I do, maybe I don’t. Yeah, no, I probably do. Not consciously, but now I’m thinking about it. And, er, maybe my posture would change, where I position the cushion might be, er, (demonstrates moving the cushion from behind where she is sitting to holding it in front of her stomach) a little bit different.”

This is a powerful illustration of both the counsellor’s lack of awareness around this prior to the interview, as well as her lack of consideration as to how her behaviours could impact on the therapy and the client’s relationship with the therapist’s body.

Due to its visibility, the counsellor’s body can be a useful tool within the therapy, but its inclusion has the potential to cause discomfort for the therapist who does not enjoy a comfortable sense of personal embodiment. C2 described “us[ing] myself as a vehicle to work through that” but admitted that “sometimes it’s really difficult for me.” As introduced in chapter four, clients will potentially sense their therapist’s unease and this can cause conscious or unconscious ruptures in the therapeutic relationship. Therapeutic success with clients presenting with eating disorders is notoriously low and it could be conjectured that these types of rupture may be one of the contributing elements.

6.6.3 Lack of somatic experiencing

As evidenced within chapters three and four, the therapist’s somatic experience within the therapeutic relationship can be helpful in understanding client experiences. None of the person-centred counsellors described any somatic experiencing in relation to their clients. For example, C1, when asked about this said “no, I don’t sort of experience physiological sensations or anything.”

Having presented the ways in which eating disordered clients can affect counsellors' experiences within the therapy room and their own personal relationships with food, eating and their body, the findings below turn towards a presentation of professional practice considerations in relation to the work.

6.7 Professional practice Issues

To support their therapeutic work, counsellors typically engage in ongoing training, self-awareness work and clinical supervision. Section 6.7 comprises of the person-centred counsellors' findings in relation to these areas.

6.7.1 The importance of training

C1, the only counsellor who had attended any workshops relating to eating disorders, felt that specific knowledge in relation to the conditions was necessary for all counsellors and should be "compulsory in training." Without it, she suggested that counsellors could be "negligent" or "at worst, potentially abusive" when working with clients experiencing eating disorders. Highlighting the prevalence of eating issues within current western society, she stated that "it doesn't matter what client group you work with, you're going to meet people whose relationship with food is disordered at the least." She also felt that "as a profession, we need to be much more honest about it," feeling that there isn't "enough honesty among colleagues about their clients' impact upon themselves and vice versa when it comes to food."

C2 too, recognised the lack of training around eating disorders in counsellor training and wondered if that was because:

"people are kind of frightened when you start doing training around eating disorders stuff that it does raise up issues for people who have never considered themselves, or who don't have an eating disorder, but it does still flag up issues, or you know, weird habits that we all have around food and eating."

Both C1 and C2 discussed the importance of counsellors engaging in personal development work around the issues so that they had an understanding of their own relationships with food, eating and their bodies.

6.7.2 Gaps in knowledge

Although the person-centred counsellors had some appreciation of the emotional and psychological component of eating disorders they were still sometimes overly influenced by the aesthetic element of the client's physical body. This could be viewed as a lack of knowledge around eating disorders, but also as a deeper reflection on their own personal beliefs around the role of the body in society. The following quote illustrates both C4's perception of eating disorders as being related to the client's body size and his lack of awareness regarding the symbolic element of the disorders:

“Some of the people that I've talked to about being bulimic, erm, I've often been sort of mystified, because I'm thinking, 'you're not really, really big, you're not really, really small.’”

In a similar way, C1 said, “I have the kind of urge to say, ‘Oh sweetheart, you are so beautiful, just as you are. You are stunning. Can you not see this?’” She then went on to discuss her deep sense of “sadness” that the client could not. This suggests that the counsellor was focusing on the client's aesthetic body and yet she also talked about “never weighing people” and knowing to “not focus on their weight.” Arguably, this indicates some unconscious contradiction within the counsellor which could have negative consequences for the therapy.

As discussed in chapter three, many individuals experiencing eating disorders tend to minimise or not recognise the severity of their condition. Wanting to acquire the idealised western image, they present a façade of perfectionism and being in control, when their inner reality is often very different. Therapists who are not aware of this, or of the ways in which the physiological effects of eating disordered behaviours can affect clients' ability to engage, may inadvertently limit the effectiveness of the therapeutic relationship. Illustrating this, C1 talked of viewing clients experiencing anorexia differently than she does those with other mental illnesses and of potentially over-estimating their psychological wellbeing:

“We talk about anorexia as being a ‘mental illness’ like depression, but unlike people who are suffering mental illness in other ways, they're often, you know, these clients are incredibly lucid. They're very smart people, and so for me, there's probably a difference in how I relate to them. So I guess that although

they might have a diagnosed mental health problem, erm, I think that their capacity is often, their capacity to function is a hell of a lot better than maybe some of the clients that I work with with schizophrenia or psychosis or depression.”

6.7.3 Use of supervision

All five of the person-centred counsellors engaged in regular clinical supervision as part of their practice and on-going professional registration requirements. As presented in chapter four, supervision is the space where counsellors can discuss their client work and any impact it may be having on them personally. For effective supervision, the counsellor needs to feel supported by their supervisor and able to talk openly about themselves and their work. All of the counsellors were aware of this and recognised its value and importance for themselves as practitioners. However, three of them (C1, C2, C5) spoke of a reluctance to discuss their own issues around food and their body within supervision. C2 believed that this was partly as a result of “shame” and not wanting to “admit to having a problem around food.” C5 felt that “as a counsellor, having a problem with my body and how I look feels very shallow” and therefore could not be disclosed. These quotes also indicate a lack of understanding around eating disorders and their being simply about how the individual wants to look.

C1 agreed that supervision was “vital” and necessary in “being able to reflect upon yourself.” However, she also recognised the impact of her supervisor’s gender and body size on how much she was prepared to disclose during supervision:

“I’ve taken it [issues related to eating or weight] to my supervisor more when I’ve had a male supervisor than when I’ve had a female supervisor. I think, that’s probably to do with the shame about talking to another woman about being kind of overweight.”

6.8 Conclusion

From talking to this group of non-specialist, person-centred counsellors and from anecdotal evidence from workshops and training events I have facilitated, there appear to be gaps in both knowledge and self-awareness related to the eating

disordered experiences. These gaps have the potential to detrimentally affect the therapy leading to frustrating experiences for both counsellor and client.

As will be illustrated in the following chapter, the specialist therapists' experiences confirmed how significant these knowledge gaps were in terms of both therapist and client experience of the therapeutic encounter. All of the non-specialist counsellors interviewed worked from a person-centred perspective and it would appear that this may have implications for both client and therapist experience, which will be discussed in chapter eight.

In the following chapter, the findings from the interviews conducted with a range of specialist therapists will be presented.

Chapter 7

Findings from the Specialist Therapists

7.1 Introduction

Within this chapter, the findings from the interviews with the specialist therapists will be presented. The title 'specialist therapist' or simply 'therapist' is used to acknowledge the more varied therapeutic approaches employed by the practitioners interviewed. Two of the thirteen (15%) specialist therapists were males, but in contrast to the person-centred counsellors, the experiences described by the male therapists were not significantly different from those of the females. Throughout the chapter the identity tag Tx is used to attribute the quotes to the relevant therapist. The corresponding therapist details can be found within table 5.2 on page 147 within the methodology chapter. As in the previous chapter, the use of italics within the quotes illustrates the therapists' emphases within their speech.

Presentation of the findings from the specialist therapists begins on the following page with table 7.1, in which the main themes and sub-themes which emerged from the findings are summarised. Many of the themes mirror those of the person-centred counsellors, although as will become evident, some of the meanings attributed to the feelings and themes differ. The implications of these will be discussed in chapter eight. Three additional themes emerged from the interviews with this group of therapists; therapists with an eating disordered history, the differing experiences of the different eating disordered presentations and somatic experiencing. None of the person-centred counsellors described having a history of eating disorders compared to four of the specialist therapists who disclosed their own former diagnoses. The other two themes may emerge from a combination of the additional experience and knowledge of the specialist therapists and their differing therapeutic approaches.

Table 7.1 Themes arising from the specialist therapists

Main theme	Sub theme	Chapter section
Feelings elicited by client work		7.2
	Fascinating	7.2.1
	Interesting	7.2.2
	Enjoyable	7.2.3
	Challenging	7.2.4
	Frustration	7.2.5
	Feelings initiated by sociocultural influences	7.2.6
	Anxiety	7.2.7
	Challenging the therapist's sense of their ability (inadequacy)	7.2.8
	A sense of reward	7.2.9
Feelings experienced in relation to the different eating disordered presentations		7.3
	Anorexic clients	7.3.1
	Bulimic clients	7.3.2
	Obese clients	7.3.3
Therapists' experiences in relation to their own bodies and eating behaviours		7.4
Self-awareness in relation to therapists' own personal histories and relationships with food, eating and their bodies		7.5
	Therapists with an eating disordered history	7.5.1
	The need for therapist reflection on their own relationships	7.5.2
The bodies in the therapy room		7.6
	As communication aides	7.6.1

Embodied countertransference or somatic experiencing	Feeling hungry	7.7 7.7.1
	Clients' projections into the therapy setting	7.7.2
Professional practice issues		7.8
	Importance of clinical supervision	7.8.1
	The need for training and self-awareness	7.8.2
	Importance of understanding the disorders	7.8.3
	The need for therapeutic flexibility; integrative working	7.8.4

The themes summarised in the table above will be illustrated throughout this chapter with verbatim narrative quotes from the therapists' interviews. The most common adjectives used by the interviewees to describe work with this client group were "fascinating," "interesting", "enjoyable", "challenging", "rewarding" and "frustrating". Illustrating the significance of researching the specific effects of working with clients experiencing eating disorders T7 stated that "[t]here is a huge difference between eating disordered clients and those of other presentations."

7.2 Feelings experienced by the specialist therapists

Using verbatim quotes from the specialist therapists' research interviews, section 7.2 depicts the first main theme which emerged; 'feelings elicited by client work'. A range of feelings were described, including frustration, fear, anxiety and self-doubt; all of which are presented below. Illustrating this array of affects and the changing nature of these, T7 describes:

"feel[ing] mostly love and compassion, but sometimes, bitter frustration. Sometimes I can come out of a session and just feel exhausted. And sometimes I can feel elated. It runs the whole gamut of emotions."

As a result of both the intensity of these feelings and their awareness of the unique attributes of eating disorders, the therapists were in general agreement (n=13) that this client group presented both personal and professional challenges.

Recognising these, T6 discussed the balance to be held when working with clients presenting with eating disorders:

“I’ve got to be on my toes all of the time, and at the same time, being relaxed and accepting, not coming too close too quickly, and accepting the countertransference until that person is ready to come towards me a little bit.”

However, by accepting these challenges and working through them, therapists (n=3) recognised that a strong sense of reward could be enjoyed. Illustrating this, T7 stated that:

“I think, narcissistically, it’s the reward out of the work that makes it tolerable in the long run, because it can be a really long haul, and sometimes very frustrating and disheartening at times ... I find it terribly challenging at times.”

In a similar vein, T6 said that she “love[d] the work, but I find it very difficult. It’s very challenging.” Echoing this, T4 said that “I love it and it’s deeply challenging; in probably equal measures.”

Experiencing such a continual sense of challenge introduces ethical implications for ensuring that therapists practice within manageable caseloads. Recognising this, T5, who worked in private practice alongside her work in a specialist eating disorders’ clinic, admitted limiting the number of clients experiencing eating disorders she saw “because it’s super-intensive work.” Similarly, acknowledging the increased challenge which results from working with more severely ill clients, T8 described how she “will limit those clients in my caseload.” T6 who was nearing retirement age said that “because it’s such demanding work that is the work I’ll give up first.”

7.2.1 Frustration

Frustration, in various guises, was a feeling voiced by all of the specialist therapists (n=13) and was mentioned most specifically in relation to clients with anorexia;

specific frustrations which will be presented in section 7.3.1 below. The various forms of frustration related to concepts discussed in chapter three including the challenge inherent in enabling clients experiencing eating disorders to engage in therapy, the typically slow progress of the work and clients' difficulties in acknowledging the physical dangers afforded by their condition. Highlighting the strength of this frustration, T7 described it as a "bitter frustration" whilst T1 described feeling "frustrated, er, tearfully, almost with them." T4 was able to distinguish that his frustration was experienced in relation to the eating disorder rather than towards the client herself, saying that "I can get *really* frustrated with the eating disorder."

Recognising the frustration that the necessarily slow pace of the work can evoke, T6 described "know[ing] I'll be in for a challenge. You need to be patient. It's not an issue that can be resolved in a short number of sessions." In a similar vein, T12 described the "sheer tediousness" of the work, which often led to her feeling "slight shame, because you know, you're tired of it."

The tendency of individuals experiencing eating disorders to maintain a sense of detachment from the well-being of their physical bodies was recognised as another source of frustration. Through this disconnection clients can deny or minimise the physical complications of their behaviours leaving the therapist feeling concerned about their physical well-being in a way not often experienced with other presenting issues. As self-efficacy around physical well-being is a significant element of recovery, one therapist (T7) voiced that "it can be so frustrating to try to get them to take responsibility for their physical health." T1 echoed this, talking about the "frustration that you've told them about the health implications, but they can still justify or minimise their behaviour."

A further frustration arises from clients' tendencies to dissociate from their feelings and project them onto their therapist. Using psychodynamic theory, T1 talked about "those clients who can't manage their physical health and they split it off; give it to you" which can prove frustrating for the therapist who feels a sense of responsibility for their client's physical health.

7.2.2 Feelings initiated by sociocultural influences

Therapists also discussed their frustration and sense of conflict in relation to images in the media and culturally prescribed body ideals (n= 4). They described the unconscious adoption of these influences and the difficulty inherent in bringing these into conscious awareness for both themselves and their clients. They were also aware of the difficulty in determining the boundaries between healthy eating behaviours and disordered practices, and of trying to promote recovery against the backdrop of Western culture where thinness, control and perfection is admired and rewarded. T10 described the media as a “toxic environment which reinforces what their disordered eating thoughts are telling them” whilst T12 found that working with clients experiencing eating disorders had made her feel “angry about the pressures on young women to look a certain way.”

Implying an assumption that cultural aesthetic pressures affect only females, T4 discussed the tendency of women in general to unquestioningly adopt the sociocultural discourses regarding body shape and size and the ubiquitous nature of this practice, stating that:

“It doesn’t even cross their mind. And I don’t think that’s an eating disorder thing. I think that’s just a cultural thing placed on women of that age.”

In recognition of the inseparability of self and culture T4 said; “I know that it’s ridiculous that culture should dictate how I look, but there’s a part of me that still buys into it.” Further illustrating how therapists are subject to the same cultural pressures as clients, T7 admitted that “it’s very difficult to get away from that kind of self-scrutiny.” Similarly, T7 acknowledged the impossibility of therapists stepping outside of these cultural influences when she said; “I’m female, I live in the UK in the twenty-first century, I’m body conscious. You can’t not be.” She went on to say how important it is that therapists are able to determine “when they are engaging in healthy self-checking or when does it become detrimental to one’s self-image?” Recognising the unconscious introjection of sociocultural influences on therapists and the benefit of bringing these into conscious awareness, T10 described how the work “causes you to look at cultural ideals you’ve subconsciously adopted.” She talked of the importance of “address[ing] what difficulties you might have with that, which have been sort of unknown, because they’ve just been unconsciously adopted.” As will be made explicit in chapter eight, such unconscious beliefs can negatively impact therapeutic engagement and affect the experiences of both client and therapist.

In the same way that being subjected to thin images in the media normalises the slim body, seeing a lot of anorexic bodies within a clinic can begin to influence the therapist's perception of a 'normal' sized body. Talking about working in a clinic setting where a lot of patients are underweight, T10 felt that the work created a "skewed vision of body image." She then discussed the importance of effective peer support, supervision and self-awareness in managing or challenging this influence.

7.2.3 Anxiety

Anxiety was commonly felt, regardless of the number of years a therapist had been working with clients experiencing eating disorders. The feeling tended to be experienced mostly in relation to clients' physiological well-being, with the therapists' ultimate fear being of a client dying during the course of their therapy. As evidenced in chapters three and four, the physical consequences of eating disorders add an additional element for therapists to take into consideration, in a way unique from most other psychological conditions. Due to their work place environments, the specialist therapists tended to come into contact with clients at the more severe end of the eating disorders' spectrum and hence needed to be acutely conscious of clients' physiological health. Clients experiencing anorexia evoked the highest levels of fear and anxiety within therapists. These particular fears will be presented below in section 7.3.1.

All of the specialist therapists were vocal in the importance of working closely with medical professionals, especially when clients were either severely underweight or experiencing physiological symptoms. Regarding the medical complications that can arise within eating disorders, T12 admitted that "sometimes it is a little bit scary" and talked about the difficulties of "containing my own anxiety about their well-being." She also described it being "so easy to feel at a loss when people are so desperately ill." Similarly, T10, describing her clients' poor physical health and recognising the interplay with their psychological problems, said that:

"I think it does frighten a lot of people. I think it's because of the sort of psychological difficulties, along with the physical dangers, which cause a lot of anxiety, I think, to professionals."

Psychological therapists who are typically not medically trained can find the physiological effects of eating disorders particularly anxiety provoking, especially when they fear a client dying during their work together. Illustrating this, T1 described working with a client at a very low weight and of feeling “frightened of the client’s ill health” and experiencing a “fear of this girl dropping dead in front of me.” Highlighting the need for therapists to acknowledge their anxieties and not simply deny them, she was concurrently aware of the need to ensure that she connected with that fear so as to remain alert to any worsening medical consequences.

T2 talked of working with a severely underweight client with an impulse to exercise excessively. The therapist was aware of needing to convey unconditional positive regard towards the client and acceptance of her behaviours, whilst balancing this against the client’s physiological and psychological fragility, and also his own professional ethics and organisational boundaries. He talked about the “huge anxiety” and “fear” he felt for both the client and for himself, and knew that he was only able to safely take such a risk due to his accumulated experience, knowledge and the relationship he had built with the client.

Acknowledging that anxiety is experienced not only in relation to clients’ physical well-being but also in relation to the therapist’s own professional conduct and reputation, T2 clarified that his biggest fear is “that somebody would die” and as a result “I could be seen to be negligent.” He admitted that “my own anxiety levels have been through the ceiling” when working with clients at extreme low weights. He then went on to talk about the need to balance the confidentiality of the therapeutic relationship with the client’s safety, whilst also being mindful of organisational policies and professional ethics.

Anxiety can also be evoked in therapists as result of the expectations of clients and other people involved in their care. For some therapists it would appear that this can be a difficult experience to overcome. T7 described herself as having been “a nervous therapist for years” when she first began working with the client group. She said that she found the work “daunting” as a result of the “high expectations” placed on therapists by clients’ families and other health professionals. It also generated within her a sense of inadequacy and she found herself questioning, “[a]m I really good enough to work here?” As will be presented in section 7.2.4, this

client group can induce a sense of helplessness and doubt (n=4) even within experienced therapists.

7.2.4 Challenging the therapist's sense of their ability

Illustrating how the therapist's subjectivity can be influenced by their engagement with clients, T1 voiced powerfully how individuals experiencing eating disorders "can make you feel like shit, and they can make you feel like you're hopeless."

The time-consuming nature of the work can cause therapists to doubt both themselves and therapy as an effective intervention. T7 said that "sometimes I can feel like I'm no good. I'm not sure if we're doing anything worthwhile and I'm questioning if I'm any use at all." She also spoke of dreaming about her clients and described waking up with a "guilty feeling" from her "internal supervisor" and questioning "what should I have been doing different?" T13 described "the hopelessness of it" and talked of finding herself "losing faith really that it can change; questioning therapy as a sufficient enough tool."

In an illustration of the feelings often projected onto therapists within this work, T1 interpreted some of the helplessness she experienced as belonging to the client and their families or other professionals involved in their care. She explained how they "can feel quite helpless" and then described how, through the psychodynamic concept of projective identification, "that seems to be projected onto you." She recounted being "on the receiving end of expectations from the client or their family to *do* something to cure the eating disorder." Unless the therapist has accepted that they cannot fulfil this role, it may lead to them feeling helpless or to colluding with these others or with the disorder itself.

To protect themselves from this, therapists recognised the need to have a sufficiently robust sense of self to ensure that clients' projections did not negatively impact on their own subjectivity (n=3). T3 stated that "you've really got to have formulated for yourself, before you start working with eating disorders, a very good protective shield." T1 felt that "you've got to be, quite robust, a real, I think you've got to have a real sense of who you are." T4 concurred with this whilst also recognising that, without this solidity, "the edge between what's mine and yours gets kind of blurry."

7.2.5 Rewarding

Despite the challenges however, therapists who choose to specialise in working with clients experiencing eating disorders find it rewarding and enjoyable. Seven of the thirteen therapists interviewed used the word “rewarding” in relation to their work. T8 described “an ever fascinating set of clients to work with” as “very rewarding.” Both T4 and T6 voiced their “love” for their work and T2 and T10 described working with this client group as “enjoyable.”

T1 explained this sense of reward in more detail by describing the satisfaction experienced from establishing a relationship in which clients can begin to discover themselves and rewrite their personal narrative:

“There’s a real sense of building up a trust, a relationship, and I think that’s what’s rewarding about it as well ... and to see that they leave with some sense of who they are.”

T2 echoed this with his “sense of pride when you see some of them doing things they could do before they were ill.” Similarly, T7 found it “amazingly rewarding” to see clients “discovering themselves and learning to live freely.”

These quotes also illustrate the therapists’ understanding of eating disorders developing as a consequence of a poorly established self and of effective therapy enabling the client to repair historic attachment and separation issues and to begin establishing their process of individuation, or rewriting their personal self-narrative.

7.3 Feelings experienced in relation to the different eating disordered presentations

The discussion in section 7.2 related to therapists’ experiences of clients presenting with eating disorders as a homogenous group. During the course of the research it became evident that the various eating disorder presentations provided different experiences for therapists. This will be illustrated in section 7.3 where the experiences and feelings relating specifically to clients experiencing anorexia, bulimia and binge eating disorders are described. Prior to this though, the words of three therapists recounting their differing experiences in relation to the presentation

of the different diagnoses are presented. These quotes also depict the symbolic mirroring of clients' body sizes with their subjective experiencing and ways of relating to the world, including the therapeutic environment.

Talking about clients with anorexia and bulimia, T4 felt that the client groups:

“are psychologically, very different groups on the whole, and my kind of, interpersonal relationship with them feels very different.”

He went on to say that he found it:

“easier to really, empathise with the anorexics and their struggle. Erm, I find I have more patience with them. at the moment, I find myself being quite irritated with, not all the time, but having moments of feeling irritated with the kind of, slight mania that can go with bulimic clients. I have less patience with them.”

T10 described how differently clients with anorexia and bulimia can be experienced in terms of discussing their issues. She reflected that:

“somebody with bulimia does tend to have an outpouring; almost a vomiting of the feelings. And somebody with anorexia is much more restrictive in how they communicate.”

Conversely, T5 describes experiencing a similar difficulty across the client groups, feeling that their atypical body size hides the person underneath:

“I find it can be hard to warm to people when they're too fat or too thin. It's hard to see the person. People are sort of hiding themselves and are letting themselves disappear. I struggle to find their sense of self with which to connect.”

7.3.1 Clients experiencing anorexia

Clients experiencing anorexia evoked very powerful and visceral feelings within the specialist therapists no matter how much experience they had accumulated. Frustration, fear and anxiety were the most common of these experiences. As previously discussed in section 7.2.3, the fear and anxiety were experienced particularly in relation to the health risks inherent within clients of extreme low

weight. The frustration was also apparent in terms of the difficulty therapists experienced in acquiring a sense of therapeutic engagement with their client.

7.3.1.1 Anxiety

The following quote is from T7, a therapist with 22 years' experience of working with clients experiencing eating disorders:

"There's something *viscerally painful* that people experience sitting in the room with somebody that's severely underweight and that, that *never* goes away. I think that's such a gut reaction and I think it's what can make people feel so nervous working with individuals with anorexia. The condition, the pain, is so visible ... and it *is painful*."

Highlighting the physiological risks of working with anorexic clients, T6 said:

"Severely anorexic clients look so fragile, and that always moves me. They really are on the point of death, and so I have that in my mind, which adds to the, sometimes my anxiety, and sometimes, my sense of motivation as well."

Illustrating not only anxiety, but a sense of clients' projecting their need for control onto the therapist and how this is experienced, T13 describes:

"I sense a sort of internal objection. I don't like the control, that level of control feels too punitive. And I feel very controlled as a therapist. I feel very, I feel I have to be as measured and as careful, and as, erm, not as spontaneous, not as flowing, not as abandoned, symbolically. I need to be much more careful. I'm walking on eggshells, and it's like that; small portions of interventions."

7.3.1.2 Responsibility

Two of the therapists described feeling a greater sense of responsibility in relation to clients presenting with anorexia. T4 found himself "wanting to nurture anorexic clients" and of feeling a "paternal kind of countertransference" which made him "want to make it okay." T8 described experiencing a sense of responsibility which "isn't there when working with somebody who's extremely obese." Illustrating their

psychodynamic understanding of eating disorders, both therapists interpreted these feelings as a client projection borne out of their avoidance of self-responsibility.

7.3.1.3 Frustration

When seeing the visibly thin client standing at their door, therapists describe being immediately aware, at an embodied level, that this client will be therapeutically challenging. Very few other presentations are so visible, hence the immediate visceral reaction often experienced. The following quote from T5 illustrates the therapist's reaction as she reads the client's symbolic body and recognises the inherent difficulties of the presentation:

“When I open the door to someone with anorexia, my heart sinks really ... I feel that sense of frustration and disconnection, and I know that it's going to be hard to get anything out of this person.”

Similarly, and also highlighting the unique nature of this client presentation, she went on to say that “anorexic people on my doorstep are the *only* people who make my heart sink. I don't get that with *anybody* else.” This was due to the frustration she felt (quoted above) in relation to their disengagement from their feelings which led to her experiencing some clients as “simplistic” and “boring.” She also described this disconnection resulting in clients having “a cold feeling” which left her personally “feeling cold.”

Recognising the role of attachment patterns and narratives in the frustration of establishing the therapeutic relationship, T6 described a similar experience:

“I experience more frustration with anorexics than I do with the other groups. Intellectually, I understand the attachment issues, but it's still frustrating to work with. Those avoidant attachment patterns make it very difficult to establish a therapy relationship. I'm also aware that they are avoiding their own discomfort from the underlying issues and are prepared to engage in life-threatening behaviours to avoid these.”

Further illustrating this, T10 recognised that “someone with anorexia is much more restrictive in how they communicate” and T6 described this as making her feel “very kept out.”

T12 described as “profoundly depressing” the tendencies of clients with anorexia to use their willpower “so destructively against herself when it could be directed into something positive out in the world.” She described the difficulty in “being able to respect the anorexic’s deadness and lack of energy as her way of surviving,” and admitted that “that can be frustrating when it’s something you feel like *not* respecting.”

Evidencing the physiological effects of low weight on an individual’s cognitive ability and the frustrations which this can cause for the therapist, T5 described:

“with anorexia, the black and white thinking can be very difficult for me to work with, because you know if they’re at a very low weight, their thinking will get simplified, and it’s like banging your head off a brick wall really trying to get them to connect with anything you know, psychological minded.”

7.3.2 Clients experiencing bulimia

In contrast to working with clients experiencing anorexia, T5 recognised that “with bulimia, there tends to be much more to get hold of” in terms of feelings and engagement in therapy.

Applying the psychodynamic concept of projective identification discussed in chapters three and four, T6 claimed that therapists can find themselves experiencing the emotions and issues which clients are denying within themselves. She recognised how psychologically draining this can be and limited her work for this reason, saying that; “I can’t imagine working full time to the degree of intensity and having to process and digest so much material.” T6 believed that symbolically, clients experiencing bulimia struggle to process their own emotional material, wanting instead to simply purge their feelings as they do with food. T10 described a similar process in which clients leave their therapists with their psychological material to digest, using therapy as “a dumping ground” for their feelings (T10).

In a similar vein T6 described her work with one particular client as “having come back to me from time to time.” Unable to process, digest and assimilate the emotions and issues for herself, the therapist interpreted that the client had projected them onto her. In an example of parallel processing the therapist had

then struggled to digest and process them for herself, finding the client coming back to her, in a process symbolic of the client's purging.

The following lengthier quote from T6 powerfully describes the client's use of therapy, their relating style and how their feelings can be projected onto the therapist. It also illustrates how the therapeutic relationship can affect the therapist's subjective and embodied experience.

"I get quite a strong reaction there. I can actually feel quite sick with a difficult session. And the way I've understood it, is that, my clients manage their relationships through projection and I get so much projected onto me, into my body and mind, that the only way I can manage that within the session, is to actually begin to feel a bit queasy. It's a very powerful feeling. Actually wanting to spit something out; something really difficult and toxic that's been projected into me. And the only way to be rid of it, at the time, is my body wants to spit it out. That can be enormously powerful and it can stay with me for quite some time."

7.3.3 Obese clients (binge eating disorder)

Recognising both the symbolic meaning of the body and the difficulty encountered in engaging with clients experiencing binge eating disorder who present in an obese body, T6 found that "[i]t can be difficult to find the client beneath the fat." She also described the difficulty such clients can experience in relating to other people, and hence engaging within the therapeutic relationship:

"I find them quite hard to work with initially, because the relationship is with the food, rather than the person. They're quite impervious. On the surface, they're working with you, but actually, nothing gets past that, because turning to food is the great comfort; it's the main relationship."

Further illustrating the tendencies of people experiencing eating disorders to turn to food rather than people, T5 recognised that "I know that what I'm going to be working on with them is really how they use food instead of people with their feelings." Similarly, T13, talking about her work with an overweight client engaging in compulsive eating, described it as "having to get through layers; layers of literal layers in order to feel the inside." T5 was the only one of the therapists interviewed

who made reference to obesity in the negative way in which it is often referred to culturally, saying that, “obesity is quite repulsive and it’s hard to get over that.”

From the above, it is evident that each of the eating disorders has a unique presentation in the therapy room resulting in different experiences for therapists. There is also an acknowledgement that although on the surface, food appears to be the main difficulty, the true problem lies with the clients’ sense of themselves and how they relate to others in the world.

Having described how the therapists interviewed experienced their clients, sections 7.4 and 7.5 show how clinicians’ own eating behaviours and understandings of their relationships with food, eating and their body can be affected.

7.4 Changes to therapists’ eating and weight related behaviours

The experiences presented below illustrate how therapists can be affected in different ways by their work. The quotes in section 7.4, and in much of section 7.5, are from therapists who had not experienced any difficulties with food and eating before working with the client group (n=9). Findings specific to the four therapists who admitted to an eating disordered history are presented in section 7.5.1, although it should be noted that at the time of interview, all four remained in recovery. The experiences depicted in this section illustrate how therapists’ selves, bodies and behaviours can be influenced by the therapeutic relationship.

T2 described how his early days of working with clients with eating disorders had affected him and his eating:

“As I became more immersed in the misery itself, I think I over-identified. I wasn’t actively restricting my eating but I was watching *what* I was eating. I just inadvertently, somehow found myself, and my weight went down, and down, and down. And I found myself then, I was frankly underweight, and it intrigued me.”

The long-lasting effect of working with this client group is apparent in T2's admission that even after 17 years' of experience within the service; "I'm always conscious of my weight and how I am in the room."

Two female therapists (T13 and T9) described how the work increased their self-consciousness regarding their own weight. They also admitted to wondering what clients might think should their weight change during the course of therapy. T13 described how she "became very conscious of my, erm, comfort eating." She went on to say, "I became more conscious about, er, more self-conscious about putting on weight." Similarly, T9 described becoming more aware of clients seeing her gain or lose weight over the course of their treatment. She described an experience of working with weight loss groups and of being left with "two voices in my head; one of which is trying to reassure myself that I'm okay, and the other one is beating me up because of my weight gain." She admitted that before she started the group work, she had been happy with her own weight, but engaging with overweight people who were deliberately losing weight had caused her to begin questioning her own body size.

In contrast, and highlighting the difficulty inherent in generalising from subjective experiences, T6, who claimed to have always enjoyed an unproblematic relationship with food, felt that the work had had no impact on her eating behaviours: "I don't think it's changed my relationship with food, which I love!"

Suggesting how complicated an individual's relationship with food can be, T1 gave conflicting information throughout her interview. She stated that "it hasn't made me eat differently" and yet earlier in the interview had talked about gaining weight when she first began working in the service as "I was probably bringing more food in." Perhaps signifying an area for personal development, she also recognised that "since coming here, I've started to weigh myself more; I don't know what that's about."

T12 described always eating cakes after her work with a group of clients experiencing anorexia; "I'm not a cakey person at all, but my colleague and I, we always used to go and get a cake from the RVS shop, and have a cake after our group." Illustrating the use of food and drink as emotional and physical replenishment or self-nurturance, she also reflected that "with all patients, I have a

cup of tea afterwards. There's probably some kind of need to replenish yourself, isn't there?"

It also became evident how the feelings evoked by clients can change throughout the course of therapy. T13 described quite complicated feelings in relation to her work with an overweight client who binge ate, which at times led to uncharacteristic bingeing by the therapist:

"[the client] evoked a countertransference, that was kind of a conflict between, erm, repulsion is too strong, but something of that on the one hand and very deep attraction to who she is on the other hand. ... countertransference was a combination of projective identification, like her disgust, and my grappling with it ... at times when she left, I could, I became aware of going into some unusual bingeing. Erm, and at others I felt a kind of erm, deprivation."

After working with one particular anorexic client, she also described finding herself "overeating in protestation. And catching it, catching myself; a kind of unconscious reaction."

7.5 Therapists' understandings of their own relationships with food and their bodies

Considering the notion of selves being created and understood in relationship with others, collectively (n= 13), the therapists voiced that their reflections on both their own eating behaviours and those of other people had changed as a consequence of their work. T13 described her experience of believing that she had a good understanding of her own relationship with food, but had found that working with clients "undid [her] own myths" as she was forced into challenging previous understandings. As exemplified by one of the therapists (T5), this can be beneficial when it enables a deeper insight into a personal situation. T5 described gaining weight when she discovered that her partner had been having an affair and became aware that she had been unconsciously eating chocolate every day. She acknowledged that "because of my work, I realised that the chocolate had an emotional attachment for me."

However, it can have a potentially detrimental impact if it causes the therapist anxiety about their own eating behaviours or those of friends and family. T5, working in an out-patient setting with a lot of young people found that, “it made me more vigilant about my daughter, who was very, very pernickety about eating.” T1 describes working with the client group as “mak[ing] me think a bit more about where do my beliefs come from about weight and shape, and the family beliefs and values about weight and shape and how they’ve impacted on me.” She also says that “I hadn’t thought about it at all really until I came here.”

T10 recognised that the work can cause therapists to question their own eating or food-buying behaviours and to reflect that “it can be hard for people to keep it in context, I think, sometimes.” She went on to describe how clients recovering from eating disorders would be discouraged from eating foods labelled “diet, low-calorie or low-fat.” However, within contemporary discourses around health, well-being and slimness, such products are positively promoted in the media and, illustrating the fine line which exists between normal and pathological behaviours, therapists themselves may be buying and eating them. T10 acknowledged that this can lead to a feeling of incongruence or hypocrisy when working with a client.

7.5.1 Therapists with an eating disordered history

In this study, 30.1% (n=4) of the specialist therapists interviewed (T4, T7, T8 and T10) admitted to having experienced an eating disorder of some description in their own past. For three of them, the work was affirming, but the other one found that it had evoked unsettling reflections upon his own experience and history.

The three female therapists (T7, T8 and T10) who had experienced their own historical eating difficulties found that the work provided an affirmation of the progress they had made with their own issues. T7 described feeling “*so grateful* that I’m okay with my body and I like my body!” She felt that her own body image had improved and that she was a lot more comfortable with her own weight and shape as a result of her work. She described it as “enabling me to make connections and a deeper understanding about the eating behaviours I used to engage in.”

T10 found the work and her reflection on it reassuring in that she “was able to see how far I’d come,” which she found “quite reinforcing in a positive way.” Her client work had caused her to revisit her own history and make greater sense of it. T8 felt that she was “more open to having a positive body image” and that she was “more content with my body image” as a result of working with her clients. She also felt that the work had led to a personal understanding that her own teenage eating issues were about her “having no power at that time. It’s really obviously clear, but I wouldn’t have made that connection without doing this work.”

Illustrating the importance of ongoing self-reflection when engaging at empathic depth with clients experiencing eating disorders, T4 disclosed his need to re-enter personal therapy soon after he began working exclusively with the client group “because of the *intensity* of the work.” He had cause to look back at his “own relationship with food, my own history of eating disorders, my relationship with my body; all of that stuff,” a process he described as “useful” but “not always comfortable.” He also disclosed experiencing “days when old thought patterns have come back, and I’ve even had days when I’ve wanted to act in old ways.” At times, he admitted that the work was “overwhelming” and “difficult to disengage from,” experiencing it as “a very embodied experience” from which he found it “very hard to switch off.” Within this experience is evidenced the importance of appropriate supervision and support from colleagues as T10 recognises that an historic eating disorder “can creep up on them. It revisits people in different ways, and it’s just being aware.”

Although the risk of therapists with an eating disordered history reconnecting to that narrative is evident, this personal experience can also be advantageous. One of the specialist therapists (T1) interviewed was aware that having not had any kind of complicated relationship with food or embodiment herself made it more difficult to empathise with clients. T5 recognised that “I’ve never dieted, never eaten much chocolate, never had a problem with food; but that could be a drawback, couldn’t it?”

7.5.2 The need for therapist reflection on their own relationships

The specialist therapists unanimously expressed the importance of anyone working with clients experiencing eating disorders to spend time reflecting on their own

relationships with food, eating and their body. Prior to the understanding accumulated through her work in an eating disorders unit and echoing the findings from the non-specialist counsellors, who had not engaged in a great deal of self-awareness work around this topic, T1 said:

“In terms of really thinking about my own identity and my own sense of self in terms of my body, weight and shape, I hadn’t thought about it at all until I came here and started to work with the client group.”

T4, recognising that the therapist’s subjectivity could be challenged within the therapeutic relationship if provoked into eating disordered behaviours voiced that:

“I honestly don’t see how you can work with people with eating disorders and not have done this work around your own relationship with your body; it’s so easily triggered when you’re working with this client group.”

To counteract this, T2 described his practice of encouraging all trainees in his hospital department to reflect on their own relationships with food. He felt that professionals needed to have personal insight in order to more effectively understand and empathise with clients. Highlighting the potential dangers of having not engaged in this kind of self-awareness work T2 said that:

“It really worries me when people are being trained to help people, and they’ve not really had the opportunity to question themselves, you know, and push the boundaries a bit, internally, for themselves.”

Echoing the importance of this self-understanding, T1 spoke of the value of an eating disorders’ workshop she had attended in which participants had been encouraged to look at their own relationships with food, eating and their bodies. She talked about “remembering stuff and making connections” which deepened her understanding of herself and enabled her to work more effectively with clients.

T2 talked of noticing colleagues who were self-conscious of their own body shape and consequently avoided the topic of weight, which made him question; “how you can work with someone and avoid the topic of weight, beggars belief for me.” He went on to say that “a lot of the supervision I do is actually addressing some of those peoples’ attitudes to their own bodies and food.” From research he had conducted within his clinic, he had discovered that clinicians “hadn’t looked at their

own stuff and truly believed that they had no beliefs, values or attitudes attached to eating.” He continued to say that it was not until he “made them talk about it and look at it that they began to discover their own narratives.”

Illustrating the significance of reflection on the therapist’s own personal narrative, T4 felt that:

“your sense of self in relation to food, in relation to your sense of hunger, your body image, your body, the relationship with the physicality in every sense; your sensory awareness, erm, mindfulness around eating, erm, looking historically at the place of food and body image an exercise in your family of origin. I think this is all really essential, basic stuff, really basic stuff that actually, I think everybody should be doing.”

7.6 The bodies in the therapy room

As the data gathering process progressed, the importance of the bodies in the therapy room became increasingly significant. Section 7.6 illustrates the presence and role of the physical bodies, before moving, in section 7.7, to the therapist’s embodied countertransference reactions.

7.6.1 The therapist’s body

Illustrating how a clinician’s embodiment can be altered within the course of the therapeutic relationship, both male and female therapists described an increased consciousness of their own body when working with clients experiencing eating disorders (n=8). T6 stated that “I’m more aware of my body when I’m working with eating disordered clients than with people without that presentation.” Almost echoing these words, T12 agreed, saying that “I’m a lot more aware of my body when I’m working with eating disorders and much less aware when I’m working with a different presentation.” T2 reflected that “I’m always conscious of my weight and how I am in the room” and T1 similarly experienced being “very aware of my own body.”

An element of this increased awareness may be attributable to the attention paid to the therapist’s body by their clients. This sense of scrutiny was described by four therapists (T7, T10, T12 and T13), with T12 believing that such clients “are very

aware of your body as a clinician” and that they “are definitely making a judgment of your body.” T7 was aware that her clients “check me out” and wondered what they thought about her body, whilst T13 had “no doubt that she looks at my body.” T10, whilst wondering, “what’s their perception of me?” recognised that:

“You do get scrutinised, particularly with the low weight clients, you know that, because they scrutinise everybody physically. So it’s important to feel comfortable and to give this projection of feeling comfortable in yourself.”

As a result of this scrutiny, it seems apparent that clients have the potential to increase therapists’ awareness of, or discomfort in, their own bodies. For example, T12 found her attention drawn to her own stomach when the client focused elements of her body hatred and distress onto her abdomen, saying that “I think they do make you very conscious of your stomach.” She went on to describe her experience of working therapeutically with a group of anorexic clients and of watching them “competitively sitting to look as thin as possible” and admitted that the experience “has made me conscious of how I sit.”

The scrutiny of clients can also cause therapists to become self-conscious during times of their own physical change. T7 and T9 described feeling self-conscious and uncomfortable during periods of their own weight gain and wondering what clients were thinking about it. Recognising the visible self-disclosure element of the therapist’s body, T9 described becoming “acutely aware of the visibility of my body and what it was saying.”

For therapists who do not feel at ease within their own body, this scrutiny has the potential to cause not only self-consciousness, but also incongruence within the therapeutic relationship. Clients’ significant others or additional professionals involved in their care may be present on occasion and the therapist’s body may be under scrutiny from these people too. T8 spoke of experiencing her body being visibly judged by the parent of a girl experiencing anorexia when they met at the client’s assessment. Fortunately, this therapist was comfortable within her own body, and aware of the possibility of this situation arising for it to have no negative impact on either the meeting or herself. She also described having had “anorexic women ask me if I’m pregnant” and “obese women saying, ‘oh thank God you’re not one of those really skinny ones.’” Comments such as these and the scrutiny

they imply have the potential to cause self-consciousness and distress for clinicians who do not feel at ease within their own body.

The importance of the therapist being comfortable within their own body and presenting their psychological and physiological selves congruently to clients was acknowledged by five of the specialist therapists (T3, T8, T10, T11 and T12). T10 reflected that “it’s important to feel comfortable and to give this projection of feeling comfortable within yourself.” Advocating the importance of modelling a congruent embodied presentation within the therapeutic relationship for clients to learn from, T11 claimed that “you’ve got to practice what you preach” whilst T3 echoed this to say that “you’ve got to walk the talk.” Developing her belief further to acknowledge that clients will recognise any embodied incongruence, T3 felt that “if you present it and you don’t walk the talk, they’ll suss you out. They are so acute, they can sense everything.”

Within this, the importance of therapists being able to talk about their own body when appropriate during therapy was acknowledged by two of these therapists. T12, who identified herself as “overweight” and who was comfortable within her own body spoke of being able to “talk about my own fat, and other people’s fat.” T8 described having had:

“open conversations with clients about my body and their body ... I’m not afraid to go there ... because I have quite a relaxed relationship with my body, they would in some way, benefit from that.”

7.6.2 The client’s body

A number of the specialist therapists considered both their own and their clients’ bodies as communication aides (n=5) and appreciated that “whenever you’re talking to somebody, the two bodies are there” (T13). Appreciating the phenomenological body, T4 reflected that “everything we experience is through our body, through our senses, physical touch.”

In acknowledgment of the idea that individuals experiencing eating disorders attempt to express what they cannot put into words through the concrete language of the body T12 reflected that:

“a lot is expressed through the body isn't it? It's kind of being able to, kind of being a midwife to the talking, communicating system to move it from the body.”

T8, considering the idea of the thin body symbolically projecting a need for nurturance, described the emaciated body of someone experiencing anorexia as “their signal to others that they need lots of care.” She went on to talk about overweight bodies, saying that obese people:

“tend to be taking care of everyone else rather than eliciting care for themselves. Their body is pushing people away and keeping them at a distance. It's also a way of them denying their own needs.”

There was also an acknowledgement that clients present information not just through the size and comportment of their bodies, but also through their style of dress (n=2). T3 felt that “you can tell what their condition is by how they're presenting.” Illustrating this, T5 interpreted that “thin, dully dressed clients” would be unlikely to take many risks within the therapy, and hence she would expect their therapeutic process “to be a struggle.”

7.7 Somatic experiencing

An experience unique to the specialist therapists was that of somatic countertransference; a psychodynamic phenomenon discussed in chapter four, which describes feelings evoked in the therapist's own body in relation to their experience of their clients. Illustrating the benefits of being aware of these feelings and of the notion of embodied communication, T13 felt that:

“our bodies are one of our main tools as psychotherapists ... our capacity to embody ourselves and actually feel, or sense, our, somatic countertransference; it's a major guide. I think that especially with eating disorders, where it is so focused on the body, I think to miss all of that bodily experience, you're missing a huge amount of therapeutic information there.”

The therapists who described experiencing somatic countertransference found it to be both powerful and therapeutically useful as a means of understanding clients' experiences. However, it was not experienced by all of the therapists, with the two

CBT-trained psychologists (T7 and T8) appearing to have only limited awareness of their somatic experiencing. T7 said that she did not experience things “bodily, not in a physical sense.” She appeared to have stopped recognising her somatic experiencing as she said “I don’t notice physiological countertransference, perhaps as much as I used to.” T8 stated that “I don’t have very many bodily responses that I’m aware of.” Significantly though, both T7 and T8 talked about feeling hungry after working with anorexic clients, which, as discussed below, could be interpreted as a somatic reaction.

7.7.1 Feeling hungry

All of the specialist therapists reported feeling hungry at times in this work, especially after engaging with clients experiencing anorexia. T8 admitted that “you get hungry when you’re working with an anorexic client” whilst T10 said that “I come out of sessions and say ‘I’m starving!’” Other comments included: “I can feel very hungry” (T6), “I do feel hungry here a lot” (T7) and “I feel hungry here all the time” (T8). T6 declared that she and her colleagues “eat and eat! We go through so many biscuits!” After facilitating a therapeutic group with individuals experiencing anorexia, T12 described feeling “starving” after each group.

Illustrating their psychodynamic interpretations, the hunger was specifically identified by five of the therapists as either countertransference or projective identification. T5 recognised her hunger as countertransference, understanding that “it might be about taking on their emotional hunger.” Both T6 and T12 interpreted their hunger as a projection from the clients with T6 claiming that “their hunger in effect, is transferred to us” and T12 describing her hunger as “some kind of projective identification.” Similarly, T9 talked about:

“feeling incredibly hungry and just wanting to eat ... aware of the countertransference coming from clients who were depriving themselves of food and just wanted to eat.”

In a slightly different experience, T5 described feeling hungry with all of the eating disorder presentations and not just towards clients experiencing anorexia:

“I always feel hungry and it doesn’t matter if they’re anorexic or some other form of eating disorder, or bulimia. But I always feel hungry when they’ve

gone, and that's the countertransference isn't it? Yeah, I guess it's about countertransference."

Talking of when he first started working solely with this client group, T4 described having found himself "leaving each session and wanting to wolf down biscuits." Not usually eating many biscuits, he remembered it taking "me a really long time to work out that that was something going on transferentially."

7.7.2 Other examples of somatic experiencing

In this section the somatic experiences of one therapist (T4) are quoted at length. T4 worked within a residential setting and hence his experience may have been intensified as a consequence of his increased immersion in the environment. Having also completed some training in body psychotherapy he may also have been more aware of somatic experiences than therapists without this. He described work with clients experiencing eating disorders as feeling "much more embodied" than that with other clients and said that:

"When I walk into this environment each day, I get a more visceral, somatic, more tangible, erm, I'm not just thinking about the work I do here, I walk in and I *feel* it, physically, I feel it."

Illustrating the effects of people within a given environment or culture on others, T4 went on to clarify how this changes depending on the client mix within the treatment facility at any one time:

"when the house is more anorexic, erm, the whole house feels more gentle. I feel more gently in myself, I feel more, I feel slower in myself ... I want to take things really slowly within myself and with the clients. Erm, I want to be very gentle. I want to be very quiet. At the moment, when it's more bulimic, I feel more energy in myself. I find it hard to, harder to physically settle it's that kind of energy level in a more bulimic house, erm, it can feel a bit manic. And I can feel that within me, I can feel, you know, I can't think as clearly, erm, I find it very hard to settle with what I'm doing, I get distracted very easily. Erm, my thinking becomes more chaotic perhaps. I guess it mirrors the more sort of bulimic house."

Unlike therapists in private practice or out-patient settings, T4 eats some of his meals with clients and other patients. Describing his experience of this, he talks of finding himself “mirroring the clients,” thus suggesting how individuals are affected by the behaviours and subjectivities of those around them. When there are more clients experiencing bulimia in the clinic, he claims to find himself “almost kind of wolfing my food down, which I don’t normally do.” In contrast, he described, “when we have a more kind of anorexic household, I find myself struggling to eat, you know, my lunch.” In contrast, When he first started working at the clinic he claimed that he would take these behaviours home with him, but now “I’m much more aware of it. I’ve done a lot of work around it, so it’s much more contained at work now.” He also talked about using the embodied countertransference and “using what’s happening in my body right now” as a way of “enabling alexithymic patients to get in touch with the somatic sensation which they might later link to a feeling.”

T4 was not the only therapist to experience such powerful somatic experiences. As discussed in chapter three, individuals with eating disorders typically experience problematic attachment patterns, which can cause difficulty in engaging therapeutically. T5 talked about the embodied empathy, or physical sensations she experiences in relation to this client group:

“I feel hyper-aroused with a lot of these avoidant clients; I find my eyes start aching, and I might get very, very sleepy. For example, with a morbidly obese compulsive eater I worked with, I would feel so tired with her; I would struggle to keep my eyes open.”

As the quote below from T6 highlights, somatic experiencing requires a high degree of self-awareness from the therapist in order to interpret the embodied feeling accurately and to separate clients’ projections from therapists’ own experience:

“I can get very anxious in a session sometimes, because I feel blocked, and that affects my body. I find I have to really monitor my body in a more relaxed way, and try to manage my anxiety. I’m aware too that it could be some projected stuff as well; *their* anxiety not letting me in. So I kind of have to unravel that a bit; of what’s mine and what’s theirs’.”

T6 went on to describe how this kind of somatic communication can be helpful as an indicator of clients’ progress: “sometimes, when people begin to feel a little better, and to, to develop an understanding, I can feel my body is much more solid.”

7.8 Professional practice issues

As in the previous findings chapter, the presentation of the specialist therapists' findings concludes with a reflection on relevant professional practice issues.

7.8.1 The need for training

The specialist therapists were unanimous in their view that in order to work effectively with this client group specific training in relation to eating disorders is essential. Despite the increase in disordered eating in western culture and the central role food plays in life, T5 reflected that "counselling courses, even at Diploma level, don't address things like eating disorders, and I think it's a mess really, training." T3 felt that "anyone who's going to do eating disorders really has to be properly trained" and T1 commented that "I think that it's so important when you're working with people with eating distress that you have quite a good grounding in it." Highlighting the potential risks of working with inadequate understanding, T5 voiced that "specialised knowledge is absolutely essential" and that "there are people out there who don't know about eating disorders, and they can be *harmful*. *Really harmful*." She described how therapists can unintentionally cause damage to clients when "they don't really know that they don't know enough."

Further to the discussion in section 7.6 relating to the significance of the body when working with clients experiencing eating disorders, the specialist therapists felt that therapy training placed too little attention on the embodied experience or the physical presence of the bodies in the room. T6 for example, stated that "the body gets forgotten about, especially the analytic therapies, psychodynamic therapy; we have completely missed the body out." She claimed that "certainly for working with eating disorders" this was a significant omission as the body can be used beneficially to monitor countertransference.

All of the specialist therapists concurred with this view, and all agreed that within their therapy training, there had been no focus on the body. T4 for example said that "the body was completely missed from my training." Two of the therapists (T4 and T13) had sought out specific body based training in order to better inform themselves of what they were seeing and experiencing in their work.

7.8.2 Understanding the disorders

The importance of practitioners having a comprehensive understanding of eating disorders in order to appreciate their clients' experiences was unanimously recognised. Illustrating this, and also the importance of therapists understanding the symbolic meanings behind the concrete behaviours, T2's words are quoted throughout this paragraph. He reflected that when he first began working with such clients he was "quite insensitive to them" and "couldn't see what the big deal was." Having experienced no personal difficulties around food T2 quickly recognised that "their experience is beyond my experience" and remembered it being "hard to understand why anyone wouldn't like food;" hence finding it difficult to empathise with clients. He was able to reflect that when he first started working with clients experiencing eating disorders, he focused too much on the "concrete symptoms; the weight and behaviours," whereas with time and experience he had learned the importance of recognising, and working with, the symbolic and psychodynamic elements. He also remembered having had to recognise quickly that "their avoidance of food is not because of lack of hunger" and that "eating disorders are not about food," going on to say that "I now don't think that eating disorders are very much to do with eating."

And yet even with this understanding, the difficulty in fully entering clients' frames of reference and engaging at empathic depth is challenging for therapists. In recognition of this and talking about a client experiencing anorexia, T1 said: "it does fascinate me that you're so hungry, and yet you choose to deny yourself the food. It's difficult for me to get that. It's beyond me."

An appreciation of the psychodynamic elements of eating disorders was also expressed as it was felt that these play a pivotal role in the development of the disorders, their recovery, and in the client's ability to engage within the therapeutic relationship. Without this recognition, therapy can prove frustrating or ineffective for both therapist and client. As T4 said:

"I think this is where it's really important to have some kind of psychodynamic thinking, because if you're not thinking about transference and countertransference, if you're not aware of your own responses, on a somatic level, you miss so much."

The significance of understanding the attachment patterns of clients experiencing eating disorders was also discussed in relation to their effect upon clients' ability to engage therapeutically. For example, in terms of the typical avoidant attachment of someone experiencing anorexia, T5 was "aware that it's going to make it very hard work to keep them on track without losing them."

Although the weights and eating behaviours of clients need to be acknowledged, specialist therapists felt it important that therapy did not overly focus on these. They claimed that affording them too much attention could leave the therapist colluding with the eating disorder and maintaining its prominence in the client's life. T4 believed that "it's not about food; it's never about food." He felt that therapists could be easily drawn in to colluding with clients whose experience was that "I've been restricting for the last ten years; it's *all* about food." Echoing this, T1 described that in her adult inpatient work, there was "more talk about relationships than there is about food." For recovery, they suggested that the psychodynamic elements should be worked through alongside any underlying trauma. Illustrating the need for a more eclectic treatment approach, T5 said that "treatment *has* to be two pronged; the behaviours and the psychological stuff."

T5 felt another potential area in which therapists risk colluding with clients occurs when they talk about "eating healthily." She explained that the client's interpretation of what constitutes healthy eating could be flawed and that therapists needed to ensure that they encourage clients to "really spell out what they mean about that." Therapists who accept clients' descriptions at face value run the risk of collusion; clients with eating disorders tend to hold a distorted idea of what eating healthily means and it is more likely to involve a very limited food range and potentially dangerously low calorie or fat intake.

Person-centred therapy was felt to have the potential to lead to this kind of unintentional collusion through its emphasis on acceptance or unconditional positive regard, which could have negative outcomes for clients. As T5 voiced; "if you go at it with a person-centred approach, which a lot of people do, you can miss some of that stuff, which can be dangerous, especially in private practice." Counterintuitive as it may seem, it was felt important that therapists recognise that when working with obese patients, "you are not working to lose weight. There should be no focus on weight loss; it happens very slowly as a side effect" (T11).

As T5 said, “it’s about building relationships and how they can begin to do that with me.” Therapeutic work needs to be focused on how the client is using food to deal with their emotions and how they are relating to food instead of to people.

All of the specialist therapists were vocal about the importance of being able to talk comfortably, openly, and in detail, with clients about their behaviours. As T5 stated: “I like to give a sense of being *really* interested, and that *nothing* you can tell me, I haven’t heard before, is going to faze me.”

As illustrated in sections 7.2.1 and 7.2.3 above, the physiological aspects of eating disorders also have implications for the therapist’s experience within the therapy room. The specialist therapists were all aware of these and of the potential complications they could cause both for client’s physical well-being and their engagement with therapy. Alongside this, a distinction was highlighted between clients with eating disorders and those who present with disordered eating or, what T2 called “starvation syndrome.” Describing the experience of individuals who do not control their food intake as a way of dealing with psychological or early developmental deficiencies, starvation syndrome delineates those people who choose to change their body in order to satisfy sociocultural ideals or accommodate peer pressure. As a consequence of the physiological effects of their eating behaviours and the psychological benefits of changing their body, these individuals find themselves caught in a cycle of body management practices. Following a discussion of the significance psychoanalyst Hilde Bruche placed on “developmental deficits in the primary anorectic condition” T2 explains how other individuals are affected by:

“media and cultural influences, and peer pressure, and people feeling a need to both stay fit and diet, as well as images of being slender, as ‘that’s more attractive’ and I find a lot of people that find themselves have started with a diet, and before they know it, they lose control, ‘starvation syndrome’ kicks in ... I think starvation syndrome is what we talk to a lot of the time, and it isn’t anorexia nervosa.”

7.8.3 The need for therapeutic flexibility

Highlighting the complexity of the disorders, specialist therapists recognised a need for flexible and integrative working to meet the differing needs of clients at different

stages of their therapy (n=6). To achieve this, therapists need to be comfortable with a degree of uncertainty at times as they adapt their approach to meet the changing needs of individual clients. T4 recognised the importance of working across therapeutic modalities in order to work with all aspects of the disorder:

“And of course, you have to think about the eating disorder mind-set in terms of what’s going on in cognition, what’s going on behaviourally; of course you have to do that. But much more so ... is the underlying psychodynamic approach.”

T2 and T10 both recognised the impossibility of employing a “prescriptive treatment model” (T2) or “flow chart” (T10) and instead accepting that “you’ve got to be flexible” and “do what works for that particular client in front of you” (T2). T10 described the frustrations of trying to stay within one therapeutic model as she had found that “when you try to work in a very sort of, formulaic way, like the CBT for eating disorders model, that can become quite frustrating because it doesn’t always fit.” Similarly, T6 recognised that “there is no, never one answer” and instead posited a need to “work in whatever way is appropriate.” She also identified that some of the therapist’s wish for an “ideal solution may be part of the countertransference” from the client wishing for an easy solution.

T12 discussed her experiences of working with clients who had previously engaged with CBT and found it to be unsuccessful. Illustrating the necessity of therapists adapting their interventions to match clients’ changing needs, she described working with individuals who had not been helped by CBT and who instead, benefited from “a period of my exploratory psychotherapy and psychoanalysis.” Following this they were able to “use the CBT ideas at the end of the therapy, but they couldn’t at the beginning.”

7.8.4 The importance of clinical supervision

As a result of the various challenges and experiences presented above, the specialist therapists were in agreement that clinical supervision is a necessary adjunct to ensure the well-being of both therapists and clients (n=13). For example T6 felt that “supervision is absolutely essential for this work.” In contrast to the person-centred counsellors who were reluctant to discuss their experiences in supervision, the specialist therapists appreciated the value and necessity of regular

supervisory input for this work. The following comment from T6 highlights the need for regular supervision and also the psychodynamic knowledge relating to eating disorders that she felt it useful for the supervisor to have to ensure efficacious discussion:

“I take my eating disordered clients to supervision much more regularly than I do other clients. We tend to work a lot more with the countertransference and we really focus on the unconscious.”

Having a supervisor with specific knowledge of eating disorders was deemed beneficial to facilitate effective reflection, with T5 claiming that “it should be mandatory to have supervision with an eating disorders specialist.”

As alluded to in the previous chapter regarding counsellors being reluctant to take their own eating and body image issues to supervision, both T5 and T10 described therapists’ own struggles with food and weight as a “taboo subject” which still has a stigma attached to it. T10 felt that there was a pressure for therapists to “present with a perfectly balanced relationship with food” when the reality is that “it’s really unusual, for someone to have a non-emotional relationship with food.”

Despite their experience and knowledge, all of the therapists admitted finding the research interview experience a useful context for further reflection upon the effects of working with this client group on therapists. Highlighting the value of the research interview and also illustrating the need for appropriate supervision around this client work T7 said that:

“I would love, one day, to have a supervisor who’s like, asking some of the questions you’ve been asking. Like, gee; I’ve never really reflected on that; thank you!”

T10 reflected that:

“talking to you has made me realise even more, how important it is for people to get, to have some work in, at least some basic self-awareness of their own relationship with food.”

Similarly, T5 found that “[a] couple of ideas came up as we were talking that I hadn’t thought about before.”

7.9 Conclusion

In this chapter the findings from the specialist therapists have been presented. These findings are more detailed than those of the person-centred counsellors of the previous chapter due both to the additional experience of the specialist therapists and also because a greater number of specialists were interviewed. The findings describe both the experiences of the therapists in relation to clients experiencing eating disorders and also key factors which the specialist therapists have learned as a result of their accumulated experience.

Some of the therapists were able to remember how they felt when they first began working with the client group, and the experience and knowledge they had gained since. Most, although not all, were able to reflect on how their work with eating disordered clients had impacted on their sense of their own body or thoughts and feelings around food, the body and their personal embodied experience. The value of self-awareness and self-understanding around the topic of eating disorders and disordered eating was extolled by all of the specialist clinicians. Other than those who had experienced eating issues themselves, none of the practitioners had considered their own relationships with food, eating and their body before commencing work with this client group. This suggests that this client group does have the potential to cause therapists to think about their own relationships and that this therefore, should be encouraged for all trainee practitioners.

In the following chapter, the findings from both the specialist therapists and the person-centred counsellors will be discussed. The similarities and differences between the two data sets will be illustrated and the conclusions which were formed from these presented.

Chapter 8

Discussion

8.1 Introduction

The therapists in this study configured into two data sets; the person-centred counsellors who formed the preliminary enquiry and the specialist eating disorders' therapists of the main study; the findings of which were presented in chapters six and seven respectively. In this chapter those findings are discussed, acknowledging the significance of the two therapist groups in relation to the analysis of their experiences.

The configuration of therapists into person-centred counsellors and specialists meant that similarities and differences between their experiences could be compared. Gaps in therapist knowledge and self-awareness became evident suggesting the need for training (Bannatyne & Stapleton, 2014; Thompson-Brenner et al., 2012), discussed in section 8.7.1 and personal development resources, presented in section 8.7.2. The differences also highlighted the effect of the therapist's therapeutic orientation upon their conceptualisation of eating disorders, the treatment provided, and their subsequent experience of themselves and their clients, discussed in section 8.6.

As evidenced in the previous two chapters, five main themes emerged from the findings which were shared across the two data sets:

1. Feelings elicited by client work
2. Therapists' experiences in relation to their own bodies and eating behaviours
3. Therapists' self-awareness in relation to their own personal histories and relationships with food, eating and the body
4. The bodies in the therapy room
5. Professional practice issues

Unique to the specialist therapists, an additional two themes emerged, discussed in sections 8.3 and 8.5.3 respectively:

1. Specific experiences of the different eating disordered presentations
2. Embodied countertransference

The affective experiences of the therapists in response to their work with clients presenting with eating disorders is considered in section 8.2 when the powerful feelings which can be engendered (Warren et al., 2009) within the therapy room are discussed. Illustrating the social constructionist notion of selves created in relationship with others (Gergen, 2015), the discussion then turns towards more personal effects on therapists in section 8.4, whereby ways in which practitioners' own subjectivities can be altered as a result of their engagement in the therapeutic relationship are presented. As discussed in chapter two, the shared historical sociocultural position (Daly, 2016) of therapist and client plays a role as both parties are subject to the same dominant discourses in contemporary western consumerist culture relating to food, eating and the body which can leave therapists vulnerable to over-identification with clients (DeLucia-Waack, 1999; Hamburg & Herzog, 1990; Zerbe, 1993).

The significance of the body when working with clients experiencing eating disorders becomes evident in section 8.5 when the body's role as a representation of an individual's identity, in relation to both their subjective experience and sociocultural discourses inscribed upon it, is discussed. Embodied countertransference (Barth, 2001; Burka, 1996; Pacifici, 2008; Petrucelli, 2001, 2015b) is considered in section 8.5.3 in acknowledgement of the specialist therapists' use of this psychodynamic concept for interpreting some of their somatic experiences. Section 8.6 acknowledges the differences between the findings of the two data sets and discusses the possibility of these being caused by the therapists' varying experience levels with the client group or their differing therapeutic approaches. Recognising the notion of multiple realities, therapists from alternative therapeutic models will work from different knowledge bases which will inevitably influence how they work and interpret their experiences. Discussion of the findings then concludes in section 8.7 with the implications of the findings for professional practice in relation to training, self-awareness and supervision.

Considering the historical cultural positioning of eating disorders as essentially feminine conditions (Bunnell, 2016; DeFeciani, 2016), as discussed in the literature review chapters, it is noteworthy that the therapists interviewed described their experiences with female clients, other than a few passing comments in relation to males. When I devised the interview schedules I did not specify the gender of clients as I did not want to influence respondents' thinking. The findings of the participants within this study can therefore be read as confirming the ongoing sociocultural positioning of eating disorders as essentially female-bound conditions (Bunnell, 2016; Dalglish & Nutt, 2013) even within professional arenas (Botha, 2010; Wooldridge, 2016).

8.2 Feelings elicited by client work

In concordance with existing literature, both the preliminary study and the main body of the project indicate that clients experiencing eating disorders have the potential to instil a range of powerful feelings within their therapist (Warren et al., 2009) discussed throughout section 8.2. Experiences and interpretations of some of these feelings differed between the two data sets, raising the question as to whether these differences arose as a consequence of increased knowledge and experience or from the therapists' varying therapeutic approaches. It is difficult to ascertain this from the findings of this study as all of the non-specialist clinicians practised from a person-centred perspective, although it seems likely that both play their part. As the literature also fails to consider the effects of different psychotherapeutic approaches, research needs to be conducted on non-specialist therapists from other therapeutic orientations approaches to draw a definitive conclusion.

The key feelings, discussed below, were frustration, anxiety, inadequacy and a sense of reward. The feelings engendered in therapists are significant as they form part of the clinician's subjective experience within the therapy room. When considering subjectivity as changeable (Elliott, 2014) and created in relationship (Gergen, 2015), the possibility of clients' experiences affecting therapists through their therapeutic engagement becomes apparent.

8.2.1 Frustration

Concurring with published literature, this study found that frustration is a feeling commonly experienced by clinicians in their work with clients presenting with eating disorders (Burket & Schramm, 1995; Franko & Rolfe, 1996; Hughes, 1997; Russell & Marsden, 1998; Satir et al., 2009; Thompson-Brenner et al., 2012). The feeling can be understood to arise in response to four elements within the work: clients, the eating disorder, therapists themselves and the sociocultural influences to which therapists recognised themselves and their clients to be exposed (Daly, 2016; Sands, 2016). Although some of the frustrations were shared by therapists across the two data sets, their interpretation sometimes differed between the two samples.

Appreciating the ways in which the behaviours associated with the conditions influenced clients' cognition, subjectivity and presentation within therapy, the specialist therapists more typically described their frustration as being directed towards the eating disorder. Although not claiming to work narratively, this suggests the narrative therapy notion of recognising the eating disorder as something external to the client (Maisel et al., 2004; White & Epston, 1990). The frustration the specialist therapists experienced towards the characteristically slow nature of therapeutic progress (Barth, 2016; Strober, 2004) was tempered by their understanding that clients' characteristic relational difficulties (Barth, 2008), personality traits (Duker & Slade, 1988) and the cognitive deficiencies associated with malnutrition affect their ability to engage in therapy (Gottlieb, 2015; Kaplan & Garfinkel, 1999; Vandereycken, 1993). Illustrating the value the specialist therapists attributed to psychodynamic theories, they interpreted clients' relational difficulties as arising from the inadequate attachment experiences (Tasca & Balfour, 2014; Tasca et al., 2011) documented in chapter three. Although the pathologised and essentialist self of psychodynamic theory is potentially problematic for the social constructionist underpinnings of this study, 'attachment narrative therapy' (Dallos, 2004, 2014), discussed in chapter three, offers a means of reconciling this. As will be discussed in section 8.7, this example and the one above regarding the separation of the eating disorder from the client, illustrate how the different therapeutic approaches can be informed by each other to promote the integrative way of working espoused by the specialist therapists (Natenshon, 2012; Petrucelli, 2016; Satir, 2013; Tasca & Balfour, 2014).

The specialist therapists' inclination towards psychodynamic theories was also evident as they attributed some of their frustration to the concept of projective

identification. From the psychodynamic perspective, the combination of their typical alexithymia (Barth, 2016; Mathiesen et al., 2015) and dissociation from their affective states (Zerbe, 1998) means that clients can project their undefined or unacknowledged feelings onto their therapist (Hughes, 1997; Petrucelli, 2015b; Zerbe, 1992). The specialist therapists who ascribed to his phenomenon recognised it as an informative therapeutic communication from their clients (Barth, 2001; Burka, 1996; Pacifici, 2008; Petrucelli, 2015b). Hence it could be argued that therapists who are unaware of this phenomenon could misattribute such projected feelings to their own subjective experience, but, as discussed in chapter three, its existence, other than as a psychodynamic construct, needs to be questioned.

8.2.1.1 Frustration regarding sociocultural influences

Recognising the shared sociocultural situation of clinician and client (Barth, 2016; Daly, 2016; DeLucia-Waack, 1999; Hamburg & Herzog, 1990; Jabobs & Nye, 2010; Matz & Frankel, 2005; Rabinor, 1995; Zerbe, 1992) both data sets described experiencing frustration towards sociocultural pressures and the media. Constant exposure to often unrealistic body shapes normalises physical ideals (Hummel et al., 2012) and the controlled eating required to achieve it, for clients, therapists and the general population (Daly, 2016; Sands, 2016). Participants of both data sets were frustrated that people in the media (Thompson-Brenner et al., 2012) or small clothing sizes in shops normalised thin bodies and thus restrictive eating for both themselves and their clients. This also contributed to their frustration when attempting to encourage clients to stop dieting or to gain weight when sociocultural and peer pressures continue to promote restriction, thinness and perfection (Daly, 2016).

The impossibility of stepping outside of one's sociocultural position (Daly, 2016; Sands, 2016) was recognised as therapists in both groups experienced frustration towards themselves for understanding the superficiality of sociocultural pressures relating to idealised body shapes and yet feeling unavoidably influenced by them. As two of the person-centred counsellors disclosed, it can be difficult to reconcile a sense of admiration in relation to the slim bodies displayed by their female clients alongside a sense of shame from their awareness of their clients' distress and the dangerous behaviours employed to achieve that thinness (Garrett, 1998). Arguably however, these pressures are not so trivial when the association between body

related discourses and an individual's identity formation (Lanzieri & Hildebrandt, 2016), as discussed in chapter two, is considered. In a further example of ways in which the work can induce personal frustration in the therapist, two of the person-centred counsellors described feeling frustrated at their own inability to lose weight whilst witnessing clients successfully losing theirs. This introduces a theme discussed below in section 8.4 in relation to therapists experiencing discomfort in relation to their own body as a consequence of the work.

A key point to note regarding the therapists' comments in relation to the media and sociocultural pressures is that they all referred to females. Even the therapists who were specialists within the eating disorders' field described the pressures on 'young women' or the normative and unquestioned internalisation (Petrucci, 2016) of sociocultural pressures by 'women' further confirming the female positioning of eating disorders in the literature and clinical practice (Bunnell, 2016; Dalglish & Nutt, 2013; Wooldridge, 2016).

8.2.2 Anxiety

Much of the anxiety experienced by the specialist therapists related to their clients' physical well-being (Hughes, 1997). Especially in relation to those experiencing anorexia, the therapists' ultimate fear was of a client dying whilst in their care (Hamburg & Herzog, 1990). There was also an anxiety in relation to professional negligence if clients' physiological health was compromised during the course of therapy which raises ethical issues around knowledge and competence levels for all therapists working with this client group (Bond, 2015; NICE, 2017; Spotts-De-Lazzer & Muhlheim, 2016 ; Williams & Haverkamp, 2010). A number of the specialist therapists worked within dedicated eating disorders' services comprising of multi-disciplinary teams including medical doctors responsible for managing clients' physical health. Those in private practice worked alongside their clients' GPs in order to ensure that weight and physiological processes were monitored effectively. This provided a degree of reassurance that clients' physical health was being supervised and reduced their responsibility for an area of clients' well-being for which psychological therapists are not usually trained (Spotts-De-Lazzer & Muhlheim, 2016). Involving a doctor in this way also helps maintain therapeutic boundaries allowing the therapist to remain focused upon the relational and psychological aspects of their client's condition. Even with this medical

reassurance, the specialist therapists described an anxiety arising from the responsibility that they felt for their client's physical health. They described needing to achieve an effective balance between respecting client confidentiality, using "detailed inquiry" (Petrucci, 2015a) to ascertain the true extent of their disorders and finding themselves paralysed against acting for fear of damaging the therapeutic relationship (Hamburg & Herzog, 1990).

Anxiety can cause therapists, especially those inexperienced with the client group, to concentrate too heavily on changing the problematic behaviours in an attempt to problem-solve (Satir, 2013). Although, as discussed in chapter three, clients experiencing eating disorders often need direct intervention in the form of cognitive-behavioural strategies and psychoeducation (Barth, 2016; Jarman et al., 1997; Wooldridge, 2016) it is important that these are introduced appropriately. In an example of their integrative way of working, the specialist therapists typically introduced such strategies mindfully alongside their psychodynamic understandings (Tasca & Balfour, 2014), understanding that, if offered inappropriately, they can be experienced by clients as intrusive or controlling (Hamburg & Herzog, 1990) and as mirroring earlier inadequate attachment experiences (Russell & Marsden, 1998).

Expectations of clients and others involved in their care, including family, friends and other professionals can also create anxiety. Arguably, this could arise within the relationships in which therapists engage with clients and their significant others as they share their experiences. However, one of the therapists who experienced this interpreted it as projective identification (Hughes, 1997), another psychodynamic concept discussed in chapter four. A clinical psychologist practising from a cognitive-behavioural approach described herself as having been a "nervous therapist" for years when she began working with clients experiencing eating disorders. She understood her sense of anxiety as having been projected onto her from her clients and their significant others without its being recognised as such. Incorporating this negative feeling within her own narrative illustrates the potential for therapists' subjectivities to be rewritten as a consequence of their client work. Recognising it as something projected onto her though, also suggests the possibility of being able to offer it back to the client as something external, which can then be worked with from a more narrative perspective.

A source of anxiety unique to the person-centred counsellors related to language. The discourses attached to body shapes and their conflation with personality traits, discussed in chapter two, meant that they were uncertain which words to use with clients for fear of upsetting or offending them. Recognising the power of symbols and language, this resulted in them being more cautious in their interventions than with other psychological presentations and potentially limited their ability to engage empathically and congruently at depth with their clients. The specialist therapists in contrast were clear about the value of “detailed inquiry” (Petrucci, 2016) to explicitly explore the meaning and significance of body shapes and sizes with clients (Orbach, 2004, 2009; Petrucci, 2015b) in order to challenge their internalised sociocultural beliefs.

8.2.3 Therapist inadequacy

Both data sets described feeling challenged by the work and of questioning their own abilities or the efficacy of the work (Russell & Marsden, 1998; Satir et al., 2009; Thompson-Brenner et al., 2012). The sense of inadequacy which arises is a potentially powerful feeling which has potential to affect therapists’ professional subjectivities and sense of competence. It was also another area in which differences were apparent in the experience and interpretation of the feeling between the two data sets. Specialist therapists described feeling “hopeless” at times during therapy and of questioning their therapeutic ability. They advocated the importance of maintaining a robust sense of themselves (Daly, 2016; Orbach, 2004) to ensure that these feelings did not affect them too deeply and challenge their personal and professional subjectivities. In contrast, the person-centred counsellors’ feelings of inadequacy were borne out of their limited knowledge in relation to eating disorders. They questioned if the conditions were a specialist presentation and wondered if they were qualified enough to work with clients experiencing them. At the more severe end of the eating disordered spectrum where the behaviours are deeply entrenched and physiological complications more evident it could be asserted that they are a specialist presentation (Natenshon, 2012; Williams & Leichner, 2006). However, and as discussed in chapter one, due to the rising numbers of individuals presenting with eating disorders in outpatient and private practice settings (Furstand et al., 2012), it is increasingly likely that therapists in general practice will encounter the presentations at varying levels of severity (Jarman et al., 1997; Natenshon, 2012; Williams & Haverkamp, 2010).

Therapists can also experience a sense of incongruence within the therapy when they find their client work in conflict with their own beliefs and values, and those of society. Within western culture, dieting and controlled eating have become increasingly normative in recent years (Daly, 2016; Sands, 2016) and therapists may be controlling their own weight or body shape for various reasons. As described by therapists in both data sets, talking to clients about gaining weight or the types of food eaten can cause clinicians to question their own buying behaviours or to feel incongruent when challenging clients' beliefs and behaviours in relation to these topics.

The specialist therapists also acknowledged that the characteristically slow progress of clients experiencing eating disorders towards recovery can cause therapists to doubt their own ability or the effectiveness of therapy (Barth, 2016; Hamburg & Herzog, 1990; Petrucelli, 2016). In this case, the specialist therapists' arguably more thorough understanding of eating disorders enabled them to recognise this as an experience to be expected with this client group (Warren et al., 2009) rather than attributing it to their professional subjectivity. Trends in current western culture err towards short term therapy (Zerbe, 2016) and in many therapeutic settings, including the NHS and some voluntary sector organisations, financial and capacity constraints limit the number of sessions available to clients. Eating disorders typically do not respond well to short term work (Zerbe, 1992, 2016) as, due to clients' typical relational difficulties (Barth, 2008), time needs to be taken in which to develop the therapeutic relationship (Dallos, 2004; Ward et al., 2000). Therapists thus find themselves attempting to treat clients within an impossibly short time period, further exacerbating their sense of inadequacy or pushing them towards the problem-solving strategies which risk engulfing clients, discussed in section 8.2.2.

An idiosyncratic, yet powerful experience occurred for the male person-centred counsellor (C4) during the research interview as he found himself feeling increasingly inadequate. Attributing this to his limited knowledge of eating disorders and dissociation from their experience he recognised the potential for inaccurate hearing and understanding of clients' experiences. Although this occurred for only one therapist, it could be assumed that his experience is unlikely to be unique. There may therefore be clients experiencing eating disorders working with clinicians who are unintentionally practising with inadequate knowledge which can be a

potentially dangerous position from which to work (Williams & Haverkamp, 2010). Part of the male counsellor's self-professed "ignorance" arose from his perceived stable body image and uncomplicated relationship with food and eating. Considering the position of eating issues within feminine discourses (Bunnell, 2016; Wooldridge, 2016), it could be questioned if this counsellor's sense of his gendered masculinity, discussed in chapter two, meant that he had not considered the option of such troubled relationships for himself. In contrast however, the two male specialist therapists interviewed both described more complicated relationships, thus determining, as the literature is now illustrating, that gender does not offer immunity to eating and body image issues. As rising numbers of men and boys are exposed to increasing sociocultural pressures in relation to their body shape (Baird & Grieve, 2006; Wooldridge, 2016) this male counsellor is potentially an increasingly minority figure in relation to enjoying a secure sense of his embodied self.

Associated with the experience of inadequacy, ethical issues around the competency of therapists working with limited levels of knowledge need to be considered (Spotts-De-Lazzer & Muhlheim, 2016 ; Williams & Haverkamp, 2010). In their Ethical Framework, BACP (Bond, 2015) draws attention to the principles of beneficence and non-maleficence to ensure counsellors are committed to promoting clients' well-being and avoiding harm. Good practice also obligates therapists to achieve a level of competence appropriate to their client work (Bond, 2015; 2017). In the case of eating disorders, it could be argued that working unintentionally from a place of inadequate knowledge leaves the therapist at risk of unknowingly breaching these guidelines and hence putting both themselves and clients at risk (Williams & Haverkamp, 2010).

Although empathy is a core condition of psychotherapy (Rogers, 1951) and recognised as necessary in order to understand the experiences of others, attempting to empathise with clients with eating disorders can leave practitioners feeling inadequate or frustrated. Therapists who experience an easy relationship with food and eating can find it difficult to understand their clients' difficulties (Lawrence, 1995). This is something which even experienced and specialist therapists can find problematic. As evidenced by the male person-centred counsellor, it is either completely out of the therapist's awareness, or as in the case of one of a female specialist therapist (T1), impossible to fully comprehend.

8.2.4 A sense of reward

It should be recognised however, that despite the challenges, working with clients experiencing eating disorders can be rewarding (Warren et al., 2009). Two specialist therapists spoke of the “love” (T4 and T6) that they experienced for their work and seven of them described the sense of “reward” they received from being part of a client’s journey towards recovery. None of the person-centred counsellors described the work as rewarding, although one (C2) did recount her sense of admiration at witnessing clients beginning to rediscover themselves and move away from disordered eating behaviour. It should be borne in mind that all of the specialist therapists had chosen to work with clients experiencing eating disorders and hence had a natural proclivity towards the work, potentially causing them to be more attuned to rewarding outcomes.

The influence of therapists’ therapeutic approach and knowledge levels are again raised in relation to this sense of reward. Due to the complex aetiology of eating disorders (NICE, 2017; Tasca & Balfour, 2014; Wooldridge, 2016), an eclectic way of working may provide a greater sense of reward as it allows therapists to work with all aspects of their client’s experience potentially increasing the likelihood of therapeutic improvement. This inevitably has implications for training, which are discussed in section 8.8.

8.2.5 Summary of therapist feelings

It is evident that therapists working with clients presenting with eating disorders can experience a range of powerful feelings within the therapy room (Rance et al., 2010; Warren et al., 2009). This is already identified in the literature, although existing studies typically focus across a range of professions rather than the concentrated sample of psychotherapeutic therapists in this research. The study’s comparative discussion between the person-centred counsellors and the specialist therapists allows for differing interpretations of the experiences to be considered. As the discussion continues it will become evident that further differences emerged between the two data sets. The person-centred counsellors appeared to be unaware of any embodied or countertransference feelings in relation to their clients which will be explicated in section 8.5.3. Similarly, and mirroring Franko and Rolfe’s (1996) findings, specific experiences in relation to the different eating disordered

presentations were experienced by only the specialist therapists as discussed below.

8.3 Experiences specific to the different eating disorders

The findings discussed so far have related to clients experiencing eating disorders as a homogeneous group. Arguably this is an accurate conceptualisation as all individuals experiencing the conditions use food and their bodies to manage their affective and relational difficulties (Farrell, 2015; Orbach, 1986; Petrucelli, 2016; Sands, 2016). However, as discussed in chapters three and four, the subjective experiences of clients presenting with anorexia, bulimia and binge eating disorders do show some differences, which can be informative for therapists' understanding of the work.

8.3.1 Anorexia

The frustration and anxiety experienced by therapists, described above in section 8.2, is exacerbated in relation to clients presenting with anorexia (Franko & Rolfe, 1996). As discussed in chapter three, and as will become evident in this section, this can be attributed to a number of factors. Much of the therapist's frustration arises from clients' difficulties with relational engagement (Barth, 2008).

Exacerbated by the physiological consequences of starvation which detrimentally affect clients' cognitive functioning (Gottlieb, 2015; NICE, 2017), relational difficulties stem from their typically avoidant attachment patterns (Ty & Francis, 2013) or attachment narratives (Dallos, 2004, 2014). As the specialist therapists described, clients' difficulties in relating can leave practitioners feeling frustratingly excluded from their client's experience and less connected to them than with other clients (Franko & Rolfe, 1996). Although the client may be consenting to therapy, an ego-syntonic element (Wooldridge, 2016; Zerbe, 1998), which relies on anorexia as a way of being in the world, fights to keep the disorder alive (Zerbe, 1998). The individual's body and self narratives have become fixed (Gergen & Kaye, 1992) and their identity conflated with their eating disordered story (MacLean et al., 2015; Weiss, 1999) and thus therapy can be experienced as a threat to the client's subjectivity and sense of control (Jarman et al., 1997). The therapeutic relationship can be experienced as reminiscent of overwhelming early relational experiences (Russell & Marsden, 1998), thus explaining some of the clients' ambivalence

around engagement and the subsequent frustration therapists feel. The specialist therapists felt that appreciating the difficult attachment patterns inherent in the anorexic client's development and how they affect clients' sense of self and ways of relating to others (Dallos, 2004, 2014; Tasca & Balfour, 2014; Tasca et al., 2011) was important in understanding this frustration. As discussed in chapter three, attachment theory is not necessarily invoked as a means of blaming or pathologising clients and their families, although it can be construed as thus through psychodynamic discourses. It can rather be used as a tool to help clients understand how their relational experiences developed and the narratives they and their families created as a consequence (Dallos, 2004). From this position, therapists can help clients recognise the stories they are living by and help them re-author more effective and healthy narratives to take forward (Madigan, 2011).

According to both the specialist therapists and the literature, clients with anorexia can induce an increased sense of responsibility in their therapists (Hamburg & Herzog, 1990; Hughes, 1997; Vandereycken & Beumont, 1998). The specialists interpreted this as projection from a client reluctant to take responsibility for themselves and their physical wellbeing (Hughes, 1997). Through psychodynamic discourses, and as discussed in chapters two and three, clients with anorexia can be considered as enacting the disembodied psyche-soma split of western culture (Barth, 2016; Soth, 2006; Zerbe, 1993) and dissociate from any anxiety for their physical health, projecting it instead onto their therapist (Hughes, 1997). With no recognition of their tendency for projective identification, clients' seeming refusal to appreciate their physiological state can prove frustrating for therapists. In recognition that projective identification is a psychodynamic concept, an alternative reading could interpret it relationally as caused by a conscientious therapist aware of the potential physiological complications of anorexic behaviours.

Considering the body as the concrete way in which individuals exist for each other (Crossley, 2004) or as a representation of self-identity (Lanzieri & Hildebrandt, 2016) the sight of the anorexic body can be powerful and informative. Illustrating the symbolic nature of the client's body size, discussed in chapters two and three, specialist therapists, through psychodynamic discourses, understood the small anorexic body as signifying an individual with very little of herself to give in therapy. The visibly thin body can elicit a visceral pain in therapists (Farrell, 2015); a pain which one therapist, even with seventeen years' experience, described still

regularly experiencing. Having this preconception has potential implications for the therapeutic relationship as beginning therapy with such an expectation may cause therapeutic bias. Conversely however, understanding the inherent difficulties may enable the therapist to be more alert to them and to be more accepting of the client's presentation which may enable more effective working. The specialist therapists were aware that clients who struggle to express their inner subjective experiencing verbally tend to use their bodies as a concrete means of communicating this (Farrell, 2015; Petrucelli, 2016; Sands, 2016; Zerbe, 1993).

As discussed in chapter 2, the bodies and behaviours of those experiencing eating disorders can also be considered to display the sociocultural discourses which they have internalised. Therapists who are not aware of this phenomenon potentially miss important therapeutic communication regarding the client's subjective experiencing as symbolised in their physical presentation. The emaciated body of the anorexic presentation is often conflated with the positive traits of western consumerist society (Malson, 1998). Slim bodies symbolise happiness, success, self-restraint and achievement (Daly, 2016; Lowell & Meader, 2005; Malson, 1998), which the individual experiencing anorexia attempts to acquire through her eating behaviours and body control. With an inadequate sense of self, the individual adopts the discourses of culture, family and peers to create a sense of identity. The increased exposure to idealised bodies establishes them as norms (Hummel et al., 2012) and individuals often acquire them without question (Petrucelli, 2016), as in Foucault's notion of docile bodies (Foucault, 1975). The findings illustrated therapists' difficulties in enabling clients to create new narratives as recovery necessitates encouraging them to challenge the societal norms which their mentally healthy peers may be ascribing to.

8.3.2 Bulimia

The therapist experience of working with clients presenting with bulimic behaviours has some differences from when working with those enduring anorexic symptoms. These are arguably due to the different relational and subjective experiences clients are conveying and how the therapist consequently responds to this. Again, the symbolic nature of the behaviours and dominant discourses attached to the presenting body relate to the clients' self-experiencing, developmental history and their subsequent engagement within the therapeutic relationship, as discussed in

chapters two, three and four. The client experiencing bulimia typically presents within a 'normal' weight range, and as one of the specialist therapists (T5) stated, "there is more to get hold of" than with the client presenting with anorexic symptoms. This increased presence is evident not just through their larger body size, but also within their subjective experience which they will more readily share, often metaphorically purging their feelings onto the therapist (Farrell, 1995).

As a consequence of what they perceived to be projective identification, one of the specialist therapists (T10) described experiencing a sense of being left with their clients' material at the end of sessions (Russell & Marsden, 1998). As posited in chapter three, individuals experiencing bulimia typically find it difficult to digest and assimilate the personal and emotional experiences of therapy (Russell & Marsden, 1998; Zunino, Agoos, & Davis, 1990) and want their therapist to metabolise it for them (Zerbe, 2016). Behaving as the compliant client (Dolton, 2000) which their sense of perfectionism leads them to be (DeLucia-Waack, 1999), clients appear to engage effectively during the session, but metaphorically purge its contents immediately afterwards (Sands, 1991; Shipton, 2004; Zerbe, 1998) as their alexithymia causes difficulty in processing emotions and dialogue (Barth, 2008, 2016; Svenaeus, 2014). Experiencing this psychosomatically, one of the specialist therapists described feeling sick (T6), both during and after sessions, and of feeling full of her client's experience and afterwards, feeling the need to purge. She used this embodied countertransference (Pacifici, 2008) as a means of understanding their client's subjective experience at a deeper embodied level than words would enable them to. This is reminiscent of my experience of using embodied knowledge creation experiences (Bager-Charleson, 2014; Gendlin, 1996; Todres, 2007) during the analysis period of this research, as discussed in chapter five. From a psychodynamic perspective, projective identification is important for clients experiencing eating disorders as their typical alexithymia makes it difficult for them to express their emotions (Barth, 2008, 2016) and hence the therapist's attunement to their own bodily experiences can be vital therapeutic information. Although seemingly powerful experiences, countertransference and projective identification need to be recognised as constructs available only through psychodynamic discourses.

8.3.3 Binge eating disorder

As discussed in chapter three, the client experiencing binge eating disorder or compulsive eating often presents in an overweight or obese body, and as with the previous two presentations, a symbolic element can be read onto that body size. Clients typically use their weight as a figurative way of keeping people at a distance and hiding their inner subjective experience (Toman, 2002). Some of the specialist therapists described experiencing difficulties engaging with the obese client and a sense of needing to metaphorically work through the layers of fat in order to find the individual hidden underneath. As with other eating disorders, clients' relational difficulties are inherent in the condition, and feeling that their clients' primary relationships were with food (Gottlieb, 2015; Petrucelli, 2001), therapists described needing to enable the client to move away from food and instead learn more effective ways of relating with people.

8.3.4 Disordered eating

Recognising that disordered eating exists along a continuum (DeFeciani, 2016; Piran & Cormier, 2005), a number of the specialist therapists highlighted the difference between eating disorders and disordered eating; a difference not mentioned by any of the person-centred counsellors. As discussed in chapter three, this difference has implications for the treatment provided to clients (Tanofsky-Kraff & Yanovski, 2004). Describing what he called 'starvation syndrome', one of the specialist therapists recognised that these clients typically do not experience the problematic early attachment experiences of those diagnosed with eating disorders. However, as a consequence of the biological effects of starvation (Duker & Slade, 1988; Kaplan & Garfinkel, 1999; NICE, 2017) they may experience similar physiological affects to those of the eating disorders which can have implications for their engagement in therapy.

8.3.5 Muscle dysmorphia

All of the therapists talked about their experiences in relation to female clients and the commonly recognised conditions of anorexia, bulimia and binge eating disorder. As discussed in chapter three, there is debate in the literature as to whether muscle dysmorphia, which is currently situated as a form of body dysmorphic disorder in DSM-V (APA, 2013) could be considered instead as a male presentation of an eating disorder. Muscle dysmorphia and anorexia share many conceptual

similarities (Dakanalis et al., 2015; Murray et al., 2010), but social constructions of masculinity and femininity cause men to turn to muscle building, whilst women claim dieting as a way of creating and presenting a socioculturally acceptable image and concomitant personhood (Andersen, Cohn, & Holbrook, 2000; Forbush et al., 2007). With no specific question in the interview schedules relating to muscle dysmorphia, the therapists' lack of discussion is arguably a further indication of the condition's positioning outside of disordered eating discourses, and of eating disorders as essentially female conditions (Bunnell, 2016; Dalgliesh & Nutt, 2013; DeFeciani, 2016) discussed in chapter two.

8.3.6 Therapists' experience of in-patient treatment settings

Although this study explored the experiences of psychotherapists working individually with clients, one of the specialist therapists (T4) described in depth his experience of working in an in-patient environment. As a sole description, it is impossible to draw generalisations from this and it seems that this phenomenon is not one discussed in the eating disorders' literature. However, his experience is notable as it illustrates the power of the clientele in a clinic to affect its atmosphere and the therapists working within it. It also suggests that the effects of individual clients on therapists can be magnified in an in-patient group setting when therapists spend more time with clients than they would in one-to-one out-patient treatment. As a microcosm of culture, this experience illustrates the power that groups of people have over individuals. As evidenced in chapter seven, the therapist experienced the unit as being slower and more peaceful when filled mostly with clients with anorexia compared to the more chaotic air he internalised when the balance was weighted towards bulimia. As an example of countertransference and projective identification, this is on a much greater scale than that of the individual within the therapy room and further research into this phenomenon would appear beneficial.

The discussion up until this point has focused on therapists' experiences in the therapy room in relation to their client work. In the following two sections the discussion moves towards the potential effects of working with clients experiencing eating disorders on therapists' personal relationships with food, eating and their body. Both the findings and the literature, concur that work with this client group has the potential to affect therapists' eating behaviours and their perception of food

and the body (Derenne, 2006; Shisslak et al., 1989; Warren et al., 2009). Constant exposure to the discourses of eating disorders during their relational engagement with clients may arguably leave therapists vulnerable to the normalisation and internalisation of those narratives.

8.4 The therapist's experience in relation to their own eating behaviours

As discussed in chapters two and three, an individual's eating behaviours and their presentation in therapy can be considered as representative of their subjective experience, developed in relationship with others and through prevalent cultural and social discourses. Hence, it is pertinent to consider how therapists' relationships with their own body and eating behaviours can be challenged as a consequence of their therapeutic conversations with clients experiencing eating disorders.

In concurrence with published literature, fifteen (83%) of the therapists interviewed described having their own view of food altered and their personal eating behaviours challenged (DeLucia-Waack, 1999; Holbrook, 2013; Kaplan & Garfinkel, 1999; Shisslak et al., 1989; Warren et al., 2009). They also became increasingly vigilant of others' eating patterns, as well as their own appearance and weight, both within and outside of the therapy room (Warren et al., 2009). All four of the female person-centred counsellors described questioning their own weight or eating behaviours as a consequence of their work, and of the thirteen specialist therapists, eleven (85%) of them described experiencing some affects, especially when they first started working with clients experiencing eating disorders. Even those therapists who claimed that their behaviours were not affected in this way reported changes in their understanding of their own and other peoples' relationships with food and eating. In this current section the discussion describes the ways in which the work can affect therapists' eating behaviours before moving on to its impact on the therapist's experience of their body in section 8.5.

8.4.1 Changes to therapists' own eating behaviours

In concurrence with the literature, this study confirmed that working with clients experiencing eating disorders exposes therapists to the possibility of changes to

their own eating behaviours (Holbrook, 2013, DeLucia-Waack, 1999, Kaplan and Garfinkel, 1999, Shisslak et al., 1989, Warren et al., 2009) and of having their personal food and body related beliefs challenged (Zerbe, 1998). Both data sets evidenced examples of therapists experiencing increased consciousness of their own weight and of becoming more aware of the food that they, or others, were eating (Shisslak et al., 1989; Warren et al., 2009). Of themselves, these changes may seem trivial, but when the power of sociocultural discourses attached to food, eating and bodies discussed in chapter two is considered in relation to how these inform individual identities (Lanzieri & Hildebrandt, 2016; Ogden, 2010), the changes gain significance.

As illustrated in chapter seven, all of the specialist therapists admitted to feeling hungry at times in relation to clients and examples of uncharacteristic bingeing, overeating or cake and biscuit eating were described. The specialist therapists tended to interpret these behaviours through their psychodynamic understandings as either countertransference responses or as a consequence of projective identification from clients, and thus they were able to understand them as helpful therapeutic experiences. This interpretation arguably helps therapists make sense of these behaviours and prevents them being subsumed into the clinician's subjectivity but, this psychodynamic conceptualisation situates these problematic eating behaviours within the client and thus risks pathologising them.

The specialist therapists recognised that the work prompted practitioners to explore their own narratives, beliefs and values relating to food, eating and bodies (Daly, 2016; DeLucia-Waack, 1999; Satir, 2013). This was especially true when they first began working with eating disorders and was found to be helpful in enabling a greater understanding of clients' experiences. Such reflection also encouraged an appreciation of the power of food or body related discourses in the development of subjective identity (Lanzieri & Hildebrandt, 2016; Ogden, 2010) for therapists and clients alike. Self-awareness of the discourses affecting one's own body and personal eating based narratives is something that both the specialist therapists and the literature highlight as essential for effective work with clients experiencing eating disorders (Daly, 2016; DeLucia-Waack, 1999; Satir, 2013; Williams & Haverkamp, 2010).

The person-centred counsellors evidenced lower levels of reflection upon their own narratives, with the male counsellor (C4) in particular, feeling that he was so poorly attuned to the subject that he would miss any reference to it from clients.

Considering the range of meanings that food has acquired in western society (Lupton, 1996, 2013; Ogden, 2010) and its role in establishing an individual's subjectivity (Lanzieri & Hildebrandt, 2016) it would appear doubtful that anyone could have such a neutral relationship. Therefore, it could be posited that this counsellor had not engaged in any self-reflective work around his relationships with food, eating and his body. The counsellor's gender is perhaps noteworthy in this and his internalised assumptions regarding the positioning of eating disorders as female conditions (Botha, 2010; Bunnell, 2016; DeFeciani, 2016) need questioned. It is possible, that his seemingly neutral relationship with food and eating arises from an unquestioned assumption relating to the marginalisation of men within the eating disordered field (Forbush et al., 2007; McCormack et al., 2014) that eating issues rarely affect men and therefore he has had no reason to consider these issues.

8.4.2 Identifying with clients' behaviours

Identifying with clients' experiences has both positive and negative consequences for therapists and clients alike. Ethically, therapists tend not to work with clients presenting with the same current issue as themselves as the therapeutic boundaries can become unclear and the literature is unambiguous that counsellors experiencing active eating disorders should avoid the work (Johnston et al., 2005; Rance et al., 2010). However, this distinction can become blurred due to the shared sociocultural discourses regarding idealised body shapes and concomitant lifestyles and personalities (Daly, 2016; Derenne, 2006; Matz & Frankel, 2005). By relating to clients' experiences of sociocultural pressures and appreciating the experience of eating for reasons other than physiological hunger, therapists' empathic engagement is potentially deepened (DeLucia-Waack, 1999). However, there is a risk that therapists can over-identify with clients' situations (Saloff-Coste, Hamburg, & Herzog, 1993; Zerbe, 1993) and question their own eating habits. Such reflection may cause clinicians, who have a slightly problematic relationship with food and eating, to unnecessarily pathologise their own behaviours, especially when recognising the fine line that can exist between normal and problematic behaviours (Starkman, 2016b). The specialist therapists were unanimous in

advocating the need for practitioners to engage in ongoing self-reflection (Daly, 2016; DeLucia-Waack, 1999; Satir, 2013) to ensure that their own behaviours are kept in perspective.

8.4.3 Therapists with a personal history of eating disorders

There is debate in the literature (Johnston et al., 2005; Rance et al., 2010) as to whether it is ethical for therapists who have a personal history of eating disorders to work with the presentation. Reflecting on the limited amount of research identifying how these therapists are affected by their work, Rance et al. (2010, p. 377) conclude that the experience can be “a double-edged sword.” All four specialist therapists with personal experience of eating disorders found that the work had caused them to re-visit and re-evaluate some of their historical behaviours and thoughts. For three of them (T4, T7, T8), this proved reassuring as it reinforced how far they had progressed from their former behaviours. However, it led to previous thoughts being reactivated for one therapist (T4) who consequently felt the need to re-access personal therapy. To ensure ethical and safe practice, practitioners need to engage in continuous self-reflection to be able to recognise when their own issues are at risk of being reignited and their eating disordered subjectivities revisited (DeLucia-Waack, 1999; Satir, 2013).

The specialist therapists working within clinics extolled the value of discussing their clinical experiences with colleagues. Such consultation enabled them to not only discuss client experiences but also to share and work through any personal experiences as they arose. Such an outlet was deemed invaluable as they felt that historic eating disordered behaviours and thoughts could easily re-emerge (T4). This highlights the difficulty of therapists working alone in private practice and the importance of their engaging in regular and appropriate supervision (DeLucia-Waack, 1999; Franko & Rolfe, 1996; Satir, 2013; Shipton, 2004). The significance of supervision for this work will be discussed below in section 8.7.3. The issue of therapists with a personal history of eating disorders warrants further research as statistics show that potentially one in three therapists working with this client group have their own historic experience (Rance et al., 2010; Warren et al., 2009), which is perhaps what motivates them to specialise in the field.

Due to the central role which food plays in an individual's life (Petrucci, 2015a), it can be difficult for therapists who have not experienced eating disordered symptoms to empathise with their client's narrative. Similarly to the experience of one of the specialist therapists (T1), Lawrence (1995, p. 17) wrote of "find[ing] nothing within myself which could help me to understand" her client's anorexia. This is one area in which therapists who have personal experience of eating disorders may have an advantage (Johnston et al., 2005). As evidenced in the findings, without that history, it can be difficult for clinicians to imagine ignoring or denying their own hunger, bingeing to the point of physical distress, or of employing aggressive purging strategies. To ameliorate this and assist in understanding, recognition of the symbolic language of the disorders, from both the social constructionist and phenomenological perspectives, is arguably beneficial.

8.5 The bodies in the therapy room

As discussed in the literature review chapters, the two bodies in the therapy room become especially conspicuous when working with clients experiencing eating disorders. The phenomenological experiencing of the body, the sociocultural discourses inscribed upon it (Malson, 1998) and its inseparability from an individual's subjectivity (Jarman et al., 1997; Lanzieri & Hildebrandt, 2016; Ogden, 2010; Petrucci, 2015a) were discussed in chapter two. The role of the body in relation to an individual's psychological development and subjective experiencing in relation to eating disordered experiences was made explicit in chapter three. Chapter four then critiqued the roles of the two bodies within the therapy room and illustrated ways in which both clients' and therapists' bodies form a prominent component of therapy with those experiencing eating disorders. The section below discusses how the therapist's relationship with their own body, both in and out of the therapy room, can be affected by their client work.

The body's positioning within the eating disordered experience is potentially problematic as the findings and the literature suggest that it can be conceptualised in two ways, from both an embodied, phenomenological perspective (Merleau-Ponty, 1962) and the sociocultural, created in relation to contemporary dominant discourses. As argued in chapter two, discourses pertaining to the idealised aesthetic body and its conflated personality and life-style attributes (Lanzieri & Hildebrandt, 2016) can be considered as powerful determinants of individual and

gendered identity within western consumerist culture. The body thus becomes 'docile' (Foucault, 1975), and as individuals engage in Foucault's "technologies of the self" (Foucault et al., 1988) in the form of dieting, exercise and other body modification techniques, the body becomes increasingly objectified and viewed through the observer's gaze as a product to be created and perfected according to socially constructed gendered aesthetic ideals (Rathner, 2001; Rice, 2014). Constantly checking in the mirror and regular weighing and measuring of the body create self-surveillance practices, echoing Foucault's depiction of Bentham's 'panopticon' in which prisoners become self-policing subjects.

This socially constructed form of identity created through the process of attaining the idealised body and internalisation of its associated discourses arguably marginalises the body's phenomenological and affective experiences. The eating disordered experience can be considered as an exaggerated version (Maisel et al., 2004) of this tendency towards body objectification and disembodiment (Soth, 2006) in which the individual's identity is conflated with the discourses of the eating disorder. As discussed in chapter three, individuals who develop eating disorders typically have a poor self-construct (Duker & Slade, 1988; Tasca & Balfour, 2014; Ty & Francis, 2013) or fixed self-narrative (Gergen & Kaye, 1992). Consequently, they have allowed the external discourses of society and their significant others to gain power over them in creating their sense of self. In order to facilitate recovery from an eating disorder, the client needs to be supported through the process of moving from their extreme objectified subjectivity towards a more integrated and embodied self experience (Sands, 2016). From a narrative therapy perspective, this can be considered as the move from a fixed self-narrative towards a more fluid notion of self changeable within social intercourse (Madigan, 2011).

8.5.1 The therapist's experience of their own body

As much of the experiencing of an eating disorder is directed towards the body or acted out upon it, a heightened awareness of the physical bodies within the therapeutic encounter is inevitable. With an increasing focus on the aesthetic in western culture and the meanings ascribed to body shapes, the influence of sociocultural discourses on both clients' and therapists' experiences is significant. In a culture where pathological body pre-occupation is becoming increasingly common, with some degree of body dissatisfaction recognised as normative for

many women (Daly, 2016, Sands, 2016), and increasingly so for men (Baird & Grieve, 2006; Dakanalis et al., 2015; Wooldridge, 2016) consideration has to be afforded as to how the therapist's perception of their own body is affected by the work.

Contemplating the body as an object to be perfected, individuals experiencing eating disorders have a tendency to scrutinise other peoples' bodies, including those of their therapist (Fairburn, 2008; Orbach, 2003; Petrucelli, 2008; Rance et al., 2014; Warren et al., 2009) and hence for practitioners who are ill-at-ease with their own body, there is potential for physical self-consciousness to arise (Derenne, 2006). Scrutiny can be directed towards the therapist's whole body or focused upon a specific body part (Lowell & Meader, 2005; Rance et al., 2014), as evidenced by the person-centred counsellor (C1) who felt self-conscious of her stomach when working with clients experiencing anorexia. The person-centred counsellors claimed not to be aware of this tendency for scrutiny but all four of the females described a heightened awareness of their own body within their client work. Arguably, this could have resulted from an unconscious awareness of this scrutiny, illustrating a knowledge gap within these counsellors. For therapists who have not adequately addressed their own body related issues, this heightened anxiety has the potential to have a negative impact on the therapy (Daly, 2016) if the therapist's discomfort or lack of self-awareness affects their ability to empathise or engage at depth.

Self-consciousness in relation to the body arises when individuals compare their physical bodies to peers or to the idealised images offered by the media and find their body image lacking. The findings show that this translates into the therapy room. and both data sets suggest that therapists compare their own physicality to that of their clients and question how clients view them through the lenses of sociocultural discourses. Although not afforded much interest in the literature, the size differential between the client's and the therapist's body can be a significant cause of potential self-consciousness or unease for the practitioner (Lowell & Meader, 2005). One of the specialist therapists (T9) described feeling uneasy with her own body size for the first time in her life after working with a weight-loss group. Similarly, a person-centred counsellor (C3) who wore a dress size 24, described a sense of discomfort when working with a slim-bodied client causing her to avoid mirrors and consider beginning to diet. Female therapists within both data sets

described a sense of incongruence when working with clients who had thinner bodies than themselves, especially when they were engaging in psychoeducational work around nutrition or weight control.

8.5.2 Bodies as self-disclosure

As evidenced in chapter four, and by the specialist therapists, the clinician's body can be considered as an always present (Merleau-Ponty, 1962) and visible form of self-disclosure (Daly, 2016; Jabobs & Nye, 2010). As such, it can be considered as an important transference object for the client (Daly, 2016) and can be a useful therapeutic tool for challenging and rewriting clients' narratives regarding body shapes. Therapists' bodies can become the site of clients' projections of internalised familial and sociocultural discourses attached to differing body sizes (Lowell & Meader, 2005; Rance et al., 2014). To enhance the efficacy of treatment, the specialist therapists recognised the importance of the therapist acknowledging and including their own body within the therapeutic dialogue in order to challenge clients' perceptions (Daly, 2016; Fairburn, 2008; Lowell & Meader, 2005; Sands, 2016) and create healthier body related narratives. Therapists who feel self-conscious within their own body (Warren et al., 2009) or who are unaware of their own internalised sociocultural and familial narratives in relation to their physicality (Daly, 2016; DeLucia-Waack, 1999) will be less likely to discuss their body during therapy. However, avoiding discussion of the bodies in the room risks the body becoming a taboo topic (Burka, 1996) and thus reinforces toxic cultural discourses (Daly 2016).

Considering the therapist's body as a form of self-disclosure (Daly, 2016; Jabobs & Nye, 2010; Orbach, 2006; Sands, 2016), any weight losses or gains during the course of treatment will be visible to the client. As evidenced in the person-centred counsellors' findings, the therapist's body or weight can be used informatively within the therapy or it can become the "elephant in the room." Due to their acute awareness of other peoples' bodies (Orbach, 2003; Rance et al., 2014; Warren et al., 2009), clients experiencing eating disorders are particularly attuned to changes in their therapists' body and may comment upon this or project their own narratives regarding body size onto them (Derenne, 2006; Lowell & Meader, 2005).

Therefore, the specialist therapists deemed it essential that clinicians have a congruent and stable body image in order to initiate therapeutic conversations with

clients about such changes and their clients' reactions to them (Daly, 2016; Sands, 2016). Through such discussions, clients' narratives in relation to their internalised discourses around the body can be made evident and then thus challenged and rewritten. The difficulty for therapists arises when considering the body as a representation of self (Lanzieri & Hildebrandt, 2016; Synnott, 1993) and thus through discussion of theirs, the therapist can be left feeling exposed and vulnerable.

Without a stable and healthy relationship with their own body (Daly, 2016; DeLucia-Waack, 1999; Orbach, 2003; Sands, 2016), the scrutiny that clients experiencing eating disorders subject their therapist's body to can be particularly challenging (Orbach, 2004). As evidenced by the person-centred counsellors (C1, C3, C5), a sense of incongruence can be experienced when therapists feel self-conscious of their body size, especially when they feel that it is contradicting what they are discussing with clients. This kind of unease is likely to be evident to clients experiencing eating disorders who are especially attuned to the bodies around them (Orbach, 2004; Warren et al., 2009). Clients who sense this incongruence are less likely to trust their therapist and, as this is a client group recognised as being difficult to engage, this could prove particularly detrimental for the effectiveness of therapy.

Recognising the bodies as always present forms of self disclosure (Daly, 2016; Jabobs & Nye, 2010) suggests the need to consider also what the client's body is communicating to the therapist. The symbolic representation of clients' body sizes was discussed in chapter three and echoing this, the specialist therapists conceptualised clients using their bodies in a concrete manner to express the subjective experiences they were unable to communicate verbally (Farrell, 2015; Sands, 2016; Zerbe, 1993). Alongside this, therapists' internalised sociocultural values may be influencing how they view their clients' bodies. Reminiscent of the notion of the body being left out of the talking therapies (Daly, 2016; Orbach, 2003, 2004; Shaw, 2003), the person-centred counsellors paid very little attention to their clients' bodies, with one in particular (C4) describing internally acknowledging them but then pushing them aside in order to concentrate on the verbal component of the therapy. This suggests an unconscious adherence to the dualist and essentialist self approach of privileging the mind, or language, over the body and its' embodied experiencing. The specialist therapists conversely asserted the importance of

paying attention to the two bodies in the room (Rance et al., 2014), understanding the client's body as a symbolic form of communication, expressing what they are unable to say in words (Petrucci, 2016). Despite their inclination towards invoking psychodynamic understanding, these therapists appeared to recognise the inseparability of self and body, and individual and culture, thus illustrating their move towards integrative practice.

Moving away from the physical presentation of the two bodies, the latter part of this section turns towards the therapist's somatic experiencing and the concept of embodied or somatic countertransference (Barth, 2001; Burka, 1996; Pacifici, 2008; Petrucci, 2001), discussed in chapter three. As presented through the examples in chapter four, these experiences can be powerful and can provide compelling therapeutic material. Situated in the psychodynamic school, not all therapists would recognise this phenomenon but it is afforded attention here due to its use by the specialist therapists' in interpreting their experiences.

8.5.3 Embodied countertransference

As recognised by a number of the specialist therapists, the clinician's body can be a powerful therapeutic tool to aid understanding of clients. Through the psychodynamic discourses discussed in chapter three, embodied or somatic countertransference experiences can be considered to arise as a consequence of clients' alexithymia (Barth, 2016) and projections of their denied feelings onto the therapist (Hughes, 1997). As such, and as discussed in chapter four, the affects can be conceptualised as an indicator of clients' processes, and its understanding by therapists who are attuned to their embodied countertransference can result in an enhanced therapeutic experience (Orbach, 2003). Recognising the somatic experience as a projection from clients meant that therapists were able to contain the feelings and present them back to the client in an appropriate way (Zerbe, 2016) which, as was discussed in chapter three, the client did not experience adequately in infancy (Russell & Marsden, 1998). The specialist therapists recognised that using their body in this way meant that they had to be highly attuned to their embodied experience (Sands, 2016) in order to ensure the effective interpretation of their own feelings and client projections.

The most common form of embodied countertransference described by all of the specialist therapists was the sensation of hunger, felt especially in relation to clients experiencing anorexia. Interpreted through the psychodynamic lens, therapists understood their hunger as a projection from their clients, expressive of their denied emotional and physical needs (Hughes, 1997). It needs to be questioned as to whether therapists were genuinely feeling a hunger projected onto them by clients, or whether it was more simply, their own subjective experience initiated as a consequence of engaging in psychotherapeutic discourse with clients.

For therapists working in inpatient settings who eat with their clients, embodied countertransference arguably has the potential to become even more pronounced. One of the specialist therapists (T4) described acting out the eating styles of the clients within the clinic, finding himself struggling to eat with anorexic patients and wolfing down his food with those experiencing bulimia. When he first began working with the client group, he described continuing to eat this way outside of the clinic too, further illustrating the need for ongoing therapist self-reflection in order to limit the impact of their client work on their personal life and subjective experience. Although this could be interpreted as a countertransference reaction, it also illustrates the social constructionist self as one developed in relationship. Without any challenge to his changing behaviours, it is possible that the therapist's subjectivity, through a changing relationship with food and eating could have been changed. Therefore, it arguably becomes apparent that the individual will always be affected by the dominant current social, environmental and cultural discourses to which they are exposed. Caution needs to be attached to this experience as it was that of only one therapist.

Despite a number of the specialist therapists vouching for the value of embodied countertransference, only limited descriptions of its experience were given in the interviews and hence its validity needs to be questioned. Such somatic experiences were described by therapists practising from a psychodynamically influenced approach and those who had recognised the significance of the role of the body in work with clients experiencing eating disorders. The person-centred counsellors and the psychologists working from a cognitive-behavioural approach did not disclose any such embodied affects. This again, furthers the discussion as to whether such discrepancies arise from lack of experience and knowledge or are due to the therapists' therapeutic orientation. It should also be noted that the more

severely someone is entrenched in their eating disordered behaviours, and the less connected they are to their physiological and proprioceptive experiencing, the more likely they are to engender strong countertransference feelings in the therapist (Zerbe, 1998). Hence for counsellors in general practice settings working with less severely affected clients, the possibility of experiencing embodied countertransference is arguably lessened.

8.6 Are differences due to therapeutic approach or differing experience levels?

Interwoven throughout the discussion have been a number of differences between the person-centred counsellors' experiences and those of the specialist therapists. Clinical experience and knowledge must play a role within this, but it is also appropriate to question the influence of the different therapeutic approaches, and hence the theoretical knowledge base, which therapists work from. This is a question not addressed to date by the literature pertaining to eating disorders. Literature searches failed to show reference to any studies specifically exploring the correlation between the clinician's psychotherapeutic orientation and their personal experience within the therapeutic relationship. There is also dissent as to whether the level of clinical experience impacts the affective experience of therapists when working with this client group. Whilst some studies (Franko & Rolfe, 1996) indicate that less experienced professionals experience more negative reactions and find the work particularly challenging (Jarman et al., 1997), others show no correlation between experience and professional affect (Satir et al., 2009; Shisslak et al., 1989). However, it is difficult to compare this with the findings from this particular study as most of the published literature is written across professional disciplines rather than looking specifically at the experiences of psychological therapists.

Although many of the feelings experienced in relation to clients were shared by both the person-centred counsellors and the specialist therapists, the postmodern notion of multiple realities is evident from the different interpretations placed upon them. Understanding their experiences from their own knowledge base, the person-centred counsellors accepted the feelings as arising from within their own experience whilst the specialist therapists conceptualised them through the psychodynamic constructs of countertransference or projective identification, discussed in chapter three. Although important for the specialist therapists of this

study, these psychodynamic interpretations are not always acknowledged, perhaps due to the cross-disciplinary nature of much of the literature, meaning that psychodynamic concepts were outwith other professions' epistemologies. As discussed in chapter three, the person-centred counselling and cognitive-behavioural therapy approaches tend not to discuss countertransference and projective identification, and hence therapists practising from these schools would not necessarily be as cognisant of them as a therapist practising with psychodynamic knowledge. If these phenomena are accepted as helpful therapeutic communications, this then leaves therapists at risk of missing their client's projected experiences or of misattributing them to their own subjectivity.

However, from a social constructionist perspective, such reliance on these psychodynamic understandings can be problematic as clients are pathologised through the interpretation of therapists' somatic experiences as representative of clients' deficiencies. Such countertransference experiences are immeasurable and can only be self-reported by the therapists who experience them and hence their validity needs to be questioned. Nevertheless, their employment by some of the specialist therapists illustrates the situatedness of knowledge and thus the potential for multiple interpretations of client experiences.

As parts of the therapy field in recent years have begun to acknowledge social constructionist perspectives (Piran & Cormier, 2005) and the role of sociocultural factors in clients' experiences, the focus on the essentialist or pathologised inner self has necessarily shifted. The newer psychodynamic theories are becoming increasingly relational and despite person-centred counselling's notion of the "authentic self" to discover (Rogers, 1951, 1961), therapy is still a relationship in which change occurs within therapeutic dialogue. Within this backdrop, narrative therapy has evolved to more fully encompass the postmodern social constructionist perspective, more clearly recognising the power of sociocultural discourses and relational creation of identity. Arguably, these social constructionist ideas can be carried into the therapy rooms of those practising from a person-centred or more psychodynamically influenced perspective to allow for more integrative ways of working. Despite the therapists interviewed for this study claiming therapeutic orientations which worked with an essentialist self, they were all aware of the influence of sociocultural discourses on the experiences of clients presenting with eating disorders.

As none of the therapists interviewed practiced from a narrative therapy perspective, it is impossible to know from this study how such clinician's experiences might have differed from those interviewed. Without the inclusion of the psychodynamic constructs of projective identification and embodied countertransference, therapists would be affected less at the bodily level, which would arguably protect them from some of the more profound effects of this client group. From the social constructionist slant of the thesis, interviews with narrative therapists working with clients experiencing eating disorders would have been helpful.

8.7 Implications for professional practice

Some of the differences between the experiences of the person-centred counsellors and the specialist therapists can be explained by their differing levels of experience of working with the client group. As discussed previously, eating disorders can be considered as a specialist presentation (Natenshon, 2012) but due to the increasing numbers of clients seeking support and tightening constraints on specialist services, more therapists in general practice setting will be seeing individuals presenting with the conditions (Furstand et al., 2012; Jarman et al., 1997; Williams & Leichner, 2006). Therefore, increasing all therapists' knowledge of eating disorders is essential (Bannatyne & Stapleton, 2014; Williams & Haverkamp, 2010; Williams & Leichner, 2006). Recognising the need to invoke multiple forms of knowledge to best accommodate individual clients (Natenshon, 2012; Petrucelli, 2001), the therapists practiced in a fluid manner, adapting their practice to the multiple realities of their presenting clients. The multifactorial (Madigan, 2011; NICE, 2017; Starkman, 2016a; Tasca & Balfour, 2014; Wooldridge, 2016) nature of eating disorders seems to suggest itself to this kind of working but it requires a depth of knowledge and confidence around the disorders.

Training areas suggested by the findings are summarised in sections 8.7.1.1 – 8.7.1.9. Domains in which therapists would benefit from increased self-awareness are documented in section 8.7.2, before implications for clinical supervision are discussed in section 8.7.3.

8.7.1 Training implications of integrative practice

Although recently published NICE guidelines (NICE, 2017) for treating eating disorders advocate eating disorder focused CBT or a manualised focal psychodynamic treatment protocol, a number of the specialist therapists discussed the impossibility of working from a definitive treatment protocol (Jarman et al., 1997; Natenshon, 2012; Petrucelli, 2016). As a consequence of the disorders' multifactorial aetiology (Hamburg & Herzog, 1990; NICE, 2017; Tasca & Balfour, 2014) and the uniqueness of each individual client's subjective experience and history (Zerbe, 2016), therapeutic flexibility and the adoption of an integrative treatment approach (Barth, 2016; Burket & Schramm, 1995; Petrucelli, 2016; Satir, 2013; Tasca & Balfour, 2014; Tasca et al., 2011) was indicated. To achieve this, Williams and Haverkamp's (2010) competency domains for ensuring ethical psychotherapy with clients experiencing eating disorders, discussed in chapter four, should be considered.

Recognising also, the difficulties inherent for therapists' practice in drawing upon alternative psychotherapeutic theories, this study does not necessarily advocate clinicians' integration of concepts from alternative clinical modalities. Rather it suggests areas of understanding, highlighted by the specialist therapists, which could be used to inform clinicians' conceptions of their clients and thus their clinical practice. This study appreciates that therapists are trained in different modalities and hence conceptualise clients and eating disorders in different ways. The thesis does not claim that any one way is the 'right' way, but rather seeks to expand the knowledge base of therapists working from their preferred model. The training topics below are suggested as areas in which therapists, from all persuasions, might gain increased understanding of eating disorders which they can then integrate into their own therapeutic philosophy. In order to not simply repeat the points discussed above and in the relevant chapters, the section below summarises the pertinent areas.

8.7.1.1 Eating disorders

The key learning point is that, as claimed by some of the specialist therapists, eating disorders are not simply about food, eating and body size (Satir, 2013) but are rather an individual's best attempt to manage themselves and regulate their emotions (Petrucelli, 2015b).

8.7.1.2 The eating disorders' multifactorial aetiology

The multifactorial aetiology (Hamburg & Herzog, 1990; NICE, 2017; Tasca & Balfour, 2014; Wooldridge, 2016) of eating disorders, in relation to both their development and maintenance needs to be understood so that therapists are aware of the various aspects of their clients' experiences which need resolving.

8.7.1.3 Inadequate self construct

The typically poor self-construct of an individual experiencing an eating disorder (Tasca & Balfour, 2014; Ty & Francis, 2013) has implications for how they present and engage in therapy. As discussed in chapters two and three, an understanding of individuals' reliance on the eating disordered narratives and behaviours to create a coherent sense of self (Demidenko et al., 2010; Troisi et al., 2005) can help therapists conceptualise clients' reliance on their eating disordered stories, and thus begin to challenge, or create a more effective self narrative. Related to this, therapists would arguably benefit from appreciating clients' tendencies towards perfectionism (Ty & Francis, 2013) which, as discussed in chapter three, can also affect their therapeutic engagement and expectations of themselves, their therapist and the therapy.

8.7.1.4 Attachment or early relational narratives

Extending the inadequate self construct of 8.7.1.3, clients' early relational experiences (Demidenko et al., 2010; Russell & Marsden, 1998; Troisi et al., 2005) can be explored to gain a deeper understanding of how this developed. Attachment experiences were discussed in chapter three and it was shown how, from a psychodynamic interpretation, they inform the eating disordered individual's development and relationship patterns and how these are enacted in therapy. So as not to apportion blame or pathologise clients, an attachment narrative therapy (Dallos, 2004, 2014) perspective is suggested to illustrate how these experiences can be used to inform understanding of the narratives clients are currently living from.

8.7.1.5 Clients' disconnection between self and body

To help heal or rewrite the unhelpful self-construct of section 8.7.1.3 an understanding of the roles that dominant sociocultural and familial discourses have played in its construction would be advantageous. Recognising the tendencies of individuals experiencing eating disorders to take western consumerist culture's disembodiment (Soth, 2006) to an exaggerated level (Maisel et al., 2004) in their

attempt to create a sense of self can help therapists appreciate the need to facilitate a move towards a more phenomenological, embodied self-experience (Sands, 2016) or a more fluid sense of identity constructed in relation to changeable social intercourse (Madigan, 2011).

8.7.1.6 Physiological consequences of the disorders' behaviours

As the physiological consequences of the eating disordered behaviours are not typically covered in therapy training (Spotts-De-Lazzer & Muhlheim, 2016), therapists may be unaware of the potential risks to their clients' health and even life (Williams & Haverkamp, 2010). The physiological consequences of starvation have also been shown to have a detrimental effect on cognitive functioning (Gottlieb, 2015; NICE, 2017), and hence clients' abilities to engage in therapy (Kaplan & Garfinkel, 1999). Therefore, an understanding of these and of the consequences of them in relation to clients' abilities to engage would be beneficial.

8.7.1.7 The different eating disordered presentations

Only the specialist therapists spoke in detail about the different eating disorders, but as illustrated in chapters one and three, all therapists could benefit from understanding how each of these develop, what the client is communicating through them, and how they present differently within the therapeutic relationship.

8.7.1.8 The role of the bodies in the therapy room

Clients experiencing eating disorders have a tendency to scrutinise other peoples' bodies (Daly, 2016; Fairburn, 2008; Rance et al., 2014; Warren et al., 2009) and hence it can be helpful for therapists to be aware of this potential. As discussed in chapter four, the therapist's body becomes a visible source of self-disclosure when working with clients experiencing eating disorders (Daly, 2016; Jacobs & Nye, 2010; Orbach, 2006). The body as a representation of self, from both the sociocultural perspective, discussed in chapter two, and the more subjective experiencing discussed in chapter three are also important considerations.

8.7.1.9 The therapist's experience in the therapy room

Clients experiencing eating disorders have been shown via the findings of this study and the published literature to instil powerful feelings in their therapists (Warren et al., 2009), as discussed in section 8.2 above. An awareness of this potential could be helpful so that therapists know what to expect from the work.

Similarly, and discussed in chapter four and 8.4 above, therapists could be better prepared if they were aware that their own relationships with food, eating and their body could be challenged through the work (Holbrook, 2013; Warren et al., 2009).

8.7.1.10 The male experience of eating disorders

Throughout this thesis, the ongoing marginalisation of the male experience of eating disorders (Forbush et al., 2007; McCormack et al., 2014) has been referred to. The findings concurred with this through the participants' lack of discussion regarding male clients and of the gendered experience of eating disorders. Therefore, to help rectify this, education around the male experience, as discussed in chapter three, would seem vital.

8.7.2 Therapists' self-awareness

As well as the training areas indicated above, the findings and literature highlight the importance of therapists working with clients experiencing eating disorders reflecting upon their own relationships with food, eating and their body (Daly, 2016; Satir, 2013). Therapists are encouraged to engage in ongoing personal development and self-awareness (Bond, 2015), but from the findings of this study, focused work around these areas and their corresponding impact on subjectivity is something that not all therapists have considered. The specialist therapists were vocal about the need for this ongoing work, but the person-centred counsellors evidenced much lower levels of awareness. The fact that the interviews provided an opportunity for personal awareness to arise suggests that there is a place for more structured personal development experiences in counsellor training in relation to this topic. Even for some of the specialist therapists (T5, T7, T10), the interview dialogues provided an opportunity for awareness to increase. As a result of realisations discovered during the interviews, the counsellors were able to deepen their understanding of how their own relationships with food and eating affected their own subjectivity or their client work. There are two strands to this self-awareness which it would appear beneficial for therapists to engage with; the role of food and eating in their own life and subjective experience and also their beliefs and values around their own and others' bodies.

8.7.2.1 Food and eating

As discussed in chapter two, food and eating behaviours are subject to contemporary sociocultural discourses (Lupton, 1996, 2013; Ogden, 2010) in a similar way to body shapes. Specialist therapists recognised that in order to enable clients to understand their relationships with food, clinicians need to have reflected upon, and gained some understanding of the role of food and feeding in their own lives and self-narratives (Daly, 2016; DeLucia-Waack, 1999).

The specialist therapists discussed the importance of encouraging clients to talk openly and congruently about their current eating behaviours (Petrucci, 2015a). Here again, and as illustrated in the findings from the person centred counsellors, the potential for over-identification is present as therapists recognise some of their own behaviours or beliefs in those of their clients (Zerbe, 1992). In a culture focused on the control and manipulation of bodies and thus food (Daly, 2016; Sands, 2016), it can be difficult for therapists to distinguish between clients' problematic eating behaviours and their own 'normal' ones (Starkman, 2016b). As one of the specialist therapists (T5) voiced for example, it may not be unusual for a therapist to be controlling their own food for health or weight loss reasons whilst working with a client, or for a therapist to be engaged in body control behaviours purely for culturally induced aesthetic reasons.

8.7.2.2 The therapist's body

As discussed in section 8.5, the therapist's body is an always visible presence in the therapeutic relationship (Daly, 2016; Jacobs & Nye, 2010; Orbach, 2006) and therefore, a congruent and comfortable physical presentation within the therapy room is essential (Daly, 2016; DeLucia-Waack, 1999; Orbach, 1986, 2003). Without this, clients may recognise their therapist's incongruent embodiment which may negatively impact on the therapy. It would be impossible to expect all therapists working with clients experiencing eating disorders to have achieved complete acceptance of their own body, but working towards this is necessary (Lowell & Meader, 2005). Therapists who do not enjoy a comfortable personal embodied experience may find that the scrutiny which clients place them under creates feelings of discomfort or self-consciousness (Derenne, 2006; Zerbe, 1998). This in turn may affect the therapists' capacity for congruence and empathy within the therapeutic relationship. Recognising the interlinked nature of embodiment and

phenomenological experiencing, the therapists' personal and professional confidence may also be affected.

The combination of the shared sociocultural positioning (Daly, 2016; Orbach, 2006) for therapists of both genders and a potential lack of self-awareness may make it more difficult for the clinician to offer unconditional positive regard (Rennie, 2007; Rogers, 1951, 1961) towards not only their clients' behaviours and bodies but also their own. The therapist who is not aware of their personal internalised corporeal beliefs may unconsciously present these in the therapy room, either in their embodied self-presentation or in how they react to their clients. Individuals experiencing eating disorders will present with a vast range of body sizes, from the extremely underweight to the obese, and it can be helpful for therapists to be aware of their thoughts and feelings towards different body shapes in order to ensure their unconscious beliefs do not influence the therapy. Sociocultural ideals can result in therapist over-identification (DeLucia-Waack, 1999; Hamburg & Herzog, 1990; Zerbe, 1993) and unconscious collusion (Burket & Schramm, 1995) with clients who are seeking to achieve the socioculturally prescribed ideal body. There is also the potential for therapists to be incongruent if they are verbally encouraging clients to challenge these ideals whilst ascribing to them themselves. Clients may consciously or unconsciously sense such contradictions in therapists' non-verbal communication and for individuals who experience relational difficulties, it may jeopardise their trust in the therapist.

8.7.3 Clinical supervision

Before concluding this chapter, there is another area of professional conduct to consider which is essential for safe therapeutic practice. Ethically, all psychotherapists are encouraged to access regular clinical supervision (Bond, 2015) and all of the therapists within this study advocated its importance. From discussion with the specialist therapists, supervision seems especially vital with this client group due to both the challenges afforded by the work (Rance et al., 2010; Warren et al., 2009) and its potential to affect the subjective experiencing of clinicians (DeLucia-Waack, 1999; Franko & Rolfe, 1996; Satir, 2013; Satir et al., 2009; Shipton, 2004; Warren et al., 2009). Due to the intensity of the work, a number of the specialist therapists recognised the need to limit the number they were working with at any one time so as to prevent therapist burnout (Warren et al.,

2009). Supervision should be experienced as the safe place where therapists reflect on the effects of their client work on themselves, both personally and professionally. In order to achieve this adequately, the specialist therapists voiced the importance of supervisors having specific experience or knowledge of eating disorders and their concomitant issues (Franko & Rolfe, 1996; Hamburg & Herzog, 1990).

Despite the recognition of the value of effective supervision, there was a discrepancy between the two data sets with some of the non-specialist counsellors (C1, C2, C5) describing a reluctance to share their own experiences with their supervisors for fear of judgement (DeLucia-Waack, 1999; Hamburg & Herzog, 1990; Holbrook, 2013). This sense of shame was evidenced by one of the person-centred counsellors (C1) whereby she had avoided talking to female supervisors about her own eating behaviours for fear of being judged by another woman, who she perceived would be influenced by sociocultural discourses around eating disorders and being a female in contemporary western society. However, in contrast, the specialist therapists emphasized the importance of taking these clients to supervision and of the therapist being able to talk freely about their own experiencing.

8.8 Conclusion

Concurring with the existing literature, this chapter has illustrated that working with clients experiencing eating disorders can prove to be demanding for therapists (Rance et al., 2010; Warren et al., 2009). The challenges inherent in the work can be experienced on two levels; the professional and the personal. Professionally, the therapeutic relationship has been shown to be challenging as a consequence of clients' attachment narratives, the ego-syntonic nature of the disorders (Barth, 2008, 2016; Wooldridge, 2016), clients' typical personality characteristics (Duker & Slade, 1988) and their difficulties with affect management and the physiological effects of the behaviours which affect cognitive functioning (NICE, 2017; Satir et al., 2009; Tasca & Balfour, 2014). The influence of sociocultural discourses (Daly, 2016; Derenne, 2006; Matz & Frankel, 2005) conflating the aesthetic with an individual's identity also add to this challenge, alongside clients' ambivalence to yield their ego-syntonic eating disordered behaviours and subjectivity (Franko & Rolfe, 1996; Strober, 2004; Zerbe, 1998). As a consequence, therapists can find

themselves experiencing a range of feelings including frustration, anxiety and inadequacy (Burket & Schramm, 1995; Warren et al., 2009).

On the more personal level, therapists' own relationships with food, eating and their bodies can be highlighted and challenged (Franko & Rolfe, 1996; Holbrook, 2013; Kaplan & Garfinkel, 1999; Shisslak et al., 1989; Warren et al., 2009). Therapists can experience changes to their own eating behaviours and body image as a result of their therapeutic dialogue and empathic engagement with clients. There is also a danger of therapist identification with their clients' beliefs, values and behaviours as a consequence of their shared sociocultural situation (Daly, 2016; Matz & Frankel, 2005). These factors gain significance when considering the fluid nature of selves created within relationship (Gergen, 2015; Lock & Strong, 2010) and how the therapist's sense of self can therefore be changed through their work.

The scrutiny to which clients experiencing eating disorders tend to subject their therapists' bodies (Fairburn, 2008; Orbach, 2003; Petrucelli, 2008; Rance et al., 2014; Warren et al., 2009) can create self-consciousness for the therapist who is ill-at-ease within their own physicality (Daly, 2016; DeLucia-Waack, 1999; Orbach, 1986, 2003). Considering the therapist's body as always present (Merleau-Ponty, 1962) and therefore a visible form of self-disclosure (Daly, 2016; Jabobs & Nye, 2010; Orbach, 1986), the importance of the therapist presenting a relaxed and congruent body image (Daly, 2016; DeLucia-Waack, 1999; Orbach, 1986, 2003) to a group of clients whose distress is situated to a large extent within their body becomes evident. Any visible changes to the therapist's body in terms of size or dress will be evident to clients and interpreted by them in some way. Clients experiencing eating disorders will tend to read their therapist's body through the dominant sociocultural discourses they have internalised relating to bodies. The therapist's body thus becomes a significant part of the therapeutic relationship and hence should be considered and discussed when appropriate (Sands, 2016).

From the psychodynamic perspective of some of the specialist therapists, the clinician's body can also be considered as a therapeutic tool which resonates with embodied countertransference communications from clients (Barth, 2001; Burka, 1996; Orbach, 1994, 2003, 2004; Pacifici, 2008; Petrucelli, 2001). These experiences can be informative and yet can only exist for therapists who ascribe to such psychodynamic concepts. The impact of the therapist's knowledge base

therefore can be seen to influence how their client work is interpreted and experienced.

The complex aetiology (Delvecchio et al., 2014; NICE, 2017; Starkman, 2016a) of the conditions was highlighted through the person-centred counsellors' inadequate knowledge level in relation to some aspects of the eating disordered experience. These gaps in knowledge have implications for the therapist's experience within the relationship, the efficacy of the therapy and the client's well-being. The person-centred counsellors also evidenced lower levels of self-awareness regarding their own relationships with food, eating and their body. Self-exploration and understanding of these areas were seen as vital by the specialist therapists in order to work effectively with eating disordered clients (Daly, 2016; DeLucia-Waack, 1999; Williams & Haverkamp, 2010).

The knowledge gaps evidenced in the person-centred counsellors' experiences could be wholly attributed to their lower levels of experience of working with eating disordered clients but due to the different therapeutic approaches used within the two data sets, it is prudent to question the effect of therapeutic orientation upon the therapist's subjective experience. Inevitably, the psychotherapeutic discourses they ascribe to will inform their treatment approach and their conceptualisations of both clients and their own experiences. From the differences noted, the importance of training, self-reflection and supervision to enable therapists to work effectively with eating disordered clients became apparent. Although eating disorders at an acute stage need specialist support (Natenshon, 2012), increasing numbers of individuals with disordered eating issues are presenting in more general practice (Williams & Haverkamp, 2010) and hence therapists need to have some level of understanding not only of the disorders, but also how they can personally be affected by the work.

Finally, the lack of discussion in relation to male clients experiencing eating disorders needs to be highlighted. The therapists interviewed for this study confirmed the cultural and clinical positioning of eating disorders as essentially female conditions (Botha, 2010; Bunnell, 2016; Wooldridge, 2016). Not wanting to influence participants' responses, the interview questions were gender neutral and it is noteworthy that the therapists, other than a few passing comments, spoke only of their experiences in relation to female clients. Interview conversations regarding

sociocultural pressures were also directed around the female experience suggesting that the therapists had paid minimal consideration to the male experience or changing gender roles. This omission suggests that the male experience of disorders is a significant one in relation to future training and awareness.

In the final chapter of this thesis, the research aim will be revisited in order to ascertain how far the study has achieved this. Conclusions formed in relation to the experiences of therapists of working with clients with eating disorders will be presented alongside the implications for professional practice. The limitations of the study will be acknowledged and directions for future research suggested.

Chapter 9 Conclusion

9.1 Introduction

This concluding chapter revisits, in section 9.2, the aim and significance of the study, initially introduced in chapter one, to reaffirm the value of conducting this research. The aetiology, experience and recovery from eating disorders is contextualised within twenty-first century western consumerist society and the conditions' positioning as an exaggerated version (Maisel et al., 2004) of cultural disembodiment (Soth, 2006) explicated. Adaptations made to the methodology are presented in section 9.3 to remind the reader of its evolving nature in response to changes within my own methodological narrative through my engagement with the research. The findings of the study are summarised in section 9.4 illustrating the ways in which psychotherapeutic therapists are affected by their work and asserting what this study has contributed to the field of eating disorders and therapists working therein. Following this, the key contributions this study makes for professional practice are presented in section 9.5 to illustrate how therapists may be more effectively prepared for their work. The limitations of the study will be discussed in section 9.6 before concluding with recommendations for further research in section 9.7.

9.2 The significance of this research study

The study explored the ways in which therapists practising psychotherapeutically with clients experiencing eating disorders were affected by their work. Combining constructivist grounded theory (Charmaz, 2006) and heuristic research practices (Moustakas, 1990), the study investigated both how therapists were affected by their clients within the therapy room and the impact upon their own relationships with food, eating and their bodies. Arguably, all clients have the potential to affect their therapist but, as illustrated by the findings and extant literature, the idiosyncratic and complex nature of eating disorders (NICE, 2017; Starkman,

2016a; Tasca & Balfour, 2014) presents therapists with a unique and challenging experience (Satir, 2013; Warren et al., 2009).

9.2.1 The relevance of studying eating disorders

Four key elements were shown to make the study of eating disorders as a distinct client presentation worthwhile. Firstly, and as illustrated in chapters four and eight, clients presenting with eating disorders tend to elicit a range of powerful feelings within their therapists (Thompson-Brenner et al., 2012; Warren et al., 2009) and are recognised as being challenging (Rance et al., 2010) and difficult to treat (Hughes, 1997; Kaplan & Garfinkel, 1999). As a consequence of the shared sociocultural situation (Daly, 2016; Derenne, 2006; Zerbe, 1992) there is potential for therapists to identify with their clients in relation to their experience of their bodies and their relationships with food and eating (Hamburg & Herzog, 1990; Saloff-Coste et al., 1993; Zerbe, 1993). Thirdly, the visibility of the therapist's body in the therapy room (Daly, 2016; Jacobs & Nye, 2010) and the tendencies of clients experiencing eating disorders to scrutinise other peoples' bodies (Daly, 2016; Fairburn, 2008; Rance et al., 2014) leaves the therapist vulnerable to challenges to their own sense of their body, both within and without the therapeutic dyad. And finally, the increasing number of individuals presenting with eating disorders (Natenshon, 2012; Williams & Haverkamp, 2010) and the inability of specialist units to accommodate demand (Jarman et al., 1997) means that therapists are increasingly likely to experience clients with disordered eating issues in their therapy room (Furstand et al., 2012).

A small number of studies exist exploring the experiences of professionals working with clients experiencing eating disorders, but they are recognised as limited in their scope (Franko & Rolfe, 1996; Holbrook, 2013; Satir et al., 2009; Thompson-Brenner et al., 2012; Warren et al., 2009). They are largely cross-disciplinary, encompassing a range of professions rather than looking specifically at the experiences of psychological therapists as within this study. Research specific to the psychotherapeutic experience is necessary as the therapy relationship is arguably a unique one between therapist and client. Privileging confidentiality and empathic collaboration to an extent not always necessary in other professional interactions, the therapeutic relationship is recognised as the key factor of client change (Rogers, 1951; Wooldridge, 2016). Although clients attend therapy in order to change or gain self-understanding, the relational nature of self and its co-

construction arguably creates potential for the therapist's self to be changed in the course of empathic therapeutic dialogue.

9.2.2 Situating eating disorders in western consumerist society

Eating disorders have been shown to be largely socioculturally situated, with dominant discourses pertaining to food, eating and the body playing a significant role in creating their meaning and the self-experience of those living with them. Their positioning as essentially woman-centric conditions (Botha, 2010; Bunnell, 2016) was illustrated in chapter two through discussion of historical discourses attributed to the feminine body and experience beginning with the 'female fasters' of the Middle Ages (Bell, 1985; Bynum, 1987). The identification of 'anorexia' in 1874 (Brumberg, 2000) furthered this and, due to an ongoing allegiance to Cartesian dualism in which the rational male experience was privileged over the irrational and emotional of the female (Grosz, 1994), contemporary male doctors claimed it as a feminine affliction (Malson, 1998). The role of women and discourses pertaining to the female body throughout Victorian society played their role in confirming this positioning before the socially constructed gendered experience of femininity throughout much of the twentieth century further reinforced it. More recently, changing gendered roles (Maine & Bunnell, 2008) and a rising interest in the aesthetic masculine body (Wooldridge, 2016) have brought the male experience of eating disorders increasingly into clinical and cultural consciousness.

Regardless of gender, eating disorders were shown, in chapters two and three, to be expressions of problematic self identity and body image. Twenty-first century western consumerist culture places significant value on the idealised body and its associated discourses of achievement, self-discipline and success (Daly, 2016; Malson, 1998). Through society's privileging of the aesthetic, the body has become increasingly objectified and viewed as something to be manufactured to satisfy the socioculturally defined 'perfect' shape (Rathner, 2001; Rice, 2014). This has created an increasing sense of objectification or disembodiment (Soth, 2006) and a culture in which many individuals' subjectivities are largely shaped through the power of dominant discourses attached to body shape and eating practices. Foucault's (1975) notion of 'docile bodies' can be invoked to illustrate the unquestioned (Petrucci, 2016) internalisation of these discourses by individuals who then afford them further power by engaging in self-policing regimes, including persistent body weighing, measuring and mirror checking. Many individuals

engage in varying extremes of dieting and body modification practices and it has been claimed that dieting has become increasingly the norm (Daly, 2016) in contemporary western culture. Disordered eating can be perceived as existing on a continuum (DeFeciani, 2016) with a fine line between 'normal' and pathological eating behaviours (Starkman, 2016b), hence the potential for therapist identification with their clients arises.

9.2.3 Body and self in the eating disordered experience

Although this thesis is heavily informed by social constructionism, the paradigm has been shown to be problematic in some ways in relation to understanding eating disorders and their concomitant notions of self and body. The social constructionist self does not accommodate the notion of self-agency and, despite self being created relationally through interaction with significant others and sociocultural discourses, the self-reflexive functioning still needs recognition (Aron, 1998; Sands, 2016). The essentialist self of the psychological theories employed by the therapists interviewed was therefore invoked as it helps explain why not everyone within western culture develops problematic eating (Riva et al., 2013; Ty & Francis, 2013) or body image issues (Hudson et al., 2007) despite being subjected to the same discourses pertaining to food, eating and body shape.

These psychological theories however do not afford much attention to the role of the body in the experiencing of self, which was shown to be a pertinent issue in relation to eating disorders. The body's unique position as both subject and object (Grosz, 1994) affords it power in the conditions' experience as something that the individual both is, and has (Crossley, 2006). As an object which the subject can control and change, situated in a culture in which the body represents the self (Jabobs & Nye, 2010; Lanzieri & Hildebrandt, 2016), individuals experiencing eating disorders believe that by controlling their body, they can control who they are. Merleau-Ponty's (1962) phenomenological body was thus introduced as an alternative construct, offering a more embodied subjectivity (Grosz, 1994), striving towards the elimination of dualism and recognising the inseparability of mind and body.

From the perspectives of both the social constructionist and phenomenological selves, the body can be considered as a representation of the individual's subjectivity (Synnott, 1993). Dominant sociocultural influences conflating body size

and personality (Lanzieri & Hildebrandt, 2016) can be read upon it through its size and presentation, and in the therapy room both therapists and clients make assumptions about the other through their observations of each other's body. Chapter three illustrated how the subjective experience of each of the eating disorders is acted out through the client's embodied presentation, eating behaviours and relational engagement. Due to their typical alexithymic disposition (Barth, 2016; Mathiesen et al., 2015) individuals who develop eating disorders have a tendency to express the experiences they are unable to articulate in language through the concrete medium of their bodies (Farrell, 2015; Sands, 2016). From the power afforded to words and symbols in the social constructionist co-creation of self, therapists thus need to be equally conversant in the language of the eating disordered body.

As the eating disordered experience has been claimed as an exaggerated form of western culture's tendency towards disembodiment (Maisel et al., 2004) and the conflation of self with body (Jabobs & Nye, 2010), this thesis posits that the phenomenological notion of the inseparable self and body (Merleau-Ponty, 1962), can be helpful in conceptualising recovery. Dualism can be drawn upon to suggest that therapy should facilitate the eating disordered individual's move away from their typically disembodied self-experience created through sociocultural discourses towards a more embodied phenomenological one (Sands, 2016). Within the therapy room, this can be considered as a move away from the fixed eating disordered self-narrative the client initially presents with towards a more fluid sense of self (Madigan, 2011).

9.3 Methodology

In some ways the methodology can be considered to have mirrored this move away from the fixed, objectified self to a more fluid experiencing as the inseparable nature of researcher from research became increasingly evident. The methodological approach taken is unique due to the way in which it was adapted to suit the changing needs of both myself and my interpretation of the research. Despite West's (2001, p. 128) claim that grounded theory and heuristic research are at "opposite end[s] of the pole," I combined them in such a way so as to ensure the maintenance of rigorous data generation and analysis protocols alongside heuristic research's more intuitive and embodied approach to analysis.

As presented in chapter five, due to my personal history of eating disorders and my ontological counselling perspective, at the outset I chose a methodology which would provide a rigorous data collection and analysis protocol, whilst also enabling me to remain at sufficient distance from the research in order to minimise potential researcher bias. Constructive grounded theory (Charmaz, 2006) satisfied this objective whilst also accommodating the voices of participants and the acknowledgement of sociocultural influences.

9.3.1 Myself as reflexive researcher

However, as the study progressed and I found myself increasingly immersed in both the empirical data and the literature, it became evident that grounded theory was becoming restrictive. As a reflective practitioner it now appears inevitable that this research would encourage my own self-reflection (Bager-Charleson, 2014; Etherington, 2004a) and in hindsight, my determination to produce an objective research study perhaps prevented me from sufficiently considering alternative approaches to grounded theory at the outset. Immersing myself in the research resulted in changing perspectives on both my own eating disordered history and my therapeutic practice. Not only did I rewrite my personal narrative, but my professional self within the therapy room developed in response. At times this proved unsettling and I was subjected to the self-doubt disclosed by some of the participants. My subjective experience of myself was challenged on numerous occasions, mirroring how this client group can challenge the embodied experiencing of their therapists. These experiences felt too powerful to ignore and I became aware that through my reflection upon them, my understanding of the literature and empirical data was deepened (Defrancisco et al., 2007). Used effectively it seemed that this had the potential to positively influence the research and I therefore sought a methodological way of incorporating this.

Recognising that I was engaging in heuristic research's (Moustakas, 1990) immersion process, I began to explore ways in which I could incorporate its methods around the grounded theory protocols already being employed. This ensured that the methodology did not change, but was rather expanded, to more effectively accommodate the needs of both the research and myself as researcher (Meekums, 2008; Nuttall, 2006). Aligning with a fluid social constructionist approach to methodology (McLeod, 2001; Simon, 2014), this ensured that the research was not forced into fitting a rigid methodological protocol decided upon at

the outset, but which no longer fitted the needs of the study (West, 2001). Another parallel emerges here with the research topic where therapists advocated flexibility within their therapeutic approach (Simon, 2014) rather than forcing clients to fit a rigid intervention structure.

Within this process, reflexivity (Etherington, 2004a) became increasingly important, but as per section 9.2.3, reflexivity can be problematic for social constructionism in a similar way to the problem of self. Despite acknowledging that my interpretation of the data arose relationally from my engagement with the emerging findings and literature, a reflexive self was also evident who was performing the reading, analysis, reflection and interpretation. This self was given a voice in the reflexive account within chapter five.

The inseparability of my researcher, therapist and personal selves has to be acknowledged in relation to the reciprocal nature of their interactions. My own historic experiences and ongoing interest in the fields of both therapy and eating disorders inevitably influenced my choice of research question. In hindsight, it seems inevitable that my ontology as a reflective therapeutic practitioner would demand a voice. As for therapists whose bodies and subjectivities were shown to both influence, and be influenced by the therapeutic encounter, so it was for me with this research. My identity as a practising therapist throughout the course of the research inevitably played a role in this process. Had I been able to continually immerse myself fully in the research it might have been possible to leave behind my therapist self. Unable to do this though, the inseparable and co-creating affect of each self upon the other has to be acknowledged. In chapter five, I discussed how I was able to transfer the skills used to understand clients within the therapy room into my analysis of the findings, thus introducing a more embodied way of knowing

9.3.2 The role of the therapists interviewed

Having acknowledged my role within the study's development and interpretation, the therapists who presented for interview have also to be recognised as they inevitably influenced the content and direction of the literature review and findings. As discussed in the methodology chapter, the participants configured into two data sets; the person-centred counsellors and the specialist eating disorders' therapists. There were a number of shared experiences between the groups but, as discussed

in chapter eight and illustrating the notion of multiple realities, the therapists' interpretations often differed. Some of the variations could be accounted for as a consequence of the specialist therapists' necessarily increased knowledge and experience of working with the client group. However, further analysis of the discrepancies suggested that the therapists' psychotherapeutic approaches were an influential factor.

The experiences the therapists shared during the interviews were interpreted through the therapeutic understandings they possessed. The specialist therapists' inclinations towards psychodynamic concepts directed my literature searches and thinking towards these theories, as discussed in chapter three. All of the therapists drew upon theories which conceptualised an inner self and thus the experiences they offered unavoidably invoked a sense of the essentialist self. However, these selves were shown to be embodied and culturally and historically situated. They were also recognised as being created either in relationship with significant others or with the therapist during the course of therapy. Invoking the therapy world's turn towards social constructionism (Piran & Cormier, 2005), the therapists were all also aware of the influence of sociocultural factors on their own and clients' experiences.

The psychodynamic concepts of attachment, projective identification and embodied countertransference created most of the discrepancies between the two data sets. The specialist therapists claimed them as helpful ways of conceptualising both the experiences of clients presenting with eating disorders and their own experiences within the therapeutic encounter. Attachment patterns were discussed in chapter three and shown to be helpful in understanding clients' past and current interpersonal difficulties. Aligning with the integrative way of working which the literature (Petrucci, 2016; Satir, 2013; Wooldridge, 2016) and specialist therapists suggest, the concept of attachment was posited as a way of extending person-centred counsellors' understanding of the development of the poor self-construct typically evidenced in the individual presenting with an eating disorder (Tasca & Balfour, 2014; Ty & Francis, 2013). A narrative therapy approach was also discussed illustrating that attachment experiences do not have to be considered as pathologising or parent-blaming, but that their exploration can facilitate appreciation of how the client created their current attachment story (Dallos, 2014).

The concepts of projective identification (Hughes, 1997) and embodied countertransference (Pacifici, 2008) were less easy to reconcile as they were discussed by only the specialist therapists. They were claimed to be helpful in understanding clients' processes, with the literature review in chapter four illustrating some powerful therapist experiences. Hence it can be argued that clinicians, including the person-centred counsellors in this study, who have limited awareness of these concepts, potentially miss significant therapeutic communications from their clients. For therapists who ascribe to the theories, a concentrated awareness of their embodied experiencing is necessary to ensure that they can distinguish between their own experiences and those being projected onto them by clients. However, working in this way arguably leaves the therapist vulnerable to more intense therapeutic affects, thus heightening the challenges of working with the client group.

Awareness of these discrepancies acknowledges that the therapist's therapeutic approach affects their understanding of clients and thus their experience within the therapy room. Remaining within a fixed treatment model also has potential to increase the therapist's frustration and self-doubt and to limit their freedom to explore all aspects of their clients' experience (Gottlieb, 2015). Combining these potential limitations with the multifactorial aetiology of eating disorders then suggests the efficacy of integrative working (Barth, 2016; Burket & Schramm, 1995; Petrucelli, 2016; Satir, 2013; Tasca & Balfour, 2014; Tasca et al., 2011), which is suggested through the summary of the study's findings below.

9.4 A constructive interpretation of the findings

As discussed in chapter five, although grounded theory aims to produce a descriptive theory, it was evident that this study would not produce sufficient findings to enable this to develop. Thus a "constructive interpretation" (Fassinger, 2005, p. 158) of the findings is presented below illustrating the ways in which the therapists interviewed were affected by their client work. The implications of this for both individual therapists and professional practice are then presented in section 9.5.

9.4.1 Feelings elicited by client work

Within the therapy room it is evident that clients experiencing eating disorders have the potential to induce a range of powerful feelings within their therapists, with some of the most common being frustration, fear, anxiety and a sense of inadequacy or self-doubt (Thompson-Brenner et al., 2012; Warren et al., 2009). Although concurring with the extant multi-disciplinary literature, this study has exemplified these feelings purely in relation to the experiences of psychological therapists. The findings suggest that these feelings arise for a number of reasons:

1. The difficulties inherent in engaging eating disordered clients in therapy as a result of their typical attachment experiences and subsequent relational narratives (Dallos, 2014; Tasca & Balfour, 2014; Tasca et al., 2011).
2. For therapists practising from a psychodynamic perspective, the tendency of individuals experiencing eating disorders to project their dissociated feelings onto their therapist (Hughes, 1997).
3. The potential health related risks of the disorders (NICE, 2004) for which therapists are not usually trained (Spotts-De-Lazzer & Muhlheim, 2016) and the associated physiological cognitive impairment (Duker & Slade, 1988; Gottlieb, 2015; Kaplan & Garfinkel, 1999) which can affect therapeutic engagement, and thus the therapist's experience.
4. The similarities and differences with the therapist's own sociocultural and subjective experience of food, eating and their body (Daly, 2016; DeLucia-Waack, 1999; Saloff-Coste et al., 1993; Zerbe, 1993), especially when considering eating disordered behaviours to exist along a continuum (DeFeciani, 2016) from the normal to the pathological (Starkman, 2016b).
5. The recognition that therapists' personal and professional subjectivities can be challenged within the therapeutic relationship and that therefore their selves can be rewritten in a similar way to those of their clients.

The specific feelings elicited by this client group and the differing experiences of the person-centred counsellors and the specialist therapists were discussed in chapter eight. Some of these feelings could be claimed to be because of different levels of experience and therefore, knowledge of eating disorders, suggesting training opportunities for non-specialist therapists. However, it became apparent that different interpretations could be placed upon both the feelings and the therapist's subsequent experience as a consequence of therapeutic orientation which perhaps helps explain the difficulty in devising a definitive treatment protocol (DeFeciani, 2016; Jarman et al., 1997; Petrucelli, 2016). Therapists who interpreted their

feelings through a psychodynamic lens conceptualised some of them as countertransferential communications from clients. This enables therapists to attribute feelings such as frustration, anxiety and self-doubt to clients' eating disordered presentations, thus pathologising the client. However, it arguably also protects the therapist from attributing such distressing feelings to their personal subjectivity. A challenge arises for therapists in accurately interpreting which of their feelings are countertransferential reactions to clients and which are their own responses initiated in relation to the work.

9.4.2 Feelings experienced in relation to the different eating disordered presentations

Although evidenced by only the specialist therapists (Franko & Rolfe, 1996), practitioners can be subjected to different relational challenges dependent upon the specific eating disordered presentation. As these differences have implications for how clients engage in therapy, as suggested in chapter eight, it is beneficial that therapists are aware of the distinctions. The typically withdrawn relational pattern of the client experiencing anorexia is enacted within the therapeutic relationship leaving therapists feeling limited by their client's difficulty in accepting the emotional nurturance on offer (Russell & Marsden, 1998; Strober, 2004). Individuals experiencing anorexia typically expose their therapists to increased levels of frustration and anxiety (Franko & Rolfe, 1996) as a consequence of their dissociated experience (Barth, 2016; Zerbe, 1993) and subsequent tendency to project these feelings onto others (Hughes, 1997). Illustrating the visceral nature of such clients' corporeal presentations (Farrell, 2015), therapists describe the pain of sitting with the extremely thin, visibly distressed body. Individuals experiencing bulimia typically present with a more ambivalent relating style (Russell & Marsden, 1998). Finding it difficult to process their emotions and experiences as a consequence of their typical alexithymia (Barth, 2016) clients can leave the therapist feeling physically sick or with a sense of having been left with unprocessed material at the end of sessions (Russell & Marsden, 1998). In relation to clients presenting with binge eating disorder, therapists describe challenges connecting at depth with the person hidden within the obese body.

9.4.3 Therapists' experiences in relation to their own bodies and eating behaviours

Moving beyond the therapy room to consider affects which impact more directly on therapists' subjective experiences, work with clients experiencing eating disorders can cause changes to the counsellor's own eating behaviours and experience of their body (DeLucia-Waack, 1999; Derenne, 2006; Shisslak et al., 1989; Warren et al., 2009). The empathic nature of the therapeutic relationship, alongside the shared sociocultural situation (Daly, 2016) and the therapist's own embodied subjectivity, create a challenge to the clinician's personal experience. Recognising therapists as reflective practitioners, it is arguably inevitable that the experiences shared by clients would initiate reflection on their own eating behaviours and embodied experience.

Therapists can find themselves over-identifying with clients' aesthetic ideals or recognising their own eating habits or body-checking behaviours in those of their clients (Hamburg & Herzog, 1990; Saloff-Coste et al., 1993; Zerbe, 1993) which can cause them to question or even change their own behaviours. Although both the literature and the empirical evidence suggested that this was most likely when therapists first began working extensively with this client group, the potential for issues to emerge or for historic patterns to re-surface within experienced therapists remains evident (Zerbe, 1993).

Although the potential for these affects is already recognised in the literature, this study advances this by concentrating on the experiences of psychological therapists. This is considered relevant due to the empathic nature of the therapeutic relationship and the professional requirement of ongoing self-reflection and awareness. The study also extends the extant literature to acknowledge the significance of these changes due to the centrality of food, eating and the body to an individual's embodied subjectivity (Lupton, 1996; Ogden, 2010).

9.4.4 The two bodies in the therapy room

The therapist's body takes on a significant role when working with clients experiencing eating disorders and, recognised as an always present and visible

form of self-disclosure (Daly, 2016; Jabobs & Nye, 2010; Orbach, 1986), becomes a magnet for clients' projections, comments and scrutiny. This can leave therapists experiencing a heightened awareness of their own body. The benefit of clinicians therefore achieving a stable sense of their own body image (Daly, 2016; DeLucia-Waack, 1999; Orbach, 1986, 2003) becomes apparent, as without it, any physical self-consciousness may be evident for clients to see. Attuned to their therapist's body, the client may sense any unease and, adding to their inherent relational difficulties, the therapist's embodied discomfort may compromise the therapeutic encounter.

The potential for embodied countertransference was recognised by the specialist therapists as a useful therapeutic communication aid in understanding clients' processes (Pacifici, 2008; Petrucelli, 2015b) (Barth, 2001; Burka, 1996; Orbach, 1994, 2003, 2004; Pacifici, 2008; Petrucelli, 2001) which leaves therapists vulnerable to powerful somatic experiences. As discussed in section 9.3.2 however, the phenomenon needs to be recognised as a psychodynamic construct and thus not all therapists will ascribe to it.

Having summarised the findings discussed in chapter eight, section 9.5 will elucidate the implications of these for the counselling fields.

9.5 Key contributions of the study for professional practice

As this study has advanced the current cross-disciplinary literature to focus specifically on psychotherapeutic practice, the findings have been contextualised in relation to the therapy field, recognising in particular, the collaborative empathic nature of the therapeutic dialogue. The most significant finding of the study is a need for increased training regarding eating disorders for all therapists (Bannatyne & Stapleton, 2014; Spotts-De-Lazzer & Muhlheim, 2016 ; Williams & Leichner, 2006) and their supervisors (Hamburg & Herzog, 1990), as without it there is a risk of unethical practice (Bond, 2015) and of potentially causing harm to clients (Williams & Haverkamp, 2010). Education relating to eating disorders should be included on all psychotherapy training course (Williams & Haverkamp, 2010) and offered as ongoing continual professional development. Eating disorders need to be understood as complex conditions whose multiple aetiological factors (NICE, 2017; Tasca & Balfour, 2014; Wooldridge, 2016) all need attention during the

course of therapy. Areas in which therapists and supervisors would benefit from increased understanding were detailed in chapter eight. Although a more integrative style of working (Petrucci, 2016; Tasca & Balfour, 2014; Wooldridge, 2016) was suggested, this thesis acknowledges the ethical, epistemological and ontological difficulties of combining different therapeutic approaches. Therefore, the key areas for training summarised in chapter eight, are offered as ways of helping therapists and their supervisors enhance their understanding of the eating disordered experienced which can then be integrated into their own therapeutic style.

In relation to their personal experience, therapists working with clients presenting with eating disorders should be prepared for a challenging therapeutic encounter (Satir, 2013; Warren et al., 2009). As discussed in section 9.4, therapists can expect to experience a number of powerful feelings in relation to their clients (Warren et al., 2009). With an increased understanding of the conditions, many of these feelings can be more effectively conceptualised in relation to clients' eating disordered subjectivities and experiences. They can thus be interpreted and used in ways which will enhance the therapeutic encounter for both client and therapist, and protect the therapist from the personal impact of the feelings.

Some of the feelings experienced relate directly to clients' engagement within therapy which can be better understood when their interpersonal difficulties (Kaplan & Garfinkel, 1999), the ego-syntonic nature of eating disorders (Barth, 2016; Wooldridge, 2016) and the potential physiological consequences of the behaviours (Fursland et al., 2012; Gottlieb, 2015; Tasca & Balfour, 2014) are appreciated.

Regardless of their therapeutic modality, therapists should acquire sufficient knowledge of the conditions to allow them to work in a more integrative way (Natenshon, 2012; Petrucci, 2016; Satir, 2013; Wooldridge, 2016), paying particular attention to clients' attachment experiences (Tasca & Balfour, 2014) and development of relational narratives (Dallos, 2004, 2014; Dallos & Denford, 2008; Dallos & Vetere, 2009). The ability to draw upon cognitive-behavioural techniques (Barth, 2016; Natenshon, 2012; Satir, 2013) or narrative practices (Dallos, 2014; Maisel et al., 2004; White & Epston, 1990) to challenge clients' beliefs and values regarding the body in contemporary western consumerist society is also suggested. A key understanding for therapists is that eating disorders, despite appearance to

the contrary, are not just about food, eating and body image (Satir, 2013), but are rather disorders of self.

A further personal challenge for therapists identified in this study is being prepared for their own narratives and behaviours regarding food and their body to be affected through the work (Warren et al., 2009). Due to their shared sociocultural position (Daly, 2016; Sands, 2016) and the fine line that exists between normal and pathological behaviours (Starkman, 2016b), therapists need to develop a high level of self-awareness in these areas (Daly, 2016; Williams & Haverkamp, 2010) and establish a robust sense of their own body image and eating practices (DeLucia-Waack, 1999; Satir, 2013). The associations between eating behaviours, body shape and identity, discussed in chapter two, mean that any challenges within these areas can have significant impact on the therapist's subjective experience.

Another key finding of this study was the visibility and roles of the two bodies within the therapy room. Therapists should be aware of their body as an always visible form of self-disclosure (Daly, 2016; Jacobs & Nye, 2010) and of clients' tendencies to scrutinise them (Daly, 2016; Fairburn, 2008; Warren et al., 2009). Clients will make assumptions about the therapist based upon sociocultural discourses conflating body size and personal characteristics and also regarding how at-ease the therapist appears in their body (Lowell & Meader, 2005). The study highlighted that therapists need to be conversant in their clients' bodies too, as, due to their typical alexithymia (Barth, 2016; Mathiesen et al., 2015) and dissociated embodied experience (Zerbe, 1993) individuals with eating disorders tend to use their bodies to enact the self experiences they cannot articulate (Daly, 2016; Petrucelli, 2016).

Turning back to professional areas, this thesis claims the importance of therapists extending their self-awareness regarding their own relationships with food, eating and their bodies, as discussed in chapter eight. This practice both informs therapeutic work with clients (Daly, 2016), and helps therapists monitor the effects of the work upon themselves and their own subjectivities. The need for continuous self-reflection upon those relationships (Daly, 2016; DeLucia-Waack, 1999; Satir, 2013; Williams & Haverkamp, 2010), both personally and within supervision (Hamburg & Herzog, 1990) is highlighted as essential.

Supervision is another professional area which warrants consideration, as its provision is essential for ethical therapeutic practice (Bond, 2015). The study suggests that supervisors should be trained in work with eating disorders (Hamburg & Herzog, 1990) to offer best practice to their supervisees. Shame regarding their own weight and eating behaviours or reactions to clients prevents some therapists disclosing their experiences openly within supervision (Hamburg & Herzog, 1990; Jarman et al., 1997) and hence the increased training and self-awareness proposed above may go some way to normalising this by reducing the stigma experienced by some therapists.

Having summarised the findings and presented the key contributions of this study, it is necessary to acknowledge its limitations.

9.6 Limitations of the study

Any generalisations from this study need to be treated with caution due to the limited sample size. Participant numbers and the therapists interviewed were limited to those who saw, and responded to, the recruitment advertising. This meant that effective saturation points within themes were not always achieved, beyond the preliminary study. The therapists' self-selection and interest in participating also suggests that these were practitioners with a keen interest in eating disorders and hence may have been more reflective in relation to their work than other therapists.

Although assumptions have been made regarding the impact of therapeutic orientation upon therapists' experience, the small sample size must be considered here too. Conclusions have been formed in relation to the experiences of the person-centred counsellors and cognitive-behaviourally informed psychologists within this study, which may not be universally true. Researching the experiences of greater numbers of such therapists, as well as those practising from other therapeutic approaches, would enable more definitive conclusions to be formed. Researching therapists in general practice who work in ways other than the person-centred approach would also be helpful to ascertain if their experiences mirror those of the person-centred counsellors within the study.

Not all of the person-centred counsellors were based in general practice and hence they had no experience of working with clients enduring the severe levels of eating disorder presenting in specialist clinics. Zerbe (1998) suggests that therapists are more likely to experience embodied countertransference reactions in relation to clients who are more severely ill and hence the lesser severity of clients' presentations may have impeded the counsellors' experience. Further research into the experiences of person-centred counsellors with greater experience of the work may be helpful. However, it is also necessary to acknowledge that neither the research (Marchant & Payne, 2002) nor the specialist therapists within this study advocate person-centred therapy as an effective sole therapeutic intervention for clients with eating disorders.

There was a clear gender bias within the study. Only three of the complete sample were male (16.7%); one of the five person-centred counsellors (20%) and two of the thirteen specialist therapists (15%). Within the group of non-specialist counsellors, the male participant evidenced the lowest levels of subject specific knowledge, sociocultural influence and self-awareness around his own relationships with food, eating and the body. It is impossible to draw general gender based conclusions from his sole experience; however, it would also be naïve to assume that other counsellors, both male and female, would not have similar experiences. Consideration also needs afforded as to whether his experience was related to his own unconscious bias towards eating and body image issues being female conditions (Botha, 2010; Bunnell, 2016) and therefore not something he has considered in relation to himself. Within the group of specialists, the gender difference appeared to have less impact on the therapist's experience, with the male clinicians responding in similar ways to those of their female counterparts. This may have been as a consequence of their experience within the field, although this was not something considered during the interviews.

The gender bias is also evident in relation to the therapists' experiences of their clients as notably, the majority of experiences recounted related to female clients. As researcher, I need to take some responsibility for this as questions relating to male clients or gender were not included in the interview schedule. Although not wanting to prejudice the therapists' responses, this omission potentially limited the research to a female perspective, furthering the current woman-centric nature of much of the literature (Dalglish & Nutt, 2013; Morgan, 2008).

Finally, the study has assumed that therapists share the same sociocultural background as their clients. The therapists interviewed held this presumption and so the study followed this inclination. However, this may not necessarily be the case and attention needs to be afforded to the experiences of both therapists and clients raised in different cultures. The age groups of the therapists interviewed should also be considered as the majority of clinicians questioned were aged over 40. Only one therapist lay within the 31-40 years' old category and hence an age bias is evident. Future research considering the effect of therapists' age upon their experience of working with clients experiencing eating disorders would be beneficial.

9.7 Recommendations for future research

The challenges for therapists of working with eating disordered clients have been recognised for many years and yet the literature is still relatively sparse (Satir et al., 2009; Thompson-Brenner et al., 2012; Warren et al., 2009). As discussed in chapter four, much of the current literature is cross-disciplinary and hence it would seem that future research focusing exclusively on psychotherapists would be beneficial. Within this, comparative studies exploring the efficacy of different therapeutic approaches, including the integrative style (Barth, 2016; Burket & Schramm, 1995; Petrucelli, 2016; Satir, 2013; Tasca & Balfour, 2014; Tasca et al., 2011) espoused by the specialist therapists would seem advantageous. As Sands (1991) discussed, if therapy focuses only on the behavioural elements, then other underlying issues will potentially surface again in the future in the same or different ways. Ensuring that clients receive a holistic therapy experience from the outset would have cost implications if it reduces the likelihood of their needing to access further therapy.

The data gathered for this study indicated differences in the experiences of the person-centred counsellors and the specialist therapists. As indicated in section 9.3 above, the numbers within this study are small, therefore categorical assertions about whether these differences are due to the differing experience and knowledge levels, a consequence of the different therapeutic approaches or a result of the severity of their clients' presenting conditions cannot be made. Further research into all three of these areas would be beneficial. There is no consensus in the literature as to whether time spent working with eating disordered clients has an

impact on professional experience. Again, the majority of studies are cross-disciplinary with only limited attention afforded to different psychotherapeutic approaches.

The presence and role of the two bodies within the therapy room became increasingly significant as the research developed and some current research is also advocating greater inclusion of the physical body within talking therapies (Barth, 2016; Crisp, 1997; Daly, 2016; Newman, 2008; Orbach, 2009; Petrucelli, 2008; Rance et al., 2014; Sands, 2016). As discussed in chapter three, the body is a key element within the eating disordered experience and, despite the two bodies within the therapy room being recognised as visible forms of self-disclosure, they appear to be missed out of psychotherapy to varying extents. Consideration therefore needs afforded as to whether greater concentration on the corporeal reality of the client may encourage a greater bodily acceptance, which in turn would potentially enhance self-acceptance. Alongside this is a greater appreciation of the idea of a person's subjective experience of themselves being represented through their physical presentation. Although this is especially pertinent for clients presenting with eating disorders, it may be the case for other presenting issues too.

9.8 Conclusion

Although research exploring the experiences of professionals working with clients with eating disorders exists, it is currently limited in its scope (Satir et al., 2009; Thompson-Brenner et al., 2012; Warren et al., 2009) conducted across a range of professional disciplines, rather than specifically to the counselling professions. This study considered the privileged position of the empathic psychotherapeutic relationship and thus focused exclusively on the experiences of psychological therapists. Confirming the findings of the published literature, the study corroborates that clients experiencing eating disorders present a range of challenges for the professionals who work with them, both personally and professionally.

From the study's social constructionist epistemology, the notion of changeable selves created in relationship was invoked to consider how therapists' subjectivities can be affected through the work. The shared sociocultural positioning of therapists (Daly, 2016) and their clients increased the potential for therapist

identification with clients' body related values and eating behaviours (DeLucia-Waack, 1999). Causing therapists to reflect on their own corporeality and eating habits, the work has potential to initiate changes to clinicians' own embodied subjectivity. The significance of this becomes apparent when considering twenty-first century consumerist society's discourses conflating eating, body shape and identity (Lanzieri & Hildebrandt, 2016).

In relation to therapists' professional experiences, the relational aspects of eating disorders were shown to present a range of challenges within the therapy room. It was argued that the attachment narratives held by clients and their characteristically dissociated embodiment (Barth, 2016; Zerbe, 1993) affect the therapeutic encounter (Tasca & Balfour, 2014; Tasca et al., 2011) affording powerful experiences for therapists.

Mirroring a movement currently in evidence towards the greater inclusion of the body within psychotherapy (Barth, 2016; Daly, 2016; Newman, 2008; Rance et al., 2014; Sands, 2016), the study also recognised the significance of the two bodies within the therapy room. As an always visible form of self-disclosure (Daly, 2016; Jabobs & Nye, 2010) and site for client projections (Lowell & Meader, 2005), the therapist's body becomes a valuable therapeutic tool for use with a client group whose distress and attention is focused on the body. The client's body also takes up a similar position and, for the therapist versed in the symbolic language of the eating disordered body and its behaviours, the client's corporeality voices what they cannot say with words (Farrell, 2015; Petrucelli, 2016; Sands, 2016).

The body was considered from two perspectives in this thesis, both of which were shown to be representative of self-experience or subjectivity. The socially constructed body was shown to have sociocultural discourses inscribed upon it in relation to western consumerist society's idealised bodies, gender roles and conflated personality characteristics (Lanzieri & Hildebrandt, 2016). It was argued that in contemporary western culture, the body is representative of the self (Jabobs & Nye, 2010; Lanzieri & Hildebrandt, 2016) and that consumerism has created a sense of disembodiment (Soth, 2006) in which people view their body as an object to manipulate and perfect (Rice, 2014), rather than experiencing it as the site of their embodied existence. It was suggested that individuals experiencing eating disorders take this cultural inclination to an extreme (Maisel et al., 2004) and create

a fixed self narrative written around body related sociocultural discourses. In contrast, the phenomenological body was invoked as a more embodied subjectivity and it was claimed that clients presenting with eating disorders benefit from moving away from the disembodied extreme towards a more embodied experience (Sands, 2016).

The configuration of the research participants into two data sets illustrated potential gaps in knowledge and self-awareness of non-specialist therapists, which were shown to have implications for training and continuing professional and personal development. It also raised questions regarding the effect of the therapist's therapeutic approach upon their understanding of their clients' presentations and the consequent impact this has on therapist experience. The efficacy of an integrative style of working with eating disordered clients in order to satisfy their multifactorial aetiology became evident (Jarman et al., 1997; Tasca & Balfour, 2014; Tasca et al., 2011). From this, it was proposed that eating disorders are given a greater import in therapist training (Bannatyne & Stapleton, 2014) as working from an uninformed position has implications for ethical practice and the efficacy of the therapy (Williams & Haverkamp, 2010). As part of such training, the importance of therapists exploring their own subjective and embodied experiences, beliefs and values around food, eating and bodies became evident (Daly, 2016; Satir, 2013).

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Appendices

Appendix A	Research Participant Information Sheet
Appendix B	Consent Form
Appendix C	Transcript Agreement Form
Appendix D	Interview Schedule

Appendix A

Research Participant Information Sheet

PhD Research Study, York St John University

PhD Student / Researcher: Sharon Cox

Academic Supervisors: Dr Lynne Gabriel, Dr David Tune,

The impact of working with eating disordered clients on the counsellor's subjective and / or embodied experience

Who am I?

My name is Sharon Cox. I am a part-time Postgraduate Research student at York St John University, carrying out this research study to inform my PhD. I am also an experienced counsellor working in GP surgeries and private practice. I have a special interest in working with clients presenting with eating disordered issues.

What is this research study about?

This research study aims to gain a detailed description of ways in which therapists may be personally affected by their empathic engagement with clients' subjective experiences of eating disorders and their subsumed issues. It is anticipated that therapists' sense of self and their embodied experiences in relation to their clients and their presenting issues will be an area under close investigation.

Why am I asking you to participate and become a part of this study?

I am inviting counsellors and other psychological therapists who have current or recent experience of working with clients presenting with eating disorder related issues to participate in this study. As I am seeking to understand the therapist's experience of working with such clients it is important that I speak to a number of

such therapists in order to gather your first hand knowledge, thoughts, feelings and other experiences.

Why is this research important?

It is hoped that this research study will inform the self awareness work that therapists engage in before, or whilst, working with clients presenting with eating disordered issues, which in turn will lead to improved therapeutic experiences and outcomes for clients. This information will also be useful for counselling supervisors and employing agencies to ensure their awareness of the potential impact of this client group on their therapists.

What am I asking of participants in this study?

I am asking participants to agree to be interviewed on a one-to-one basis by myself or to participate in a focus group with a small number of other therapists. A list of some of the areas I anticipate being discussed can be found at the end of this information sheet.

Interviews will be conducted by myself in a private room at a venue to be agreed between us. I anticipate them lasting approximately 1½ hours. They will be audio recorded and later transcribed verbatim, by myself. Immediately after the interview, I will provide time for a debriefing session should you feel the need to discuss anything that has arisen for you during the interview.

I will send a copy of the completed transcription to you for your approval. If there is anything in the transcription which you want removing, just let me know and I will delete it from the transcript and not use it in the study. You will also be given the opportunity at this time to add anything else you feel may be relevant.

Focus Groups will be arranged at a convenient venue and will typically consist of 8 – 12 participants. In small groups we will discuss therapist experiences of working with eating disordered clients. Flip charts will be provided for groups to record their ideas; I will later write these notes up and send them to you for your approval. Immediately after the focus group, I will provide time for a debriefing session should you feel the need to discuss anything that has arisen for you during the discussions. If there is anything in the notes I write up which you want removing,

just let me know and I will delete it from them and not use it in the study. You will also be given the opportunity at this time to add anything else you feel may be relevant.

I will be happy to provide you with a brief summary of my preliminary research findings if you would be interested in reading them.

How will this research benefit participants?

As a participant, I am offering you the opportunity to have your voice and thoughts heard and considered within an academic study. This will then hopefully go on to inform the future practice both of myself, and other counsellors, therapists and supervisors working with this clients group, ensuring that our clients have a more satisfactory counselling experience.

As the study is focused on the therapist's experience, it will also give you the opportunity to think about the counselling process for yourself. I see this as being a potentially useful personal development exercise for participants.

Are there any risks in agreeing to participate in this research?

The only risk I can foresee is that the interviews, focus groups or self reflection needed for this study may cause you to question some of your current thoughts and feelings about your own subjectivity or embodied experience when working with this client group. However, I trust that as therapists, we are all aware of the potential for our client work to affect us in this way and are actively engaged in ongoing self-awareness and reflection, supervision and / or personal therapy.

Following the interviews / focus groups, I will provide a debriefing session during which we can discuss any issues which may have arisen for you and explore how these can best be managed or taken forward.

How will confidentiality be managed?

All information shared with me for the purposes of research will be anonymised so that you can in no way be identified in any written work or oral presentations which arise from the research. Any personal details you give me will be stored in a locked

filing cabinet separately from the research study. All personal details, recorded and written records of the research will be destroyed on completion of my PhD.

Are participants free to withdraw from this research at any time?

Yes. If, for any reason, you change your mind about being a participant, just let me know and I will remove your information from my study. You do not need to give me a reason for this.

If you have any further questions regarding this research study, please feel free to contact me and we can discuss them.

Sharon Cox

Tel: 0191 257 9234

Mobile: 07751 722 744

E-mail addresses: sharon.cox@yorks.ac.uk sharon.cox@live.com

Potential areas for discussion

To give you an idea of what to expect during our interview / focus group, the following points are a list of possible areas we could discuss. I've listed these to give you an idea of the things which I believe may be relevant to this research. However, as it is *your* experience I am interested in hearing, please feel free to raise other themes which you believe may be relevant or which you personally have experienced or considered as a result of your work.

- Any general information you wish to share about your experience of working with clients presenting with eating disorders or related issues.
- How your work with this client group may have influenced your own ideas or thoughts about your own body and / or eating habits.
- Personal embodied experiences you have been aware of during your work with this client group.
- Personal development work you might have engaged with around your own relationship with food, eating, and your body.
- Anything you've learned from your clients about the role of the body and / or food in a person's life (including your own).
- The influence of bodily experience on a person's sense of self.
- Your thoughts and feelings around people who present with eating related issues.
- How the type / severity of the eating disorder affects how you experience your client or your self during the sessions.
- Your own understanding of eating disorders; their development, purpose, treatment, etc.
- The role of the media and / or Western culture in eating disorders and body image sensitivity
- Things you wish you'd thought about or known before engaging in work with this client group.
- How you feel other counsellors / therapists could be better prepared for working with this client group.

Appendix B

Consent Form

PhD Research Study, York St John University

PhD Student / Researcher: Sharon Cox

Academic Supervisors: Dr Lynne Gabriel, Dr David Tune

Title of study: "The impact of working with eating disordered clients on the counsellor's subjective and / or embodied experience"

Please read the statements below and circle the appropriate answer.

Please bring the completed form to our meeting.

I have had the research satisfactorily explained to me in verbal and / or written form by the researcher and have a copy of the Participant Information Sheet for future reference.

YES / NO

I have had the opportunity to ask questions and have any queries I had about this research answered.

YES / NO

I understand that the research will involve me participating in an interview with the researcher, Sharon Cox, which will last for approximately 1½ hours. I understand that this interview will be audio recorded and transcribed verbatim at a later date for analysis within the study.

YES / NO

I understand that I may withdraw from this study at any time without having to give an explanation.

YES / NO

I understand that all information about me will be treated in strict confidence and that I will not be named in any written, spoken, or published work arising from this study.

YES / NO

I understand that any audiotape material of me will be used solely for research purposes and will be destroyed on completion of your PhD.

YES / NO

I understand that you will be discussing the progress of your research with others (including your research supervisor and other appropriate individuals) at York St John University.

YES / NO

I freely give my consent to participate in this research study and have been given a copy of this form for my own information.

Name:

Signature:

Date:

Appendix C

Transcript Agreement Form

PhD Research Study, York St John University

PhD Student / Researcher: Sharon Cox

Academic Supervisors: Dr Lynne Gabriel, Dr David Tune

Transcript Agreement Form

Name of Researcher: Sharon Cox

Title of study: "The impact of working with eating disordered clients on the counsellor's subjective and / or embodied experience "

Please read the statements below and circle the appropriate answer.

Please return the completed form to me in the enclosed SAE.

I have read the transcript of my research interview and I agree to its being used in its entirety for the purposes of this research study.

YES / NO

I have read the transcript of my research interview and I have made relevant amendments. I agree to its being used in its amended form for the purposes of this research study.

YES / NO

I have had further opportunity to ask questions and have any queries I had about the research at this stage answered.

YES / NO

I understand that I may withdraw from this study at any time without having to give an explanation.

YES / NO

I freely give my consent for the information in my transcribed interview to be used for the purposes of this research study and have been given a copy of this form for my own information.

Name:

Signature:

Date:

Appendix D

Interview Schedule

“The impact of working with eating disordered clients on the counsellor’s subjective and / or embodied experience”

Interview Prompt Questions

Individual Level: Personal Impact on the Therapist

- Tell me about your own experience of working with clients presenting with eating disorders / body image concerns.....
 - Did it affect you in any way?
 - Reflections / learnings as a result of your work?
 - How did you feel about the clients and what s/he was telling you?
About their behaviour? About their description of their experience?
About their beliefs and thoughts?
 - What was your response to their presentation; ie: their body shape / size, the clothes they were wearing
 - Does the client's age make any difference to you?

- Were you aware of any impact on your own embodied experience?
 - Whilst you were with the client?
 - Immediately after the session?
 - At some other time?
 - During supervision?

- Has your work changed your view / thoughts / feelings towards your own body?
 - Or how you experience yourself in any way?

- Has it changed your attitude towards body shape / size or eating habits of other people in any way?
- Were your eating habits influenced in any way?
 - Your thoughts around food / your own diet?
- Have you engaged in any personal development work around your own relationship with food, eating and / or your body?
 - Did this help you with your client work?
 - Has your client work led to you engaging in personal development work around this topic?
- What are your feelings / thoughts in general around people who present with eating related issues?
 - What are your feelings / thoughts around people who present with body image related issues?
 - Describe the most commonly experienced feelings towards your clients.
- I'd like you to think about any differences experienced in working with clients presenting with different eating disorders (Anorexia, bulimia, binge eating disorder, obesity):
 - Does your experience of your client change?
 - Does your experience of yourself change?
- I'd now like you to think about any differences you experience when working with eating disordered clients compared to other types of presenting problems:
 - In terms of your feelings
 - Your way of working
 - Your embodied experience
 - Your reflections on the client after the session or in supervision

Society / Theoretical Level

- What are your thoughts / understandings in general around eating disorders?
 - Individual sufferers
 - Our current society

- Have you learned anything about the role of food, eating, body shape and size from your clients:
 - The role of the body in a person's subjective experiencing of the world and their place / role within it?
 - The influence of bodily experience on a person's sense of self?
 - The role of food and eating within a person's life?
 - The role of food, eating and body shape / size within your own life?

- What are your feelings around the cult to be thin which seems to be very prevalent within our society; particularly within the media and the focus on celebrities body shapes and sizes?
 - Size zero?

- What role do you think the current discourse around the "obesity crisis" is playing within people's experience of their bodies?

Learning for the future

- How do you think that counsellors new to this client group could be most effectively prepared?
 - Support / supervision available?
 - Training?
 - Personal development in relation to your own embodied experience?