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Exploring the Complex Treatment Experiences of Eating Disorder Clients

By
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Submitted in fulfilment of the requirements for the degree of:

Doctor of Psychology

Department of Psychology
City University, London

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Finally, to my family, my partner and friends, thank you for your love, unwavering support and understanding, not just over the last three years but always. I dedicate this portfolio to you.
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I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission only covers single copies made for study purposes subject to normal conditions of acknowledgment.
Section A: Preface
This portfolio consists of three pieces of work which each say something about my development as a Counselling Psychologist and the skills, knowledge and experience that has shaped this portfolio and my clinical interests. Firstly, there is a case study demonstrating the successful treatment of a client who presented with comorbid Eating Disorder Not Otherwise Specified (EDNOS) and Body Dysmorphic Disorder (BDD). Then, there is the research component, in which the eating disorder client’s experience of having their therapist disclose personal experience of an eating disorder to them is explored. Finally, I present a combined process report and client study of a client who was treated for bulimia nervosa. In this section I will introduce each component in some more detail, highlight the links between them and reflect on the different positions I hold within them.

The focus of section B is a case study of the treatment of a client who presented with a primary diagnosis of EDNOS with comorbid BDD. This case is presented as it highlights the similar and sometimes overlapping symptoms and psychopathology of both disorders and how the chosen primary treatment model of Cognitive Behavioural Therapy for Eating Disorders (CBT-E) can be flexible to include more specific but complementary BDD interventions (Rosen, 1995) in the treatment for the primary diagnosis of an eating disorder, thereby producing significant improvements in symptoms and pathology and, consequently, better outcomes in therapy.

The research study in section C is the principal element of this portfolio. The study explores how therapist disclosure of personal recovery from an eating disorder is experienced by the eating disorder client. Six participants were interviewed with the aim of gaining an understanding of the resulting impact on them, the client, the therapeutic relationship and the outcome of therapy and the therapeutic process.

While undertaking a literature review to explore the appropriateness of therapists with a personal history of an eating disorder working in the treatment field of eating disorders, it became evident that many therapists with personal experience of an eating disorder often seek positions in the field. In addition, and importantly, many recovered therapists have reported that they use self-disclosure in their treatment approach. Reasons and benefits reported have come from the perspective of the therapist, and so this research
study sought to explore the clients’ experience of receiving such disclosure. The interview transcripts were analysed using Interpretative Phenomenological Analysis as this type of analysis allows for exploration of each individual’s unique experience and meaning applied to the phenomenon in question (Smith & Osborn, 2003). Emerging themes highlighted the ambivalent nature of the participant’s experience of their therapist’s disclosure. Experiences shifted between conditions of hope and understanding to feelings of jealousy, competition and resentment. The participant’s perception of their therapist, their therapist’s body, and aspects relating to how they saw their therapist’s recovery and expectations for their own recovery all impacted on how the participants and the therapy was influenced by their therapist’s disclosure.

The final section of the portfolio is a second piece of clinical work, this time a combined process report and client study. It is intended to show the reader the micro and macro elements of my practice with a client who presented to a specialist eating disorder service for treatment for her longstanding Bulimia Nervosa. Along with presenting my use of CBT-E, I have included a ten-minute extract from a recording from one of our treatment sessions together and my critical reflections on my choice of interventions, their impact on the client, the therapy and the therapeutic process. The reasons for presenting the extract in question are discussed and its influence on the case formulation and therapeutic focus is highlighted. I wanted to include a therapy extract within the study to give the reader a sense of me as a clinician and an insight into a therapy session with the client in question and show something of my use of and relationship to CBT as a therapy model.

As the reader progresses through the different components of this portfolio, they will see that they contain common threads such as eating disorder pathology, ambivalence, treatment and recovery, to name but a few. However, in addition to these, the reader will notice the different styles in which each piece is written and my role or identity in each.

Throughout the first piece of client work presented in section B my tone is much more ‘clinical’ than in the other elements of the portfolio and within the chosen cognitive behavioural model. Moreover, in the final piece of client work presented, the attention shifted between my experience of the therapy and its process and aspects related to the
client; indeed, within this first case study the focus remains on the client, her presentation, the treatment, the client’s progress and the implications of the case. In the research component I am researcher and write in a more analytical style than other parts of the portfolio. At moments throughout this study my position takes a very personal stance where I attempt to account for how my personal experience might have influenced each area of the research process. In this section I give the reader insight into the many identities I hold within the process and the complexities and layers this adds.

The tone shifts again when it comes to the final section of the portfolio, the combined process report and client study. Here, I take a critically reflective position when presenting this piece of clinical work and take an in-depth look at the process elements of the therapy. My style is more reflective and introspective of my learning and development as a Counselling Psychologist. Along with highlighting my progress and successes, I draw attention to the struggles and difficulties I have experienced as a therapist working with this client group, with my chosen model and the process aspects of the therapy.

The most obvious theme or link within the three pieces of work is eating disorders and the impact on those who experience them and the treatment utilised to target the symptoms and underlying pathology. This is prominent primarily in the examples of clinical work but is also explored within the research component. In addition, the theme of ambivalence cuts across all three sections of the portfolio. Ambivalence is something that is commonly associated with eating disorders; it was an overriding theme in the research component but was also an aspect of both client presentations in the two pieces of clinical work presented. The clients’ and participants’ ambivalence about their eating disorders, the therapy, their therapists and recovery is perhaps the strongest thread running through each section of the portfolio and ambivalence is also representative of this clinical population.

Above, and at times throughout this portfolio, I use the term ‘pathology’. Although it may not have a natural fit with the more humanistic underpinnings of Counselling Psychology, over my training it has become part of my vocabulary. This is not necessarily through the university teaching element but through the clinical placements I have undertaken and been influenced by. Working within multi-disciplinary teams in
NHS mental health services, it can be difficult to resist aspects of the biomedical model, but this is not to say I have abandoned my humanistic, Counselling Psychology roots, and I believe the reader will see this throughout both the research and client work presented in this portfolio. While some are critical of the use of the term ‘pathology’ in that they believe that clients become defined by it or their illness (White, 2002), due to the importance of the current environment of evidence-based practice, it is difficult not to be influenced by diagnosis. However, I hope that while reading this portfolio the reader will see that despite my making reference to pathology, diagnosis, evidence-based practice, I also take a holistic view of my clients and research participants. I place significant value on the relationship in facilitating change and consider myself reflective and relational in my use of CBT in the client work presented. Furthermore, despite utilising empirically supported manualised treatment models such as CBT-E, my training and ethos as a Counselling Psychologist helps prevent or inhibits me from becoming ‘manualised’ or robotic in my approach.

The research process and clinical work presented in this portfolio has inevitably left me reflecting on the type of Counselling Psychologist I am and might be. Although working with high levels of client ambivalence can be frustrating, as a result of this process, I feel encouraged and vitalised about continuing to work with those affected by eating disorders and related difficulties. I feel fortunate to have gained knowledge and awareness that will be highly relevant to and influential on the way I practice in the future.
Section B: Case Study

The Integration of Cognitive Behavioural Approaches for the Treatment of Comorbid Eating Disorder Not Otherwise Specified and Body Dysmorphic Disorder: A Case Example
Abstract

This case report provides a description of a course of therapy with a client who presented to a specialist eating disorder service for treatment for her primary diagnosis of Eating Disorder Not Otherwise Specified (EDNOS) but who also had a previous diagnosis of Body Dysmorphic Disorder (BDD). The client was treated primarily with Fairburn’s (2008) “transdiagnostic” model of Cognitive Behaviour Therapy for eating disorders (CBT-E) with integrated conceptualisations and interventions from a CBT approach for BDD as outlined by Rosen (1995). The recommended treatment for both disorders and the similar and sometimes overlapping symptoms and pathology the disorders share will be outlined. The client, her presenting difficulties and relevant background will be introduced and case conceptualisation outlined. The reader’s attention will then be drawn to the treatment and clinical strategies integrated from both CBT models. Treatment was associated with improvement in eating symptoms, body image disturbance and mood. Implications of the case are discussed.

Keywords: Eating Disorders, Body Dysmorphic Disorder, Cognitive Behaviour Therapy, Case Study
Introduction

Links between Eating Disorders and Body Dysmorphic Disorder

Eating disorders and body dysmorphic disorder have much in common with each other. Similar to those with eating disorders, individuals with BDD have an excessive concern about their physical appearance.

BDD is classified as a somatoform disorder, but its features have much in common with obsessive-compulsive disorder, social phobia and eating disorders. It is characterised by an excessive, exaggerated preoccupation with a perceived flaw in bodily appearance that is either imagined or minimal (Rabinowitz, Neziroglu & Roberts, 2007). The preoccupation results in compulsive and safety-seeking behaviours, for example, mirror checking or avoidance, reassurance-seeking from others and camouflaging. Individuals with BDD fear being noticed by others, experience feelings of shame and embarrassment and avoid social situations and exposure of physical appearance and often seek cosmetic treatment for their perceived flaws (Rosen, 1995). BDD is a distressing and disabling body image disorder where the sufferer experiences excessive preoccupation with their physical appearance despite appearing normal (Rosen, 1995). For a diagnosis of BDD to be made, the individual’s preoccupation with the imagined defect in appearance must not be better accounted for by another disorder, such as dissatisfaction with body shape and size, as in Anorexia Nervosa (APA, 2000).

Authors such as Jolanta and Tomasz (2000) and Ruffolo, Phillips, Menard, Fay and Weisberg (2006) have produced findings that suggest that some individuals who have been diagnosed with an eating disorder often have symptoms of BDD that precede their eating disorder manifestations or presentations. The preoccupation with their appearance often leads these individuals to strive to change and improve their appearance through dieting and exercise, and when taken to extreme levels can result in psychopathological symptoms that when assessed fulfil the diagnostic criteria for an eating disorder. Authors such as Cororve and Gleaves (2001) and Rosen and Rameriz (1998) have suggested that body image dissatisfaction may be the essential pathology underlying both BDD and eating disorders. Didie, Reinecke and Phillips (2010) summarised that both BDD and eating disorders share features such as body image dissatisfaction (Rosen & Ramirez, 1998), obsessional thinking (Godart, Flament,
Perdereau & Jeammet, 2002; Halmi, 2005), poor interpersonal functioning (Fairburn, 1997), and chronic low self-esteem (Polivy & Herman, 2002). Although in BDD the focus of appearance concerns tends to be related to the skin, hair or nose and concerns with body weight and shape tend to be evident in those with eating disorders, both disorders can overlap in regard to excessive concern focused on the same body parts or aspects, e.g. large legs and stomach (Grant & Phillips, 2004; Phillips, 2005).

Studies have shown a higher prevalence rate of eating disorders in those with BDD when compared to the general population (Gunstad & Phillips, 2003; Zimmerman & Mattia, 1998). In addition, Didle et al. (2010) have suggested that comorbidity between BDD and eating disorders results in greater impairment for the individual. Ruffolo et al. (2006) have found that individuals with such comorbidity also tend to have a number of additional comorbidities, greater body image disturbance and, in the past, have received significantly more treatment for their psychological health. Studies by Grant, Kim and Eckert (2002) and Philips (2005) have shown that individuals with comorbid BDD and an eating disorder had a greater suicide attempt rate than those with an eating disorder alone. Grant et al. (2002) also found that 69% of their participants considered suicide because of their BDD symptoms. Considering these findings, Ruffolo et al. (2006) highlighted the need for professionals to assess those diagnosed with one disorder for the other disorder, as the authors pointed out that these patients often conceal their symptoms because of feelings of embarrassment and shame (Phillips, 2005; Grant et al., 2002).

**Theoretical Model Used**

CBT has been shown to be effective in the treatment of BDD (Rosen, Reiter & Orosan, 1995). Several trials of CBT in the treatment of BDD have been reported in the literature (Williams, Hadjistavropoulos & Sharpe, 2006; Veale, Gournay, Dryden, Boocock, Shah, Willson, & Walburn, 1996; Rosen et al., 1995). In the UK, current National Institute for Clinical Excellence (NICE) guidelines (NICE, 2005) for BDD recommend two treatments: CBT and serotonergic anti-depressant medications. Moreover, adapted forms of CBT are recommended by NICE for the treatment of Bulimia Nervosa and binge eating disorder patients as it has shown to be the fastest, most effective form of psychological intervention for these presentations (Fairburn & Harrison, 2003). However, in response to the less supportive literature in regard to its
specific use with Anorexia Nervosa or with the largest diagnosis of an eating disorder not otherwise specified (EDNOS) (Fairburn & Harrison, 2003; NICE, 2004), Fairburn, Cooper and Shafran (2003) developed the “transdiagnostic” model of CBT. Their “enhanced” transdiagnostic model was designed to incorporate new strategies aimed at enhancing treatment outcomes and improving its applicability to all eating disorder presentations. This enhanced CBT approach considers overevaluation of control over eating, shape and weight to be central to the maintenance of all clinical eating disorders and that patients tend to migrate between eating disorder diagnoses over time (Fairburn & Harrison, 2003). The transdiagnostic model suggests that interventions aimed at the common mechanisms that play a role in the maintenance of eating disorder psychopathology should be effective regardless of the eating disorder diagnosis. This latest version of CBT-E is currently the leading evidence-based treatment for eating disorders, and CBT has also been shown to be the most effective treatment for those with BDD. Despite the comorbidity of these two disorders having influence on the severity of distress experienced by those affected and the overlapping features they share, there has been a lack of clinical research or case examples on the integration of aspects of CBT for BDD with CBT-E. In light of this, a case conceptualisation and treatment plan following that recommended by Fairburn (2008) for my client’s eating disorder was agreed upon; this incorporated some interventions for BDD as recommended by Rosen (1995).

Case Introduction

Kelly1 was a shy thirty-year old white British woman. She spoke in a low tone of voice and avoided eye contact where possible. She lived at home with her parents. She reported that she found them both supportive and encouraging of her but felt that they were embarrassed by how she presented herself. Her brother, who was 34, sometimes stayed at home also. She was unemployed. She was last employed five years ago when she worked as a catering assistant. Kelly said she enjoyed this to begin with but found it too difficult as she became more aware of people staring at her and became increasingly anxious and uncomfortable. She recently finished a degree in History from the Open University that she enjoyed. She would like to utilise this in some way in the future but

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1 Kelly is a pseudo name. All identifying information has been removed or changed to protect the client’s identity.
felt her current problems made it very difficult. She has never been in a relationship and she believed nobody would want her because of her appearance.

Presentation
Kelly attended our sessions punctually, wearing baggy clothes and a baseball cap. She presented as shy and anxious but was pleasant and co-operative. Eye contact was intermittent at first but became more frequent as our sessions progressed. I felt we built a good rapport and she was engaged in our sessions.

Presenting Complaints
Kelly had a longstanding history of low self-esteem and distorted body image. Using the current diagnostic criteria set out by the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), she had been diagnosed with EDNOS. However, it is worthy of note that using the proposed revised criteria set out in the upcoming DSM-5 due to be published in 2013, Kelly’s diagnosis would change to Atypical Anorexia Nervosa, which specifies that all the criteria for Anorexia Nervosa are met, except that, despite significant weight loss, the individual’s weight loss is within or above the normal weight range (APA, 2010). Kelly was restricting her diet to 400kcal per day in an effort to lose weight and alter her appearance. Kelly reported that she was exercising for two hours a day and her diet was limited to fish, vegetables, grapes, chewing gum and ice cubes. Kelly had abused laxatives in the past (up to 10 a day) and had been diagnosed with irritable bowel syndrome (IBS). This, along with feeling bloated and constipated, meant the temptation to take laxatives was prominent. She denied bingeing or inducing vomiting.

Two years ago, Kelly was diagnosed with Body Dysmorphic Disorder (BDD). She believed she looked “horrible” and “disgusting” and wore oversized clothing and avoided mirrors and seeing her reflection and bathed in dim lighting as she found her appearance “distressing”. Kelly previously engaged in body-checking behaviours such as measuring her body parts with a tape measure and “mirror-gazing” but stopped this as it became too distressing and overwhelming. Kelly had a particular dislike for her hips and thighs and had previously unsuccessfully sought plastic surgery on her nose. Kelly was no longer weighing herself but judged if she had lost or gained weight by how her jeans fitted and how her hips looked and felt to her. As is common in
individuals with BDD, Kelly wore a baseball cap pulled down over her face in an effort to camouflage her nose as she believed it to be “crooked” and too big for her face (Veale, 2001).

Her weight at assessment was 61.2kgs and her height is 1.76m, giving her a BMI of 19.8, which was slightly in the underweight range (Healthy BMI: 20-25). Kelly reported that she was menstruating normally. She was feeling distressed by her apparent inability to lose further weight despite eating such a low-calorie diet and engaging in excessive exercise. The fact that Kelly was maintaining her weight despite reporting a very low-calorie intake did make me question the eating behaviours she was reporting. When I shared my thoughts on this with Kelly, she denied engaging in bingeing or eating more than reported. However, I continued to keep this in mind; because feelings of shame and embarrassment are common in those with eating disorders (Swan & Andrews, 2003), Kelly may not have felt comfortable sharing this with me right now. Kelly had significant shape and weight concerns and was fearful of returning to her previous highest weight of 74.3kg. In her mind, Kelly had an ideal weight of 55kg and believed she would be happier and more confident at this weight despite it placing her in the underweight weight range with a BMI of 17.8.

At the time of assessment, Kelly was very isolated. She described herself as an outsider and felt she was not part of society. She believed that people reacted negatively to her because of her appearance. According to Veale (2001), beliefs about being defective and the importance an individual places on appearance will encourage social anxiety and avoidance. Kelly reported feeling inferior to other women and not “good enough” or “pretty enough”. She constantly compared herself to others in a negative light and she believed that people stared at her because she is “different”. She feared her distress being added to by further rejection. Like many individuals with BDD, Kelly valued both aesthetics and social acceptance (Veale, 2001).

**Relevant Client History**

Kelly had a longstanding history of negative self-image and interpersonal difficulties. She was overweight as a child and at secondary school she was bullied over her appearance. Growing up, she was taller than her peers and she felt out of place. She was told that she looked like a man, “took up too much space” and had “legs like tree
trunks”. This was something that has stayed with Kelly throughout her adult life. Much of her attempts to alter her appearance were aimed at what she hoped would make her, in her own eyes and that of others, more feminine and womanly. Throughout her adolescence, Kelly became increasingly withdrawn and socially anxious and began experiencing anxiety and nausea. Around this time, her weight dropped from 74.3kgs to 57.2kgs, changing her BMI from 24.0 to 18.5. This pleased Kelly, had a temporary positive impact on her self-esteem, and encouraged her to make a conscious effort to keep weight off and lose more weight. It was at this point that she started to consciously restrict and monitor her food and weight. Her lowest weight was 55kgs, which she feels was a “good weight”. Kelly believed that if she got back to this weight she would feel better about herself once more.

Kelly has a history of self-harming and has scars on her arms from this period. Although she still sometimes feels the temptation to self-harm, Kelly feels she is “punishing” herself enough without resorting to harming behaviours once more. Kelly avoided people seeing her arms because, while undergoing medical tests a few years ago, she received a negative reaction over her scarring by some nurses. This made her feel “hideous” and “ugly” and, as Kelly feared getting this reaction again, she wears long-sleeved clothes all year round. She finds this most difficult in summer as, for Kelly, it reminded her that she is “different”. Kelly’s history of self-harming made me question the possible presence of Borderline Personality Disorder (BPD). Consultation of previous assessment reports documented that Kelly had been assessed for BPD in the past but the psychiatrist did not make the diagnosis and, as such, I decided not to formally assess for BPD. While I acknowledge that this might have been helpful, as Counselling Psychologists we develop and utilise formulation to guide treatment, not diagnosis, and so features of both diagnoses were targeted in the treatment. However, I do understand that a formal assessment and diagnosis (if applicable) of BPD may have been helpful in legitimising some of Kelly’s distress (Pilgrim, 2007). Such formal diagnostic assessment is something I will give consideration to in future.

**Case Formulation**

Kelly had difficulties in how she relates to herself, others and food. Her negative thoughts, beliefs and distorted body image that stem back to her childhood and teenage years relate to her feeling different and “not good enough”. Her eating disorder had
developed from her attempts to change her weight and shape and as a way for her to try and feel better about herself. Kelly experienced positive reinforcement and increased care and attention after her initial weight loss eight years ago. These secondary gains, alongside a temporary increase to her self-esteem, encouraged Kelly to pursue further weight loss and also made her fearful of regaining the weight.

Her distorted body image, combined with avoidance behaviours, led Kelly to overestimate her size, which further increased her distress and her desire to change these. The bullying she experienced over her appearance growing up was traumatic for Kelly. She was fearful of others’ judgements of her and was fearful of gaining weight and being vulnerable to further taunts. Kelly’s fear of negative judgement and her preoccupation not only with her weight and shape but also with others’ perception of her meant she experienced difficulty relating to and communicating with others. Her resulting anxiety made her scared and uncomfortable, which led her to isolate herself from others and avoid situations that she found difficult. In some ways, her difficulties kept Kelly safe and prevented her from having to face these potentially challenging and anxiety-provoking situations.

Course of Treatment and Assessment of Progress
Kelly described feeling hopeful about treatment and reported feeling “relieved” at my assessment report that I shared with her. She was anxious that she wasn’t explaining her experience “properly”, but after reading my report she was pleased and relieved that I appeared to understand her experience. As a result, Kelly appeared to have more “faith” that this type of treatment could be helpful and was motivated to engage. After we completed our assessment, we agreed to meet for 20 weekly sessions with no breaks if possible.

Early Stages of Treatment
Our sessions together were guided by the CBT-E as set out by Fairburn (2008), although this was tailored to suit Kelly’s presentation and needs and to allow for the inclusion of more targeted BDD CBT interventions. The initial aims of our sessions together were to engage Kelly in treatment and the prospect of change. After our assessment sessions and the creation of our formulation of the processes that were maintaining her eating disorder and BDD, real time self-monitoring of eating and
associated thoughts and behaviours was introduced. Psychoeducation about body weight regulation and fluctuations was provided, along with information on the ineffectiveness of laxative misuse as a means of weight control and the adverse effects of dieting. As CBT-E requires weekly weighing, this was also introduced at this point. Being weighed was something that was highly anxiety-provoking for Kelly as it was something she had avoided doing for some time. The rationale for this was explained to Kelly as being a way of providing an accurate weight and BMI information in a safe environment where her feelings of fear and anxiety could be processed and contained. As is normal, Kelly’s weight fluctuated from week to week. She reported that seeing her weight plotted on a weight graph and the trends of the fluctuations played an important role in reassuring her about weekly changes in her weight. Alongside this, we began introducing a more regular pattern of eating. Kelly was educated about normal eating patterns consisting of her meals and three snacks per day and not going for more than four hours without food. Our initial goal was to have her eating something regularly every three to four hours. Although Kelly was provided with sample meal plans and had outpatient appointments with one of the team dieticians, at this stage, the content of Kelly’s meals was less of a priority than focusing more on her eating something every three to four hours to get her accustomed to breaking her fast on a regular basis. Kelly managed to establish this regular pattern of eating; however, increased difficulty and resistance was evident when the focus did shift to the content of her meals. This resistance was driven by Kelly’s fear of weight gain and her continued desire to lose weight. Although at assessment Kelly agreed to suspend her weight loss goals while engaging in treatment, this was proving a greater challenge than anticipated and appeared to be very influenced by her BDD-associated beliefs around her appearance and the strong assumption she held that changing her appearance by losing weight on her hips and legs would lessen her distressing thoughts and make her less “defective” and “different” and help her “fit in” better. Kelly was accepting of the fact that her strong desire to lose weight was a barrier to treatment and change, and before moving on to the next stage of treatment we engaged in some additional motivational enhancement exercises (e.g. pros and cons of change, letter to self in future). At this point, I was reminded of the fluctuations in motivation often seen in those with eating disorders (Waller, Cordery, Corstorphine, Hinrichsen, Lawson, Mountford & Russell, 2010) and that although Kelly was once more feeling motivated to continue with
treatment, motivation is not a fixed entity and it needs attention throughout the course of treatment.

As Kelly’s diet was restricted to foods she felt were ‘safe’, once she became comfortable with eating in a more normalised pattern, Kelly was encouraged to introduce avoided foods back into her diet. Collaboratively, we drew up a list of foods she used to enjoy before her eating disorder developed. These were divided into breakfast, lunch, dinner and snacks. They were graded using a traffic light system hierarchy and each week new foods from the list were agreed upon and scheduled into her meal plans. This structured way of introducing new food made Kelly feel more secure and prepared to challenge her thoughts around food and weight gain. The weekly weighing sessions provided Kelly with tangible evidence that her feared consequences were not materialising, which helped motivate her to continue to challenge herself further with her diet and exercise.

**Addressing the “Core” Psychopathology**

After Kelly had established a regular pattern of eating, was comfortable with self-monitoring and had started introducing feared and avoided foods back into her diet, we began to focus on some of the core clinical features that were maintaining her eating problem. According to Fairburn, Cooper, Shafran, Bohn, Hawker, Murphy and Straebler (2008), the therapist does not need to address every clinical feature that the eating disorder clients presents with, but rather focus should be on the core “structural” features as it is they that maintain the disorder and, if removed, will result in the resolution of the many secondary features such as preoccupation with thoughts of food and weight, compensatory behaviours, calorie counting, etc.

**Overevaluation of Shape and Weight**

It was at this time in treatment that interventions also targeted some of Kelly’s BBD features that were acting as inhibiting factors or blocks to her engaging in exercises aimed at the maintaining aspects of her eating disorders. Kelly based the majority of her self-worth on her shape and weight. To help her reduce the importance she placed on these aspects of her self, together, we created a list of areas in her life that are important to her self-evaluation. Initially, Kelly struggled with this, but after I provided her with some typical examples, she was able to generate some items that were personal to her,
such as her singing, her family and her interest in reading and studying history. However, as expected, when assessing the importance she attributed to each aspect in terms of self-evaluation, her appearance, shape, weight and her ability to control these dominated. When this was demonstrated with the use of a pie chart, Kelly reported feeling embarrassed and ashamed about the importance she attributed to her appearance, but I took care to normalise this experience in terms of her eating disorder presentation, reassuring her that it was something that can be changed. In addition, the resulting consequences of placing such high value on these aspects were discussed. As a result of what Fairburn et al. (2008) call “putting all her eggs in one basket”, when she failed to restrict her diet or lose weight, she was left with little else to feed her sense of self-worth. Kelly’s overvaluation of shape and weight had resulted in the marginalisation of other areas in her life that could potentially positively feedback into her self-evaluation. As such, the focus changed to expanding other pieces of her pie chart and developing new areas, thus, reducing the importance attached to her appearance, shape, weight and her ability to control these. However, Kelly’s belief that she was “hideous”, “different” and “abnormal” was strong and needed to be challenged before Kelly was willing to take the necessary steps to develop her interests, particularly when it came to communicating and socialising with others. Furthermore, Kelly felt that she would only ever be able to engage in these activities if she could change her defects and appearance. Rosen (1995) suggested that recovery from BBD would be facilitated if the client were able to identify alternative explanations for their problems other than their appearance. In line with Rosen’s recommendations, cognitive restructuring techniques were used to help Kelly identify other reasons or behavioural traits that might cause people to look at her or may result in her becoming isolated. Once Kelly became open to the possibility that factors outside of her appearance play an important role in how she relates to others and how others relate to her, her thinking and behaviour became more flexible and open to change. Once this level of flexibility was achieved, Kelly was better able to engage with strategies designed to develop other areas of her life, and throughout treatment, we continued to monitor and revise her pie chart and Kelly was motivated by her growing interests and pleasure achieved in these developing areas. Kelly began attending weekly singing lessons and joined a book club in her local area. As time progressed, Kelly added to her list of activities that she was interested in and each week she engaged in at least two activities. As most involved contact with other people, her social support increased and her isolation decreased. This encouraged and
prepared Kelly for the difficult next stage of addressing her shape-checking and avoidance of her shape and appearance.

**Appearance-checking**
Kelly avoided seeing her shape and appearance, but at this stage, she had grown more comfortable with knowing her weight as a result of being weighed on a weekly basis. Kelly was aware of the lengths she would go to in order to avoid seeing her appearance, shape and weight, but was not aware that she engaged in shape-checking and that the frequent comparisons she made between herself and others was a special form of this (Fairburn et al., 2008). Due to the frequency that Kelly engaged with this and the distress it caused her, it was agreed that it needed to be addressed. Kelly was educated about body-checking and comparison-making in that it involves scrutiny and selective attention to body parts that are disliked and results in the magnification of perceived defects and increased dissatisfaction with shape (Fairburn et al., 2008). When making these comparisons, Kelly would select women who she deemed to be “pretty”, “slim” and “feminine” and, as such, she felt “different” and “defective” in comparison. Monitoring records were used to identify how and when Kelly compared herself with others and, together, we explored how these comparisons may be unfair in terms of evaluation. Homework tasks were designed to show Kelly that even the “better” people she compared herself to also had “flaws” when looked for. Kelly was surprised at how automatic her comparison-making had become and the distressing effect it had on her. From these exercises Kelly could see the influence that making such comparisons had on her preoccupation with changing her shape and weight and her low mood. With this awareness came a reduction in the frequency of her comparison-making and she became more objective in her view of those she compared herself to, which all led to an improvement of affect.

**Appearance Avoidance**
At this stage, a number of sessions were used to address Kelly’s shape avoidance, as this was an important aspect of her presentation that was very impairing for her. Fairburn et al. (2008) highlight that such avoidance acts to maintain an individual’s distress and dissatisfaction with shape as the assumptions they make go unchallenged. Her shape avoidance was also contributing to her social impairment and isolation and was also making other aspects of treatment, such as developing other areas of self-
evaluation as described above, more difficult. This was a feature of Kelly’s presentation that had much in common with her BDD, and techniques recommended by Rosen (1995) and Fairburn et al. (2008) shared the same underlying principles and so targeted both her BDD and eating disorder pathology. Kelly would camouflage her face with a baseball cap and wear baggy clothes in an effort to hide her appearance and would avoid going out in public as much as possible as she felt people stared at her because of her appearance. However, she was able to see that her camouflaging techniques had the effect of drawing more attention to her and so was motivated to change this. Kelly also avoided mirrors and showered and dressed in the dark. These aspects of her behaviour were identified as targets for change and exposure techniques were employed. As recommended by Rosen (1995), exposure tasks were graded in terms of difficulty and distress and exposure exercises were designed and built upon each week. For example, to begin with, Kelly began removing her baseball cap in our sessions. Soon, she began leaving it off for the remainder of the day, then the entire day of our session and, next, additional days were built upon until she no longer wore it at all. Kelly was educated about mirrors and interpreting what she sees. Exposure to mirrors began with a body part she felt most comfortable with and was built upon from there. Kelly was “surprised” that the experience wasn’t as distressing as she had previously anticipated and this helped to motivate her to go further with these exercises. This work was difficult but very helpful for Kelly, and once she became familiar with her appearance she felt it easier to address other aspects of her avoidance, such as showering and dressing with light. This aspect of our work had many positive knock on effects in other areas of her presentation and it supported other work done in treatment, such as her overevaluation of shape and weight as the changes made in her shape avoidance, e.g. no longer wearing baseball cap, reduction of her feelings of being “different”, and this made it easier for her to engage in social activities involving others, such as the book club as previously mentioned. It also helped Kelly challenge herself with avoided or feared foods as Kelly was becoming more accepting of her weight and shape and her drive to lose weight lessened. Additionally, although the avoidance of the scarring on her arms wasn’t directly addressed in treatment, at the end of treatment she reported that the exposure work undertaken had encouraged her to look at her scars herself and she was “surprised” that they weren’t as “horrible” as she remembered and that she had worn a short sleeved t-shirt for the first time in years and she was pleased with this experience.
Preparing for Ending
The ending stages of treatment were focused on ensuring changes and progress made were maintained and reducing the risk of relapse and identifying areas in need of further development. We both agreed that it was important for Kelly to continue to challenge herself further with avoided foods and she was encouraged to persist in trying new activities to continue to broaden areas important to her self-evaluation. Further body exposure exercises were identified and guidelines around maintaining the progress Kelly made in terms of her body-checking and avoidance behaviours were outlined. In addition, the strengthening of her urge to diet and lose weight was highlighted as a red flag in terms of relapse.

Complications of Comorbid BDD
As mentioned earlier, Kelly was referred to the service for treatment for her eating disorder and this was the primary focus of our work together. This was determined, in part, by the service requirements and guidelines and also by Kelly’s wishes. While we agreed that this would be the case, given the core psychopathology underlying her eating disorder, many of her BDD-related features would also be addressed in our sessions. Although Kelly experienced body image disturbance in relation to features not related to that of shape and weight, e.g. her nose, the techniques utilised to challenge and change her eating disorder symptoms would directly impact on some beliefs and behaviours related to her BDD and be transferable to others. This was difficult for Kelly as she found this more embarrassing and shameful to discuss than her eating disorder, as she was worried I would think she was “vain” and “arrogant”. This type of thinking is common in those with BDD and is one of the reasons why BDD goes undiagnosed for many years (Veale, 2001). Kelly was in agreement that her preoccupation with her appearance was resulting in significant distress, but given the nature of BDD, her thinking around her appearance was very rigid. Kelly found it very difficult to suspend her beliefs around her appearance and was initially reluctant and dismissive of exercises and strategies designed to challenge her beliefs and assumptions around her appearance. In response to this, instead of trying to target Kelly’s beliefs about her appearance, following the recommendations of Veale (2001), focus changed to the assumptions and meanings she holds about being “different” and defective and the importance of her appearance to her identity and purpose. Indeed, this did prove more effective and allowed Kelly to experience an improvement in her distress around her appearance and,
thus, became more flexible and willing to challenge herself further in her eating disorder thoughts and behaviours.

**Treatment Implications of the Case**

This case study supports the use of CBT for eating disorders as suggested by Fairburn et al. (2008), specifically, the authors’ suggestion that addressing the core psychopathology that supports the eating disorder will result in the resolution of other aspects and features of the disorder. Although this study focuses on the treatment of one individual, it does provide support for the use of CBT-E in the treatment of those presenting with EDNOS and further exemplifies Fairburn’s (2008) “transdiagnostic” approach to eating disorder treatment. In addition, and importantly, this case study also demonstrates how aspects of CBT for BDD can be integrated into the treatment of those presenting to services with comorbid diagnoses of an eating disorder and BDD. As authors such as Cororve and Gleaves (2001) and Rosen and Raeriez (1998) have suggested, the essential pathology underlying both BDD and eating disorders is a disturbance in body image, therefore, it seems reasonable to suggest that these disorders need not be treated separately; instead, conceptualisations and interventions should be integrated to target the similar and overlapping clinical features of both disorders. However, Ruffolo et al. (2006) have found that individuals with both an eating disorder and BDD have greater overall body image disturbance because they have two body image disorders, and Gupta and Johnson (2000) have suggested that body image disturbance may be greater when both weight and non weight-related body image concerns are present; consequently, the therapist does need to allow more treatment sessions for body image and associated work than is normal for eating disorders, given the increased rigidity of thinking as a result of the presence of BDD.

**Recommendations**

Clinicians assessing those for BDD and/or eating disorders should be careful to also screen for the presence of the other disorder in the individual. As is the case in most disorders, in both eating disorders and BDD, early diagnosis and engagement in appropriate treatment is recommended. As studies by Ruffolo et al. (2006) and Grant et al. (2002) have found the that in the majority of comorbid cases, the onset of BDD preceded the development of an eating disorder and, as such, these authors have questioned whether the body image disturbance of BDD predisposes and develops into
dissatisfaction with weight and shape and disorder eating behaviour. Also, Killen, Taylor and Hayward (1994) found that a preoccupation with thinness predicts the onset of eating disorders. As such, in some cases, if BDD is diagnosed early and treated adequately, perhaps the onset of an eating disorder could be prevented. In addition, as comorbid BDD and eating disorders are associated with increased suicide attempts (Grant et al., 2002), care should be taken by therapists to assess their clients’ concerns about their appearance beyond those in reference to their eating disorder. The clinician should also be aware that the shame and embarrassment that individuals with BDD feel around disclosing true preoccupation with appearance might disguise the true extent of the disorder.
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Section C: Research

Ambivalence: Eating Disorder Clients’ Experiences of Therapist Self-Disclosure of Recovery
Abstract

A growing body of literature suggests that many professionals who work in the field of eating disorders are drawn to work with this client group at least partly because of their personal experience of recovery (Barbarich, 2002) and that, currently, there are a significant number of therapists working in the field who themselves have a history of an eating disorder (Bloomgarden, Gerstein & Moss, 2003; Barbarich, 2002; Costin & Johnson, 2002; Johnson, Smethurst & Gowers, 2005; Warren, Crowley, Olivardia & Schoen, 2009). The literature also suggests that many therapists with personal experience of an eating disorder use self-disclosure in their treatment approach. Existing theories regarding the benefits of such disclosure comes from the perspective of the therapist. The eating disorder clients’ experience of therapist disclosure of personal recovery from an eating disorder has never been explored in depth. This is the first research study to do this. Six participants were interviewed about their experience of having their therapist disclose personal recovery of an eating disorder to them. The resulting narratives were analysed using Interpretative Phenomenological Analysis. This process revealed the ambivalent nature of the eating disorder clients’ experience of this kind of therapist disclosure. Aspects that contributed to the ambivalence included conditions of hope and understanding mixed with feelings of competition, jealousy and resentment. Also influential in shaping the clients’ experience was the concept of recovery, the therapist’s body, weight and shape, and whether the client wanted what they perceived their therapist to be offering. The findings highlight the complex nature of this kind of therapist self-disclosure with this clinical group. The discussion focuses on the implications for the fields of Counselling Psychology and Eating Disorders. As a result of the findings and implications discussed, recovered eating disorder professionals will feel more informed of the therapeutic use and risks involved and, in turn, make more informed and considered decisions regarding its use.
Introduction

Within the field of eating disorders there has been much published regarding treatment, theory, research and practice. An area that has recently begun to receive attention is the personal experiences of therapists who treat eating disorder clients. However, less consideration has been given to the experience of those treated by this group of professionals. I hope that by writing this thesis, awareness will be raised regarding how the clients of recovered eating disorder therapists’ experience their disclosure of a personal eating disorder history.

I begin by introducing a brief overview of the motivation behind the study, followed by the influence that theoretical orientation has on how therapists position themselves in terms of disclosure. Following this is a review of the existing research on therapist disclosure in more general terms, followed by exploration of the literature on the wounded healer and the concept of recovery from an eating disorder. The reader will then be given an overview of eating disorders regarding what they are, what causes them and how they are treated. Subsequently reviewed is the literature on recovered eating disordered professionals and the therapist variables that can be influential on the course of therapy. Following this, the focus becomes more specific to recovered eating disorder professionals and disclosure and its influence on the client and the therapy, of which the vast majority comes from the therapist’s perspective. Within this section of the literature review, the role of the clinical supervisor in assisting a therapist with an eating disorder history manage the therapy of eating disorder clients is examined. The issue of abuse of therapist power in relation to disclosure is then highlighted before, finally, the rationale for exploring the client experience is explained and the research question outlined.

Overview

It is thought that current figures underestimate the proportion of therapists with a history of an eating disorder now working in the treatment of eating disorders. Recent literature has commented on the observation that therapists with personal experience of an eating disorder often seek out positions in the field (Bloomgarden, Gerstein & Moss, 2003; Costin & Johnson, 2002). Although no official figures exist, Barbarich (2002), Johnston et al. (2005) and Warren et al. (2009) have estimated that one in three eating
disorder practitioners have a eating disorder history, while Bloomgarden et al. (2003) and Shisslak, Gray and Crago (1989) have suggested it to be one in four. Professionals working in the field having personal experience of an eating disorder often don’t report such personal experiences as they fear discrimination and stigma from their employers and colleagues (Bloomgarden et al., 2003). The literature suggests that many therapists with personal experience of an eating disorder use self-disclosure in their treatment approach. Although many articles have cited benefits of such disclosure (Bloomgarden et al., 2003; Costin & Johnson, 2002; Jacobs et al., 2010), these have been from the opinion or perspective of the therapist. Having completed a full literature search using Psychinfo Service, Science Direct, Ovid Online and The International Bibliography of Social Sciences databases, it appears that no research literature yet exists on the eating disorder clients’ experience of such disclosure and the current study is the first to address the subject.

In other areas, e.g. substance abuse, it is also acknowledged that many who have struggled with substance abuse in the past go on to make a career of helping others overcome similar struggles (Lowell & Medar, 2005) and those they help are aware of this. However, as a consequence of the psychopathology and mindset of those who struggle with an eating disorder, and the dynamics of the eating disorder therapist-client relationship, it is reasonable to suggest that similar disclosure within eating disorders may not necessarily be appropriate or helpful. These aspects that make the experience of those with eating disorders unique with regard to therapist disclosure of recovery will be explored within this review of the literature.

Review of the Literature

Theoretical Orientation and Disclosure
Those writing from different theoretical orientations have shown to differ in their opinion about therapist self-disclosure within the therapeutic relationship. The view or opinion that self-disclosure was indicative of bad practice originates from Freud. As such, psychoanalytic approaches in the past have taken the stance that therapist self-disclosure was always inappropriate within the therapeutic relationship (Jacobs, 1999). Freud opposed self-disclosure as he believed it interfered with transference, which he proposed to be the focus of the therapy. Freud believed that the therapist should remain
a “blank screen” for the client to project transferences onto (Carew, 2009). Psychoanalytic therapists have also taken the position that self-disclosure is a symptom of the therapist’s countertransference (Lane & Hull, 1990) and so is likely to be exploitative as it is serving the needs of the therapist and not the client (Peterson, 2002). However, more recently in relational psychoanalysis, therapists such as Bridges (2001) have begun to consider using self-disclosure as a result of shifts towards the importance of relationships and away from classical drive theory (Carew, 2009) and the new debates on the usefulness of enactment in inducing movement in the analysis (Aron, 2003; Black, 2003). In addition, psychoanalytic/psychodynamic therapists have begun to acknowledge that total anonymity is impossible as their dress, office and other factors inevitably reveal something about themselves (Lane & Hull, 1990).

Feminist therapists see self-disclosure as a means of creating an equal relationship, decreasing the client’s feelings of shame and transmitting values from the therapist to the client (Mahalik, Van Ormer & Simi, 2000). In systemic therapies, a key part of working in reflecting teams is being explicit about where one is coming from, e.g. as a woman, as a mother, etc (Roberto, 1991). Postmodern ideas suggest there is no “view from nowhere” and that knowledge is situated to the perspective of the knower, e.g. Gergen’s (1991) view that “I am linked therefore I am”.

Authors from other theoretical backgrounds have also written about self-disclosure. In rational emotive therapy (RET), Dryden (1990) suggested that therapists should disclose their own experiences to provide an example of how the ABC framework can lead to psychological difficulties. Dryden (1990) suggests that, by disclosing some of their own weaknesses, the therapist demonstrates human fallibility. Dryden (1990) maintains that therapist self-disclosure is necessary for successful therapy. Those from a cognitive behavioural orientation also tend to view therapist self-disclosure as a potentially beneficial intervention that can strengthen the therapeutic alliance and encourage client change (Knox & Hill, 2003). It can help to normalise the clients’ difficulties and model effective coping techniques and model client self-disclosure (normalisation is a core skill in many CBT protocols to reduce distress, e.g. Morrison, 2005).
Therapists from a humanistic orientation have been the first to regard therapist self-disclosure in the therapy. In humanistic therapy, the therapist is encouraged to be genuine and congruous in the therapy and, in doing this, they might employ self-disclosure. Humanistic therapists believe that when a therapist is genuine, congruent and self-disclosive, it encourages the client to be self-disclosive as well (Peterson, 2001).

Although therapists from different theoretical orientations can hold differing views on self-disclosure and its use, studies that have examined self-disclosure along with therapist theoretical orientation did not produce reliable differences between orientations (Anderson & Anderson, 1989; Berg-Cross, 1984; Edwards & Murdock, 1994; Simi & Mahalik, 1997).

In the following section I review existing literature on therapist disclosure. Despite the theoretical influences discussed above and their bearing on how different authors view self-disclosure, it was surprising to me that the studies and papers reviewed below do not position their own theoretical stance to allow for contextualisation of their findings and recommendations. Presenting views as atheoretical occludes the very radical differences in the models. In fact, in their qualitative review of the literature on therapist self-disclosure, Henretty and Levitt (2010) highlight this as one of the major problems with the existing research on self-disclosure. Although it may have been possible to speculate on the theoretical orientation of the authors based on the journal where the research was published, the language used and a search of previous work by the authors, I decided to avoid such speculation; however, this gap in the available knowledge is something I wanted to bring to the readers’ attention while reading the literature that will now be reviewed.

**Therapist Disclosure**

Existing research on therapist self-disclosure has focused on more general and varied types of therapist disclosure. The majority of this research has also tended to look at the therapist’s perspective on the use of self-disclosure and few have examined how therapist self-disclosure is received by the client in regard to their relationship with the therapist, the therapy or its effect on themselves.
Hill and Knox (2001) suggest that therapist self-disclosure is one of the rarest techniques, with an average of 3.5% of therapist interventions. Although Hill and Knox (2001) suggest that it is an infrequent intervention or technique, other researchers report that over 90% of therapists acknowledge that they have at one time used self-disclosure in therapy (Edwards & Murdock, 1994). This suggests that most therapists have used self-disclosure, although infrequently.

After a detailed review of the literature, Henretty and Levitt (2010) suggest that there are several problems with the existing research on therapist self-disclosure. One of the major problems highlighted was its use of analogue methodology which limits the applicability to actual therapeutic situations. Knox, Hess, Petersen and Hill (1997) argue that these types of studies are unable to capture the real clients’ experience of therapist self-disclosure in genuine therapeutic situations and are unable to provide any information of possible consequences to the client, the relationship and the outcome of therapy.

In an exploratory study, Knox, Hess, Petersen and Hill (1997), interviewed thirteen adult psychotherapy clients about their experience of helpful instances of therapist self-disclosure. They found that instances of helpful disclosure occurred when discussing important personal issues and were perceived as being intended by therapists to normalise and reassure clients. Disclosures were also found to consist of personal information about the therapist. Clients reported positive consequences as a result of a more equal relationship, normalisation and reassurance.

After reviewing thirty quantitative studies on therapist self-disclosure versus nondisclosure, Henretty and Levitt (2010) reported that, of the thirty studies reviewed, twenty showed results that were in favour of the use of therapist self-disclosure, while four studies reported results in favour of non-disclosure. Overall results from quantitative studies suggest that therapists who self-disclose elicit more positive responses and perceptions from their clients than therapists who do not self-disclose. Henretty and Levitt (2010) concluded that therapist self-disclosure had no consistent effect on how clients perceived their therapists in regard to the qualities of trustworthiness, level of regard, empathy, congruence, unconditionality and attractiveness. Yet, when perceived warmth was examined, clients were found to
consistently report positive results (Fox et al., 1984; Murphy & Strong, 1972). Henretty and Levitt (2010) also concluded that therapist self-disclosure had a positive impact on clients; in other words, clients liked therapists who self-disclosed more, and they were perceived as warmer and, as such, clients disclosed more to therapists who self-disclosed. Again, different therapy modalities might not necessarily want these outcomes. For example, analysts wouldn’t necessarily want to be liked by their clients for model reasons and it would be useful to have information on the theoretical background of the studies to be better able to contextualise the findings.

In their review of the existing literature, Henretty and Levitt also found that clients reacted more positively to self-involving therapist disclosures than to self-disclosing therapist disclosures. They suggest that therapists need a more coherent and concrete appreciation of the possible advantages and disadvantages of using self-disclosure in their work in order to be better informed of when, where, how and with whom self-disclosure may be an appropriate and useful intervention. This is also true for the more specific therapist self-disclosure of personal recovery from an eating disorder, which is the focus of this research study. Henretty and Levitt (2010) recommended that future researchers give more attention to topics such as therapist disclosure of past struggles similar to that of the client. The research question in the current study aimed to do this in relation to the eating disorder therapist’s disclosure of personal recovery.

Kelly and Rodriguez (2007) examined therapist self-disclosure and its impact on the therapeutic alliance. Using the Working Alliance Inventory ratings, they reported no significant results. However, in an analogue experiment, Van de Creek and Angstadt (1985) found that analogue clients rated their relationship with therapists who self-disclosed higher than with those who didn’t disclose. Kelly and Rodriguez (2007) also found that therapist self-disclosure was not significantly related to symptom change. However, in their naturalistic experiment, Barrett and Berman (2001) reported results that showed that an increase in therapist self-disclosure was associated with a decrease in client symptomatology.

As previously mentioned, many of the existing studies on therapist self-disclosure as perceived by the client have been carried out using an analogue client group. This type of methodology is unable to capture the real experience of genuine and authentic
therapy settings as it cannot truly take account of the context, timing, content, client readiness, intimacy and depth and many other possible factors that could influence how it is experienced and perceived (Faber, 2006; Henretty & Levitt, 2010; Knox et al., 1997).

**The Client Perception**

Barrett’s and Berman’s (2001) quantitative study is one of the few reviewed here that utilised real clients, real therapists and real relationships. To test the competing views that therapist self-disclosure impedes treatment as opposed to enhancing its effectiveness, the authors instructed therapists working at a student counselling service to increase self-disclosing practices with certain clients and abstain from self-disclosing with others. Assessments were obtained on symptom distress and client perception of the therapists, client expectations and how much had been disclosed. In addition, audio recordings of the sessions were listened to by observers who evaluated the self-disclosures made by both therapists and clients. The authors were able to assess if self-disclosure by the therapist had an effect on symptom distress and if it affected or influenced how the client felt toward the therapist and client self-disclosure. Barrett and Berman (2001) found that self-disclosure by therapists did influence the outcome of the therapy. Analyses showed that clients who received increased levels of therapist self-disclosure reported more symptom improvement than the clients whose therapist refrained from self-disclosing. Results also indicated that therapists who self-disclosed were liked more by their clients than those who didn’t. However, therapists in this study were instructed by Barrett and Berman (2001) to disclose personal information about themselves only in response to similar disclosures by the clients. As such, the authors acknowledge that the results reported may be limited to similar reciprocal disclosures. In addition, therapist self-disclosures dissimilar and unconnected to client concerns may well have elicited different responses from the client and could have a negative impact on the course of treatment and outcome.

A further problem with existing quantitative research is that it fails to account for factors or variables that can influence how therapist self-disclosure can impact on the client, the therapeutic process and outcome (Collins & Miller, 1994). Henretty and Levitt (2010) listed some of these variables to be: the type of information disclosed, similarity to the client’s experience, its timing and whether the information was
requested by the client. Information regarding these potentially influential factors would be conducive to qualitative research and many of them are explored within this research study.

Hanson (2005), using a mixed methods study, asked clients about their perceptions of both self-disclosure and non-disclosure. The interviews with clients also covered general therapy experience, how the participant got along with the therapist, whether or not the therapist disclosed, how often it occurred, the content of the disclosure, whether the disclosure or non-disclosure was helpful or unhelpful and what made it so. After quantitative analysis, Hanson (2005) reported that participants were two and a half times more likely to find disclosures to be helpful and twice as likely to experience non-disclosures as unhelpful. Qualitative analysis showed that when discussing helpful disclosures, participants reported a more genuine relationship with increased closeness, trust, feeling understood and identification with the therapist. When the therapist disclosed similar experiences to that of the participants, participants reported feeling safe and not judged, along with taking the disclosure as an indication of the therapist’s understanding and empathy. When participants discussed unhelpful instances of therapist disclosure, negative impacts such as decreasing trust and safety and a need to manage the relationship was reported. Most participants reported incidents of non-disclosure to be unhelpful. The main effects were a damaged relationship, inhibited client disclosure and feeling invalidated. Hanson (2005) found that the level of skill with which the techniques were employed had a big part in how the participants’ experienced the therapist disclosures or non-disclosures. A disclosure was found to be better received when it was context-appropriate, brief in duration, contained few details and was appropriately timed. Disclosure was found to be less helpful when made too early in the relationship, when they occurred frequently and when they took a long time to recount.

Therapist technique was also found to be an important factor in how instances of non-disclosure were received. Participants reported less negative feelings when the therapist’s refusal to disclose was framed compassionately and in a way that they could understand and accept. Therapist rigidity was the most frequently cited skill deficit when discussing non-disclosure. Hanson (2005) also found that skilful instances of both disclosure and non-disclosure helped develop a good therapeutic alliance and those
delivered with less skill had damaging effects. The author also reported that an initial strong alliance was a protective factor against unskilful disclosures.

This study by Hanson (2005) is one of the few to examine the clients’ experiences. It is also strengthened by the fact it looked at both helpful and unhelpful instances of therapist disclosure and non-disclosure. All participants had seen more than one therapist, which enabled them to compare experiences, and the use of qualitative methodology allowed for the client’s experience to emerge. All participants were relatively well functioning at time of data collection and at the time at which the disclosures occurred. Thus, the results of this study may not be generalisable to clients with impaired functioning or who continue to experience distressing thought patterns and behaviours.

In their qualitative study on the client’s perspective of counsellor self-disclosure, Audet and Everall (2003) chose to focus on disclosures about the personal life of the counsellor outside of the therapy. Four participants were interviewed about both their positive and negative experiences of counsellor disclosure. Consistent with previous findings by Knox et al. (1997), Wells (1994) and later findings by Hanson (2005), Audet and Everall (2003) found that counsellor disclosure had both positive and negative effects on the therapeutic process and relationship and client perception of counsellor qualities. The context in which the disclosure took place and how the disclosure was delivered was found to influence how the disclosures impacted on the clients. In light of this, the authors recommended that counsellors should be judicious in their use of disclosure and be attuned and responsive to the needs of the individual client. In line with the conclusions of Henretty and Levitt (2010), the authors also suggested that counsellors who disclose are viewed more favourably by their clients than those that don’t.

Similar results were also reported by Barrett and Berman (2001), who found that clients who experienced therapist disclosures given in response to similar disclosures that they had made reported less symptom distress after treatment and they also revealed that they liked the therapist more as a result. However, it should be noted that not all therapists strive to be liked by their clients, and more information on theoretical backgrounds would have been helpful to better position these findings.
Knox and Hill (2002) and Faber (2006) have commented that therapist self-disclosure is an intervention that can be beneficial if used discerningly. In their paper, Knox and Hill (2002) defined self-disclosure as “verbal statements that reveal something personal about the therapist”. They examined the immediate and distal effects of therapist self-disclosure on clients. Positive effects were reported with respect to the immediate outcome. Clients rated therapist self-disclosure as something helpful. In their review, the authors also reported that this type of intervention facilitated client insight and made therapists appear more human and real. As a result, clients felt more reassured and normal and, consequently, the therapeutic relationship was improved. Clients then felt it easier to be more open and honest in the therapy. Nevertheless, when discussing distal outcomes, Knox and Hill (2002) reported more mixed results, and an increased difficulty was acknowledged in assessing the impact of self-disclosure interventions on treatment outcome when the disclosure was given some time in the past.

When reviewing the literature on therapist self-disclosure in general, findings and views appear mixed (Faber, 2006; Goldstein, 1997; Knox & Hill, 2003; Peterson, 2002). All authors acknowledge that therapist self-disclosure is a complex and multifaceted issue. They highlight the need for therapists to be highly reflective on all aspects that are influencing the decision to disclose. Bottrill, Pistrang, Barker and Worrell (2010) summarised some of these considerations to be: is the disclosure of benefit to the client or myself? Could the disclosure be burdensome for the client? How will the client perceive the disclosure? Is the disclosure relevant to the therapy?

**The What, When and Why of Disclosure**

Goldstein (1997) recommends that, as opportunities to self-disclose often present spontaneously in therapeutic sessions and given that considered reflection is not always possible, therapists should give advance consideration to ways of handling requests, opportunities and potential consequences of self-disclosing.

Bloomgarden and Mennuti (2009) acknowledge the possibility of therapist self-disclosure being destructive. They state that it can be abusive, excessive and unattuned and its effect can be damaging. The authors suggest that self-disclosure of this nature that is not done for the benefit of the client “will be at minimum, unhelpful and possibly
a harmful and truly destructive encounter” (p.9). According to Bloomgarden and Mennuti (2009), therapists who are too “chit-chatty” and reveal too much information about themselves, their family and their personal struggles utilise time in the therapy that should be used for their clients. They suggest that it can be a violation of their clients’ trust as it shifts the focus from their well-being and, as a result, the clients get much less out of the therapy that they could or should. The authors also state that “loose-lipped over-sharing” results in treatment goals being overshadowed and clients can become uncomfortable with too much information. They highlight that many clients are unfamiliar with therapy and may not recognise therapist errors and may not feel able to assert their needs or walk away from something that is ultimately unproductive and unhelpful. However, Bloomgarden and Mennuti (2010) recognise that therapists who keep themselves very distant and uninvolved can cause the client to feel distant, disconnected and detached and can result in the clients missing out on a valuable relationship that could facilitate change. In addition, they suggest that not feeling able to emotionally connect with their therapist can result in increased hopelessness and isolation. In light of this, Bloomgarden and Mennuti (2010) go on to state that when a balance is reached with therapist disclosure, it can be “among the most powerful positive instigators of healing” (p 11). To do this, a therapist needs to use their professional judgement to sensitively adapt to the needs of their clients and they caution against therapists using a “one-size fits all” approach when it comes to self-disclosure (Bloomgarden & Mennuti, 2010).

According to the psychoanalyst Watchel (1993), a therapist’s disclosure about his or her personal information or life outside of the therapy has the effect of removing the focus from the client. Watchel (1993) also suggested that this type of disclosure is a selfish act by the therapist that can negatively impact on the needs of the client, which should always be of utmost importance. However, the author felt that if the disclosure was pertaining to his or her reactions to the client or in the therapy experience, it can be beneficial to the therapy and process.

In contrast to Watchel’s (1993) views about therapist disclosure of personal information, Knox et al. (1997) reported that when asked about instances of therapeutically helpful therapist self-disclosure, all clients reported instances when their
therapist disclosed personal information that included details of past struggles and
difficult experiences.

Alternatively, Epstein (1994), a psychiatrist, cautioned against therapists disclosing
personal information, particularly details regarding personal problems. He put forward
the strong view that such personal and intimate disclosures on the part of the therapist
are a frequently cited behaviour of those who develop sexual relationships with their
clients. Epstein (1994) also suggested that frequent personal disclosures are reflective of
a therapist’s inability to maintain a professional role.

The why of the therapist disclosure is one of the most important aspects of self-
disclosure discussed in the literature. The therapist must give consideration to their
motivation for wanting to disclose. Many authors have written about beneficial reasons
for using self-disclosure. Clients in the study by Knox et al. (1997) reported that they
felt their therapists disclosed in order to offer reassurance and normalise their
experience and initiate change. Goldstein (1997) supported the use of self-disclosure if
its purpose is to express empathy, but also highlighted how it would be unethical and
damaging to the client if used for inappropriate or selfish reasons. She also suggested
that therapists must be aware of the needs of the individual client and their personal
history before making the decision to disclose. This view is supported by Peterson
(2002), who stated that how therapist self-disclosure is perceived by the client is
dependant on factors such as the client’s personality, outlook and past experiences.
Therefore, the therapist should always consider how their clients could be impacted as
result of their disclosures. However, even when taking all of these aspects into
consideration, Peterson (2002) suggested that a therapist may still find it difficult to
correctly judge how disclosure of personal information will be perceived and the
possible resulting consequences.

The majority of existing literature on therapist use of self-disclosure has focused on the
therapists’ experience of using disclosure and these have examined therapists’ reasons
for disclosing. Mathews (1998) and Simon (1998) reported motivations such as desire
to strengthen the therapeutic alliance, introduce alternative ways of thinking and
normalisation of the client experience. Few studies have looked at how therapists
perceive the impact of their disclosure on clients and even fewer have investigated the clients’ perspective. This study adds to the scarce research on the clients’ experiences of therapist disclosure, and, importantly, it utilises real clients and explores actual experiences of therapist disclosure and its influence on the course of therapy. This study is unique in that it does this in relation to a specific type of disclosure, and the reasoning for this will now be explored.

**Eating Disorders**
The Diagnostic and Statistical Manual (DSM) IV (2000) defines eating disorders as a disturbance in perception of body weight, shape or size and a morbid “fear of fatness” (American Psychiatric Association, 2000). Approximately 1.5 million people in the UK are affected by an eating disorder (Lipcynska, 2005). They are associated with significant psychosocial and physical disability and are particularly prevalent in young women aged between 15 and 24 years old (Birmingham & Beumont, 2004) but can also affect those aged between 6 and 80, including men (Ballard, Handy, McGibben, Mohan & Silveria, 1993; Mangweth-Matzek et al., 2006).

Those with eating disorders will use methods such as starvation, bingeing, purging, chewing and spitting, use of laxatives and excessive exercise as a means of weight loss and compensatory behaviours. Those with eating disorders can experience significant psychiatric co-morbidities such as depression, anxiety, obsessionality and substance misuse.

**Classification of Eating Disorders**
Anorexia Nervosa and Bulimia Nervosa are the two most well-recognised eating disorder diagnoses and are both included in the DSM-IV and International Classification of Diseases (ICD)-10 (2007). Yet, according to Fairburn and Cooper (2011), these two presentations are only two presentations among many seen in clinical reality. Fairburn and Cooper (2011) state that about half the cases seen in practice come under the residual diagnosis Eating Disorder Not Otherwise Specified (EDNOS). As a result of shortcomings in the current DSM-IV classification scheme, alterations have taken place and a much anticipated revised version is due for release in May 2013. For the purposes of this research, this chapter will review the current DSM-IV classification of eating disorders; however, the proposed revisions will be highlighted in the appendix.
alongside the current criteria.

It is worthy of note that Counselling Psychology has a critical relationship with the DSM. Questions have been raised with regards to the reliability and validity of diagnosis (Kirk & Kutchins, 1994; BPS, 2000), its functions and its negative effects (Rhodes & Jakes, 2000; Bentall, 2007). The Counselling Psychology community has also proposed alternatives to psychiatric diagnosis and a call has been made for further critique and reflection (Coles & SPIG, 2010).

**Anorexia Nervosa**

Those affected by anorexia experience an intense fear of weight gain and strive for and achieve sustained weight loss and their self-evaluation is overly influenced by shape and weight. Despite being very underweight, people with anorexia can experience a distorted view of their body and shape and often perceive themselves as being too fat (Santrock, 2005). Anorexia has two sub-types: restricting type and binge eating/purging type. Those with restricting type restrict their food without regular binge eating or purging behaviour that includes self-induced vomiting, misuse of laxatives, diuretics or enemas. In contrast, those with binge eating-purging type regularly engage in binge eating or purging behaviour (the complete DSM-IV (2000) criteria for a diagnosis of Anorexia Nervosa and proposed DSM-5 revisions can be seen in Appendix 1a and 1b). Anorexia has an average prevalence rate in females of 0.3% (Van Hoeken, Seidell & Hoek, 2003). It tends to have a prolonged course, severe medical and psychiatric morbidity and high mortality (Steinhausen, 2009). In studies of clinic populations, at five-year follow-up, only 75% of those who attended specialist clinics are even partially recovered, 20% have become chronic and 5% have died. At twenty-year follow-up, 80% have recovered, 15% have died and 5% remain chronic. People with anorexia are 30 times more likely to die from suicide than the general population (Birmingham & Beumont, 2004).

**Bulimia Nervosa**

Bulimia Nervosa has a better prognosis and a shorter course in comparison (Birmingham & Beumont, 2004). It has an average prevalence rate of 1% in young females. Bulimia is characterised by a recurrent pattern of binge eating, subsequent feelings of guilt and shame and compensatory behaviours such as induced vomiting,
laxatives, and excessive exercise to avoid weight gain. Those with this disorder feel that they are out of control during episodes of bingeing. As in all eating disorders, those with bulimia place a great deal of importance on shape and weight in how they view themselves. There are also two sub types of bulimia nervosa: purging type and nonpurging type. In purging type, the person regularly engages in self-induced vomiting and/or the misuse of laxatives, diuretics or enemas. In nonpurging type, the person uses other inappropriate types of compensatory behaviours such as fasting or excessive exercise. (Please see appendix 2a for the full DSM-IV diagnostic criteria for bulimia nervosa and appendix 2b for the DSM-5 proposed revisions.)

**Eating Disorder Not Otherwise Specified**

A third diagnostic category within the DSM-IV is that of Eating Disorder Not Otherwise Specified (EDNOS) (please see appendix 3 for DSM-IV diagnostic criteria and appendix 3b for the revisions proposed in DSM-5). This category is comprised of the group of people with eating disorders who do not fulfil the diagnostic criteria for anorexia or bulimia. It includes those with milder forms of these disorders, those who have partially recovered and those who may progress to them. EDNOS or atypical eating disorders have received less research than both anorexia and bulimia, yet it is accepted that they are more common than the better known anorexia or bulimia (Birmingham & Beumont, 2003).

Binge eating disorder (BED), indicated if bingeing is present without compensatory behaviours to prevent associated weight gain, is also included with the EDNOS group. It is associated with obesity and has a better prognosis than both anorexia and bulimia (Birmingham & Beumont, 2003). Those with a diagnosis of EDNOS who engage in purging behaviours are vulnerable to the same risks as those with anorexia and bulimia as they engage in the same damaging behaviours. In the current DSM-IV, those with BED fall under the diagnosis EDNOS. However, in the upcoming revised DSM-5, BED is due to become a formal psychiatric diagnosis. (Please see appendix 4 for proposed classification criteria.)

All eating disorders are psychological illnesses that cause large amounts of emotional distress and physical risks to those affected. I will now try to give the reader a brief
overview about potential causes and influential factors in the development of these illnesses.

The Aetiology of Eating Disorders
Eating disorders are complex psychological illnesses can arise from a combination of many biological, emotional, social, psychological and interpersonal factors (Birmingham & Beumont, 2003).

Although eating disorders are manifested through preoccupations with weight and food, they are symptoms of greater underlying difficulties (Gowers & Shore, 2001). Common eating disorder behaviours, such as dieting, binging, and purging and excessive exercise, are used as a means of coping with emotions and symptoms that feel difficult and overwhelming. An eating disorder can begin as a means for those affected to feel in control of their life, but soon leaves the person with damaged physical and psychological health and a reduced sense of control (Treasure & Schmidt, 2003).

Low self-esteem, depression, anxiety, loneliness, and feelings of anxiety and lack of control over one’s life can all leave persons susceptible to developing an eating disorder. Negative emotions, such as depression and anxiety and markedly low self-esteem, are very prominent features of eating disorders and have been found to be reliable precursors in their development.

Environmental stressors, such as relationship problems (Schmidt, Tiller, Andrews, Blanchard & Treasure, 1997) and severe or traumatic life events, can trigger the onset of an eating disorder (Smyth, Heron, Wonderlich, Crosby & Thompson, 2008). Personality features, such as the need for control and inadequate identity formation, have been reasonably argued as being necessary for the development of an eating disorder (Polivy & Herman, 2002). Societal pressure to be thin (Stice, 1998), dieting, genetic predisposition, family influences, personality variables, such as perfectionism (Castro-Fornieles et al., 2007) and obsessive-compulsive traits, have all been found to contribute to the development of an eating disorder. Thompson (1996) states that eating behaviour and attitudes are learnt as a result of watching parents around food and, therefore, parental dieting, weight and body consciousness can increase the importance that a person places on food, weight and appearance.
Freeman (2002) acknowledges that dieting can lead to an individual becoming obsessed with staying thin. Research has found that females that diet at an average level were five times more likely to develop an eating disorder than those who don’t diet (Patton, Selzer, Coffey, Carlin & Wolfe, 1999).

It is known that biological, social and psychological factors and life stressors contribute to the development of an eating disorder. The research literature suggests that they can result from the convergence of the aforementioned influential factors (Polivy & Herman, 2002). Those treating patients with eating disorders strive to understand that which has been influential in the development of an eating disorder and the mechanisms acting to maintain it so that they can devise treatment that is tailored to the needs of the individual.

**Treating Eating Disorders**

The process of recovery from an eating disorder is complex and requires much more than establishing a normal eating pattern and weight gain. According to Kohn and Golden (2001), for treatment for an eating disorder to be effective it should address both the physical and psychological aspects of the illness. It is well recognised that the longer a person has been caught up in the vicious cycle of their eating disorder, the more difficult is the recovery (Birmingham & Beumont, 2003). For this reason, early identification and intervention are important to allow those affected the best chance of recovery.

People with eating disorders receive treatment in both outpatient and inpatient settings. Treatment in both these settings can consist of group therapy, family therapy, nutritional counselling and individual psychotherapy, usually cognitive behaviour therapy, but also interpersonal therapy, cognitive analytic therapy and, more recently, schema therapy and dialectical behaviour therapy (Treasure & Schmidt, 2003). When someone’s symptoms are severe and/or they are at a very low weight, inpatient treatment may be required to manage the medical risks, serve as a means of symptom interruption and weight restoration. Inpatient treatment is more intensive and recovery is the primary focus.
Motivation

Despite the distressing and debilitating nature of an eating disorder, the decision to engage in treatment is not a straightforward one for those affected. Many experience internal conflict when they attempt to change their behaviours. According to Serpell, Treasure, Teasdale and Sullivan (1999), this conflict is a result of the patient experiencing both positive and negative aspects to their symptoms. As a result of the positive or “egosyntonic” aspects of the disorder, patients can experience high levels of ambivalence about treatment and recovery and, therefore, can be challenging to treat. Patients can feel proud of their weight loss and receive praise and admiration as a result. They can enjoy the sense of self-control they experience around food and weight. Their eating disorder can also provide an escape from life’s responsibilities and expectations they find difficult or challenging (Waller et al., 2010). These are all aspects of a person’s experience that can promote the maintenance of an eating disorder. However, just as the patient can experience positive aspects, they also experience many negative emotions that can make it difficult to engage in treatment. These include feelings of shame resulting from bingeing and vomiting, fear of change as they worry about their ability to manage and cope with distress without the eating disorder behaviours and fear of feelings of emptiness. If a therapist fails to recognise a patient’s feeling of ambivalence, it can result in the patient feeling frustrated, not heard, invalidated and feeling that their therapist does not understand them or their problems. This can impede the development and maintenance of a good therapeutic alliance and decrease motivation further. Therefore, evaluating ambivalence about recovery and identifying the factors influencing it are of critical importance to successful treatment.

Recovery

The concept of recovery from an eating disorder has been extensively discussed in the literature; however, no consensus exists on a definition of recovery. Researchers such as Garfinkel, Moldofsky and Garner (1977) have suggested that a large proportion of those who do “recover” from an eating disorder continue to experience impairments in physical, social and psychological functioning even after normal weight and menstruation have been restored. Criteria used to assess recovery vary from symptom reduction, cognitive and emotional aspects of eating disorder recovery to broader areas of emotional, social and occupational functioning. D’Abundo and Chally (2004) state that, although behaviour change is a crucial aspect of recovery from an eating disorder,
it does not necessarily tell us that the individual is at peace with their feelings towards themselves and their life and the world. Garfinkel et al.’s (1997) findings have suggested that for an individual to be considered “recovered” from an eating disorder they need to demonstrate sustained recovery to a healthy weight, resumption of menses, a loss of the psychiatric psychopathology and improved psychosocial and occupational functioning.

In a study on the attainability of recovery for those suffering from an eating disorder, Bersesin, Gordon and Herzog (1989) looked at the personal accounts of thirteen women who described themselves as “recovered” from anorexia. Seven of the women expressed believing that one can fully recover from anorexia and six disagreed as they felt it was a lifelong illness that can be progressively controlled with less and less effort.

Root’s (1990) investigation of recovery and relapse from bulimia nervosa identified three categories of recovery outcome based on different underlying perspectives. The first perspective, based on the “twelve step programme” used in eating disorder organisations such as Overeaters Anonymous, suggests that complete recovery is not reachable regardless of the length of time the individual is abstinent from eating disorder behaviours (Yearly, 1987; Root, 1990). Within the next stance, recovery is seen to be possible; however, residual factors such as body image issues and food distortion remain as these have now become social issues (Root, 1990; Bowlby, 2007; D’Abundo & Chally, 2004; Jarman & Walsh, 1990). According to D’Abundo and Chally (2004), in the final perspective complete recovery is encouraged and the individual is seen capable of reaching a position where they no longer struggle with their weight, food or body image as the factors that contributed to the development of the disorder have been resolved (Weaver, Wuest, & Ciliska, 2005; Bowlby, 2007; D’Abundo & Chally, 2004).

**Therapists with Personal Experience of Recovery**

Much has been written about the wounded healer and the ways in which the healer’s own wounds or experiences can become vital in the healing or recovery process (Stone, 2008; Mongtomery, 1991; Rogers, 1961). Carl Jung was the first to use the term ‘wounded healer’. Jung believed that personal illness or suffering of the soul provided a healer with the best possible training to help heal the wounds of others (Dunne, 2000).
Winnicott (1960) said “Those who have experienced and borne the scars of emotional pain appear to have an enhanced capacity to understand and empathise with it in others.” (Winnicott, 1960, p. 127) If an individual’s wounds have been adequately cared for and learned from, they have the potential to offer a wisdom that can enrich the lives of those they treat (Bowlby, 2007). According to Sanford (1977),

“If a person has gone through a crisis, died to an old personality, and fought his or her way back to health and a more conscious life, that person may gain a certain quality that enables him to put others in touch with healing too. A certain faith in the healing process is generated by having found healing oneself, not to mention a capacity for empathy with those who are ill.” (p. 81)

Clarkson and Nuttall (2000) stated that one’s own wounds can provide empathy, compassion and a willingness to guide another vulnerable individual on their road to recovery or fulfilment. For therapists to be able to utilise their own experiences in a positive healing way with their clients, the therapist must acknowledge their own woundedness and have a resolution and continued awareness of their personal issues (Bowlby, 2007). However, the authors also caution that these same qualities or sensitivities can impact on the client and the therapy in ways that are unhelpful. Similarly, Grapp (1992) used the term double-edged sword to highlight the possible risks that go with the wounded healer. Grapp (1992) states “If the healer continues to identify with the wounded part of herself, the wounds can bring knowledge, sensitivity and empathy; if the healer does not acknowledge and resolve her wounds, she may become professionally impaired.” (p. 21) Timm & Blow (1999) highlight that therapists need to be aware of how their personal experiences can potentially be both obstacles and strengths. If a therapist is experiencing high levels of personal distress and has difficulty separating their experience or process from that of those they treat, their ability to practice may be impaired and its influence quite negative. The wounded healer must strive to maintain appropriate levels of therapeutic distance and objectivity while remaining empathic and avoiding becoming overidentified with those they treat. According to DeLucia-Waack (1999), such overidentification can make it difficult for therapists to challenge their clients on issues, especially if they are experiencing the same or similar issues themselves.
While the concept of the wounded healer has received lots of attention in published literature, little attention has been given to how professionals with personal experience of recovery from an eating disorder who now work in treatment of eating disorders are perceived by the colleagues, clients and place of employment.

Within the health care profession, eating disorders have sometimes been highlighted as conditions that can interfere with the sufferer’s fitness to practice (Johnston, Smethurst & Gowers, 2005). Standard 12 of the Health Profession Council (HPC, 2008) standards of conduct, performance and ethics states: “You [a registrant] must limit your work or stop practising if your performance or judgement is affected by your health” (p.14). It goes on to recommend that a registrant had a duty to take action if their physical or mental health could be harming their fitness to practice. Therefore, it could be argued that a therapist’s fitness to practice might be impaired if they have an active eating disorder and are treating eating disorder clients. However, if a therapist considers themselves to be recovered and their eating disorder to be a thing of the past, should their fitness to practice be called into question? In 1994, the Clothier Report and the 1997 Bullock Report (British enquiries into the actions of two nurses) recommended that people with a history of an eating disorder be barred from working in all health care professions (Johnston et al., 2005). However, under the Disability and Equality Act (2010), people who have had a disability in the past meet the definition of “disability” and are protected from discrimination by the act. Therefore, individuals who meet and satisfy job requirements should not receive less favourable or prejudicial treatment. Despite such official guidelines, discriminatory opinions continue to exist and many therapists do not disclose a personal history of an eating disorder when seeking employment as they fear that it would be thought inappropriate to work in the area if one had a history of an eating disorder (Bloomgarden et al., 2003). Bloomgarden et al. (2003) also state that disbaring this group of professionals from working with eating disorder patients would be in breach of anti-discriminatory policies, lead to stigmatisation and would also result in the loss of an effective group of professionals and, thus, impact negatively on service users.

In their study, Johnston, Smethurst and Gowers (2005) aimed to address the question of whether a personal history of an eating disorder would help or hinder a clinician’s ability to provide therapy to eating disorder patients. They surveyed 56 adults who
currently suffer from an eating disorder, 39 adults who considered themselves recovered, 11 carers and relatives and 96 mental health professionals involved in the treatment of those with eating disorders. One third of the professionals surveyed acknowledged personal experience of an eating disorder. Of the total surveyed, 81.7% believed it was appropriate for professionals with a past history of an eating disorder to work in eating disorder treatment, 3% felt that it would be inappropriate, 15% were undecided and 1% did not respond. When participants were asked if they felt people involved in the treatment of eating disorders should be obliged to disclose any previous history of an eating disorder, 38.1% responded yes, 40.1% replied no, 19.8% were undecided and 2% did not respond. Professionals both with and without a history of an eating disorder tended to be against the obligation of self-disclosure.

When therapist attributes that were seen as important in the therapeutic relationship were analysed, respondents felt the strength of the relationship between the therapist with a previous eating disorder and client would be at least equal to, if not stronger than, the therapist with no prior history of an eating disorder and client. Professionals with a history of an eating disorder tended to hold more positive views. Results also showed that participants thought that therapists with an active eating disorder would possess fewer positive attributes. With regard to therapeutic advice, each of the groups surveyed perceived the therapist with a history of an eating disorder as been able to offer more useful advice than a therapist without a history of an eating disorder. Participants also specified a number of possible advantages and disadvantages of a therapist who has a history of an eating disorder. The advantages reported concerned empathy, expertise, role model and interpersonal dynamics, whereas disadvantages were concerned with enmeshment, therapist vulnerability, therapist subjectivity and negative traits.

This study by Johnston et al. (2005), is one of the few studies to originate from the UK that looks at the role of therapists with personal experience of recovery from an eating disorder working in the area of eating disorder treatment. It is also one of the few pieces of empirical research that currently exists in the body of literature as a whole that examines the relative advantages and disadvantages of therapists with a history of an eating disorder working with eating disorder clients. The questionnaire used in this study yielded both qualitative and quantitative data responses. This mixed-methods approach worked well for this study as it managed to elicit beliefs, opinions and
attitudes. As the results were based on responses from members of the UK Eating Disorder Association, responses may not be generalisable as being representative of all those with an interest in the area. Also, the authors might have made this study more comprehensive if had investigated the clinical outcomes of therapy with clients treated by different therapists.

What might be the advantages and disadvantages of having recovered professionals involved in treating eating disorders? Costin and Johnson (2002) contacted ten treatment programmes in the US to explore their experience and current position regarding the hiring of treatment staff with personal recovery. None of the programmes contacted had written guidelines regarding the hiring and monitoring of staff with personal recovery. Mixed results were found regarding the preference of hiring recovered staff. Four of the treatment facilities contacted embraced employing staff with experience of personal recovery, five reported not taking previous personal experience into consideration and one facility reported that they avoid hiring staff with a history of an eating disorder. None of the facilities contacted were able to give definitive answers on the number of staff currently employed in their facility with personal experience of recovery, but estimates ranged from 30% to 80%. Two of the facilities that welcomed staff with a personal history of recovery had an informal two-year recovery criterion, while another facility had a one-year recovery criterion. What constituted recovery was ill defined, but there seemed to be a consensus between the programme leaders that comfort with their shape and size was important. The authors found that all the treatment providers contacted were interested in receiving guidelines on the issue.

Both authors of this study act as programme directors of two different eating disorder treatment facilities in the United States. At his facility Johnson (Costin & Johnson, 2002) has hired eleven staff members with experience of personal recovery. He reported that he has found that these members of staff have made a positive contribution to the programme, although the involvement of these recovered professional in the treatment process has not been without its problems. He reported that three out of the eleven hired had periods of feeling psychologically vulnerable, one had what he regarded as a moderate relapse and one other had a severe relapse requiring hospitalisation. By increasing supervision, the three staff members who were feeling vulnerable were able
to overcome their difficulties. The staff member who experienced a moderate relapse engaged in outpatient therapy and had her client hours reduced until her relapse was remedied. Residential treatment was required for the staff member who experienced a severe relapse and by mutual agreement her employment was terminated.

Costin (Costin & Johnson, 2002) reported that approximately 75% of the staff members at the treatment facility where she is director have recovered from an eating disorder. She reported that none of her staff have experienced a relapse since joining the treatment team, but over six years, two have left due to feeling triggered. Costin sees the recovered professional as offering many benefits to clients, but emphasises that the therapist must be “recovered” and not “recovering”. She states that for her to hire a therapist with personal experience of an eating disorder, the recovered therapist must see her eating disorder as a thing of the past and have made peace with food and body issues. Costin also states that she has found no more problems with staff with a history of an eating disorder than she has with other staff members. According to Costin, the recovered therapist is able to offer hope to clients that recovery is possible. As the therapist has direct experience of the client’s experience, they have credibility in challenging the client and encouraging them to take the ‘leap of faith’. Costin sees recovered staff as better at confronting the client’s distorted thinking and narcissistic attitudes and better at building rapport to allow such challenging. Perhaps recovered professionals or wounded healers feel more able to target the murky, destructive and ambivalent feelings towards recovery, while those who haven’t “been there” can have a tendency to see it as an illness that people want to recover from in a simplistic way.

Among the potential disadvantages that recovered therapists can bring to the treatment of eating disorder clients include countertransference vulnerabilities and increased risk of relapse (Costin & Johnson, 2002; Delucia-Waack, 1999). As a result of their own experience of recovery, the recovered therapist may have biased ideas of what is and is not helpful in the recovery process, rather than tailoring the treatment to the unique needs of the client (Costin & Johnson, 2002).

Although both authors are the directors of two of the leading eating disorder treatment facilities in the United States and have many years of experience working with eating disorder clients, the advantages and disadvantages of having therapists with personal recovery involved in the treatment process put forward in this article are not derived
from any form of scientific research and is therefore less reliable and generalisable. Rather, they are a result of their own experience and observations from their many years of experience working in the field and from their position of responsibility with regard to the hiring and managing of staff. Also, there is the possibility that the positive views expressed by Costin may be biased due to the fact that she herself has had personal experience of recovery from Anorexia Nervosa and has gone on to become a successful treatment provider to eating disorder clients and has remained relapse-free.

Given the access that both authors have to recovered therapists working in the field, it would have been interesting if the authors were to ask their recovered staff to evaluate their experience of treating eating disorder clients and how they thought their own recovery influenced their work.

Barbarich (2002) also sought to examine the prevalence of eating disorders among professionals in the field. The Eating Disorders Background Survey was mailed to 823 members of the Academy for Eating Disorders; 399 of the questionnaires were returned. Results indicated that 33.2% of the females surveyed and 2.3% of males reported a personal history of an eating disorder, giving an overall prevalence rate of 27.3%. Of this sample, 46% reported to having a history of Anorexia Nervosa, 49.5% reported having history of Bulimia Nervosa, 23.9% reported experience of binge eating disorder and a further 16.5% reported personal experience of a sub clinical eating disorder. Of those who reported a personal history of an eating disorder, 64.2% reported having received some type of treatment in past and 24.7% admitted to having relapsed since entering the field.

In addition, Barbarich (2002) looked at the association between relapse and a number of other variables in order to establish whether certain factors predicted an increased rate of relapse in professionals. Results indicated the duration of the eating disorder, a history of anorexia (purging type), a history of more than one type of eating disorder and having received treatment all indicated a greater rate of relapse among professionals. When general polices were assessed regarding the hiring of staff with personal history of an eating disorder, results showed that 6.3% actively hired recovered staff, 32.5% hired recovered staff but a personal history of recovery did not influence decision in either direction, 9.0% preferred not to hire recovered staff and 24.1% of
those surveyed were not aware of their employer’s policy regarding the issue of employing recovered staff and a further 2.6% did not have a policy.

The Eating Disorder Background questionnaire used in this survey was not validated and eating disorder diagnoses were self-reported by those surveyed and should be considered with caution. However, as the prevalence rate found in this study is similar to that found by Bloomgarden et al. (2003) and Costin and Johnson (2002), it would be reasonable to suggest that there are a large number of therapists working in the field of eating disorders having personal experience themselves.

Bloomgarden et al. (2003) sought to examine the prevalence of eating disorders among professionals in the field. Spurred by their own ‘special interest’, they surveyed 150 staff members at a large treatment facility regarding their personal experience with eating disorders. The aim was to create a more open and honest culture within the realm of eating disorder treatment so that therapists would feel more comfortable and supported using supervision to discuss issues of countertransference and feelings of vulnerability. The survey asked questions like, “Did you ever have an eating disorder?”, “If so, how long ago?”, “Were you in treatment for it?”, “Do you ever self-disclose this to clients?” (Bloomgarden et al., 2003, p.164). Results of the survey revealed that 24% of the staff admitted having had an eating disorder in the past, another 7% admitted to having eating problems and a further 13% reported to having had a family member who had an eating disorder. The authors believe that the results underestimate the number of therapists with personal experience of an eating disorder as more therapists approached the authors after the study and admitted personal experience but stated that they did not disclose such information previously as they feared discrimination and possible repercussions as a result.

This study is based on a survey conducted in one large treatment facility in the US and should therefore be interpreted with caution as results may not be representative of other facilities. However, other authors have documented similar prevalence rates among eating disorder treatment professionals (Barbarich, 2002; Costin & Johnson, 2002). This might have been a good opportunity for the authors to conduct some qualitative research into what effect having personal experience of an eating disorder has on their work with clients. Both positive and negative aspects could be explored. To
take it further, it would have been interesting to see whether working in an organisation where their employer was unaware of their personal experience of an eating disorder influenced the material brought to supervision if supervision was provided internally.

Of particular importance for the current research, Bloomgarden et al. (2003) found that all therapists surveyed who acknowledged personal experience of an eating disorder reported that they used self-disclosure in their treatment approach. The benefits of self-disclosure to the client and the therapeutic relationship that are documented in the literature are by case report only and more research needs to be conducted within the field of eating disorders in order to examine the effects of such therapist disclosure on the client and therapy.

**Therapist Variables in Relation to Eating Disorders**

In the field of eating disorders, therapist variables and characteristics that are seen to relate to diagnosis criteria and factors that are possibly influential in the therapy process have received more attention in the literature. The gender of the therapist is one such variable. Kopenig et al. (2001) consider female therapists to be better suited to treating clients with eating disorders. However, no consensus exists in the literature on ideal therapist gender when working with clients with eating disorders. Zimmer (1995) has suggested that male therapists are more likely to express feeling ineffective when working with body image struggles, and Burket and Schramm (1995) have said that male therapists are more likely to feel hesitant about treating clients with eating disorders. Satir, Thompson-Brenner, Boisseau and Grisafulli (2009) have suggested that the female therapist and female client relationship can be subject to intense feeling and interactions. Authors such as Bilker (1993) and Hamburg and Herzog (1990) have commented on how similarities between female clients and their therapists in regard to demographics, culture, and education can influence both therapist and clients’ reactions and impact on the therapeutic process. Delucia-Waack (1999) and Stair et al. (2009) suggested that such similarities can promote identification that can be beneficial to the relationship but, likewise, can lead to overidentification, which can cause conflict, competitiveness and therapists becoming overly nurturing with clients.

Eating disorder clients are known to compare their bodies with other women. According to Burka (1996), overweight therapists have reported that clients with eating disorders
feel frightened by their overweight therapist’s body as they fear they will become overweight themselves and look like the therapist. Lowell and Meader (2005) stated that the female therapist is also an object of comparison and, therefore, speaking about the therapist’s body as well as the client’s is essential to the therapy; however, little has been written about how the therapist’s body impacts on the treatment process.

In their article exploring issues of transference and countertransference assumptions about thin therapists, the therapist’s body and body image and its influence on the therapy, Lowell and Meader (2005) reflected on their experience of being thin therapists who work with eating disorder clients. They reported hearing comments like “I want to work with you because you’re thin and you can teach me how to be thin too” and “When I look at your thin arms, it makes me want to run out of the room. I’m filled with self-hate because my arms are so fat and grotesque.” (p242) Lowell and Meader (2005) suggest that therapists faced with distorted projections when working with eating disorder clients can absorb their client’s disgust and struggle to maintain a realistic view of themselves and begin thinking distortedly about their own body. They suggest that talking and exploration of these issues can uncover unconscious ideas and fantasies that can be instrumental in moving the therapy forward.

Eating disorder clients often assume that their therapist has or has had an eating disorder (Lowell & Meader, 2005). These authors also contribute to the growing body of evidence about recovered professionals now working in the treatment of eating disorders by acknowledging that many of their colleagues have identified themselves as having recovered from an eating disorder. They also state that it is common for eating disorder clients to assume that naturally thin and never-eating disorder therapists are unable to understand what it is like to struggle with weight, food, eating and body image struggles. Speaking from their personal experience of working with an eating disorder population, Lowell and Meader (2005) state that eating disorder patients will often question therapists on their eating, exercising and weighing habits and ask if they have ever had an eating disorder. They suggest that these exchanges usually happen early in treatment and the therapist should carefully decide if, how and when to disclose any of this information. Lowell and Meader (2005) also documented that, in accordance with guidelines used in the substance abuse field, many of their colleagues choose to disclose their eating disorder histories from the beginning, while some choose
to disclose at a later time and others decide never to disclose. Furthermore, the authors state that clients usually feel that if their therapist has recovered from an eating disorder, it “enhances or, at times, revitalizes the hope for personal recovery” (p. 244). However, they also acknowledge that some clients would rather think that their therapist is in good health both mentally and physically and is therefore not vulnerable to relapse. They continue to say that some therapists choose not to disclose their own eating disorder history because they assess it to be in the client’s interest, but, as a result, often feel that they are being dishonest by not disclosing. Lowell and Meader (2005) recommend that therapists explore all potentialities with the client, as this can be more beneficial than disclosing details of their personal struggles.

In an empirical study, Vocks, Legenbauer and Peters (2007) sought to assess how important the therapist’s figure or shape is to eating disorder clients. In their study, 34 participants with eating disorders were asked to indicate how important a therapist’s figure was to them and, also, what their preferred therapist shape was. Results were compared to that of a control group consisting of participants with anxiety disorders. Analysis showed that a therapist’s figure was more important to participants with eating disorders than the control group. Both groups of participants favoured therapists with an average figure and with a shape similar to their own. This study was the first to empirically investigate the relevancy of the female therapist’s figure to her eating disorder clients. However, the authors acknowledge that due to the diversity of participants and small sample size used in this study, results should be cautiously interpreted. Although authors such as Lowell and Meader (2005) had previously written on the subject, their article was based on opinions and observations expressed from their personal experience of working with the eating disorder population. Even though the therapist’s body, weight, shape and overall appearance was not explicitly detailed in the research question of the current study, it proved to be an important influential element in how disclosure of personal recovery from an eating disorder was experienced by the participants.

**Recovered Eating Disorder Professionals and Disclosure**

Within the addictions models like Alcoholics Anonymous, treatment providers’ self-disclosure of their personal substance abuse histories has long been used to motivate and provide hope for their clients (Urschel, 2009). The treatment providers continue to
attend support meetings throughout their lifetime and the boundaries between them and their clients tend to be more flexible than the majority of therapist-client relationships (Jacobs & Nye, 2010).

In a personal reflection on her career as a therapist working with eating disorder clients, Rabinor (2009) commented on how occasions where she spoke with her clients from a personally vulnerable position impacted on the moment and the therapy in a beneficial way. As a therapist, she described herself as feeling more “solid” and “present” in the moment with her clients.

When exploring the role of self-disclosure and genuine caring in the therapeutic relationship, Bloomgarden (2000) reflects on a time when running an adolescent eating disorder group, for fear of “outing” herself to her colleagues she became overly boundaried and remote from the group members, despite feeling they were looking for her authenticity to forge a meaningful relationship. As Bloomgarden (2000) thought they would, the group members asked about her understanding and experience with eating disorders. The author reveals she felt disingenuous in her avoidance of her personal experience and she felt disconnected from the group members and them from her. She describes wanting to disclose her experience to prove her understanding as she felt the group members doubted this. From her personal experience of the illness, Bloomgarden (2000) remembers longing for a connection with an adult that felt genuine and offered empathy and wisdom. This experience went on to encourage Bloomgarden (2000) to find the courage to take reasonable and considered risks around self-disclosure with her clients and it became something that she thoughtfully utilises in her practice today.

Bloomgarden (2000) acknowledges that there are pros and cons to self-disclosure and suggests that more needs to be done to assess its effects on the therapy process. In her article, she encouraged the reader to consider and begin to speak about personal and professional risks needed in their work. Bloomgarden (2000) asked therapists to think about their boundaries and how tightly they are held, to ask themselves whether their disclosures take up too much space so that it impacts negatively on the therapy, to look at their willingness to share their boundary struggles with colleagues and supervisors.
and, finally, to critically re-examine existing assumptions in what’s appropriate and inappropriate within therapeutic boundaries.

Rance, Moller and Douglas (2010) used semi-structured interviews to investigate the experiences of seven recovered eating disorder counsellors. Areas explored in the interviews included the impact of working with eating disorder clients on the counsellors’ own body image, weight and relationship with food. Responses were analysed using Interpretative Phenomenological Analysis. Three main themes were identified: “double-edged history”, “emphasis on normality” and “selective attention”. Within the theme “double-edged history” the participants discussed their awareness that having an eating disorder history holds benefits and dangers for them. The participants felt that a primary benefit of their experience was their increased understanding and empathy towards their client’s experience. These particular findings are in line with that suggested by Johnston et al. (2005); however, contrastingly, they did not view themselves as role models but did think that their experience enabled a belief in the possibility of their client’s recovery. Rance et al. (2010) suggest that a reason for not viewing themselves as role models for recovery may be due to the fact that they reported a tendency towards non-disclosure of their experience which is dissimilar to that reported by authors like Bloomgarden et al. (2003) and Johnston et al. (2005). The participants’ viewed possible dangers of their experience to be damaging to the therapeutic relationship like enmeshment and over-involvement but not risk of relapse as reported by Johnston et al. (2005). Within the second theme “emphasis on normality” the participants felt that their recovery was absolute and complete and that a return of eating disorder thoughts and behaviours was implausible to them. Rance et al. (2010) highlight that these opinions are in opposition to those proposed by Johnston et al. (2005) in terms of risk of relapse. The authors suggested that their “emphasising just how little they were impacted by the work in terms of their own body image, weight and relationship with food, they were able to make a pre-emptive strike against any questioning of their fitness to practice” (Johnson et al., 2005, as cited in Rance et al., 2010 p. 388). Rance et al. (2010) acknowledge the questionable plausibility and abnormality of having no issues with food, weight and body image in today’s society, but suggest that the freedom these counsellors experience in relation to this was a result of their deep engagement with these during the recovery process and they now have a
healthier relationship with their own body and weight than the majority of the female population.

The final theme reported by Rance et al. (2010) was “selective attention”. The authors reported that this theme discussed strategies used by the counsellors to help them remain adamant about their own recovery and fitness to practice.

Rance et al. (2010) recognise that, as a result of the stigma and uncertainty regarding the appropriateness of recovered professionals working in the field of eating disorders, the counsellors may have censored their experience to give socially desirable responses as a result of fears and questions regarding their fitness to practice and, in reality, their work with the eating disorder population may have a greater impact on themselves than they were willing to disclose.

An article by Jacobs et al. (2010) was written in response to exchanges on an Academy of Eating Disorders listserv where a member requested advice on addressing a co-worker at her eating disorder treatment facility who she thought was “dangerously thin”. Responses to the post encouraged the writer to address the issue with her co-worker and a discussion ensued around the impact of the therapist’s body on the transference and whether self-disclosure should be part of treatment carried out with recovered professionals. Picot, McClanahan and Conviser (2010) explored how recovered professionals could use body image transference in the treatment to help enable recovery. They suggested that there was no consensus among recovered eating disorder professionals with regard to self-disclosure in treatment; some tended to be very open and honest about their personal history, while others saw it as unnecessary and perhaps damaging to do so. They highlight that within the literature there is no favoured stance, although Costin and Johnson (2002) have highlighted the need for guidelines on the issue.

Picot et al. (2010) suggest that, regardless of whether recovered therapists choose to disclose their personal experience to their eating disorder clients or not, “size, appearance, weight, dress and overall presentation of one’s physical self are fundamental statements we present to our patients and can be conceived of as indirect forms of self-disclosure” (p 166). Picot et al. (2010) suggests that those working with eating disorders should allow time for reactions to their physical appearance to be
processed as it helps to promote a sense of trust and healing in the relationship and encourage insight and revelation in the therapy.

Costin (2010), a recovered professional working in the field, discusses the process around her own decision to self-disclose her personal history to her clients. Talking about her first experience with an eating disorder client, she shares that she felt it would have seemed “bizarre and voyeuristic” not to discuss her own anorexia and recovery with clients who were referred to her because of her personal experience of an eating disorder. Costin (2010) felt that self-disclosure was inevitable, as the knowledge and understanding she portrayed through the questions she knew to ask would have revealed her “insider knowledge” and personal history. Costin (2010) states that throughout her sessions with this client, she chose to disclose certain things to demonstrate to her client that “she got it” and also to share what helped her get better and she recommends that recovered professionals do the same thing. In the article, Costin (2010) states that details of their problems are unnecessary, but sharing resources used to achieve recovery can be valuable to the client and their treatment. She proposes that

“Recovered clinicians must navigate a fine line with their ‘insider knowledge’ and work hard to remain both ‘expert’ and ‘novice’ with each client. Even though they think they understand what a client means or is going through because they have ‘been there’, it is critical that their understanding of each client is not being coloured by their own personal experience.” (p. 168)

Costin (2010) goes on to state that self-disclosure can be “tricky” and can quickly become a “slippery slope”. She recommends that, if in doubt, one should choose not to disclose until one has thought through all the issues that may arise as a result so that information shared is done wisely in order to encourage healing to those being treated.

Rabinor (2010) goes on to discuss the transformative power of self-disclosure and shares a time where her client asked her about her body image and she responded in a way that disclosed that she too worried about her weight and eating too much. She was aware that this might have been deemed to be “taboo”, but, instead, she chose to allow herself to be vulnerable as she believes that selective self-disclosure encourages authenticity and reciprocal self-disclosure (Rabinor, 2010; Rabinor, 2009).
Also within the same article written in response to the discussion on the AED listserv website, Hornstein (2010) discussed how changes in her own body and weight have been observed and have influenced her clients. She acknowledges the importance of bringing these issues into the therapy room and how exploration of these can be a powerful process for the client, which encourages and promotes growth for the client in relation to their beliefs about their own body.

Murray (2010) speaks of her dismay that there was no response to comments made by therapists on this same listserv about times when they were told that their being thin was triggering to patients and comments referring to overweight therapists lacking creditability. Murray (2010) describes herself as a person of colour and size and reflects on her observation that staff at eating disorder treatment facilities tend to be of a uniform shape and size that is not reflective of the population at large. Murray (2010) highlights the need for greater diversity among eating disorder staff, which will not only make it more representative of the population at large, but also of the clients attending the services. She suggests that services have a responsibility to demonstrate that “worth is not measured on a scale” and that this must be practised within the eating disorder treatment community.

The Role of Clinical Supervision for Recovered Professionals

Within the practice of Counselling Psychology in the UK, regular supervision for all practitioners is a non-negotiable element of professional practice where they review work with clients and explore their own personal reactions. One of the objectives of supervision is “to offer the supervisee intellectual challenge enabling reflection, transformational learning and psychological support to maximise a supervisee’s self-responsibility for appropriate self-care”. (BPS, 2007, pg 5). However, according to Bond (1993), the benefit of this supervisory relationship can very much depend on the willingness of the supervisee to present their work with clients openly and truthfully without neglecting to include information about any ethical or personal dilemmas they experience.

Shisslak, Gray and Cargo (1989) report that a significant percentage of health care professionals working with eating disorder clients perceived themselves to be
moderately to greatly affected by their work with this client group. Changes were attributed to an increased awareness of food, their physical appearance and feelings about their body.

Therapists in the study by Warren et al. (2009) stated that the number one piece of advice they would give to other treatment providers about effectively treating those with eating disorders would be to receive supervision and consultation on a regular basis. They also recommended that therapists working with this population utilise outside social support and engage in self-care; they also felt that it is important to feel confident with one’s own eating behaviours and body image and that clinical supervision can also be used to address such issues, judgement and feelings.

Levine (2010) observes that in her experience of supervising eating disorder therapists, it is often the thoughts and behaviours that should be brought to supervision that are the very ones that are omitted. She suggests that this is sometimes due to therapist inexperience or a desire to look more skilled. She highlights that issues around self-disclosure of past struggles, diet and exercise can have influential effects on patients, and the therapist and supervisor need to work together to be able to discuss sensitive topics that impact on the therapy in a non-defensive way. Here, Levine (2010) is referring to all therapists who work with eating disorder clients. Clearly, then, the clinical supervisor of a therapist with an eating disorder history has a crucial role in assisting the therapist manage the ways in which her eating disorder history might influence the therapy she provides to eating disorder clients. Not only would supervision provide a place to discuss important issues, such as using self-disclosure with clients, the motivations for doing so and managing the impact it has on clients, but as Delucia-Waack (1999) highlights, it also provides a protective space for the therapist as it can help them to continue to have a realistic sense of body image, food and weight or to help them achieve a level of comfort with these issues. She suggests that a therapist may think they are comfortable in these areas, but a particular event or session can “resurrect” it as an issue for them; as such, it is important to examine this issue to ensure it does not influence responses or interventions with clients. Dulica-Waack (2009) states that supervision is not to become therapy, but it is important that personal issues be examined in supervision in order to be aware of the extent that they could possible influence the treatment process. Again, given the possibility for increased
vulnerability to these issues for the recovered therapist, particularly if the therapist is within their first few years of recovery, it is important that recovered therapists can speak with their supervisor about these issues for the protection of themselves and those they treat. By doing so, they will be better able to assist clients in confronting these same struggles.

Abuse of Power in the Therapy

Thus far, this literature review has already looked at some of the ways that therapist disclosure of personal recovery of an eating disorder can be helpful to the therapy of eating disorder clients. Attention has also been given to ways in which such disclosure can be unhelpful to the therapy and sometimes harmful to the client. An important point in need of discussion is the issue of abuse of therapist power in relation to disclosure in the therapeutic relationship.

Through disclosure the therapist can convey information to the client that can be harmful, distressing and compounding of their difficulties. Clients enter the therapeutic relationship in a vulnerable position and are led by the actions of the therapist, who is seen as the “expert” (Strand, 2006). Due to the imbalance of power inherent in the therapeutic relationship, when the therapist says or does something that does not best serve the needs of the client, it can be difficult for the client to raise the issue with the therapist. The therapist’s actions remain unchallenged, which allows the therapist to repeat the same unhelpful actions, despite it being potentially damaging to the client.

Although self-disclosure can be used as a vehicle to balance the power differential between therapists and clients (Simi & Mahalik, 1997), the therapist can use this power differential to meet their own needs in the therapy. According to Zur (2011), self-disclosure that is done for the benefit of the therapist is considered a boundary violation. It can create a role reversal where the client is burdened with unnecessary information and they feel the need to take care of the therapist (Gutheil & Gabbard, 1998; Zur, 2004). To ensure that therapist self-disclosure is ethical, the intent of the therapist is important. The focus of therapy should be the client’s welfare and done for clinical and therapeutic purposes. When it is done for gratification of the therapist’s needs or desires, the therapist is abusing the position of trust they hold and this can be punishing for the client (Bridges, 2001, Mallow, 1998; Zur, 2007). To avoid such therapist
exploitation of the therapeutic relationship and resulting harm to the client, the balance of power in the therapeutic relationship should be monitored and examination of the therapist’s intent examined in a supervisory context.

**Rationale for Exploring the Client’s Experience**

Researchers and those treating eating disorders are beginning to acknowledge that many are drawn to work in the field at least partly as result of personal experience of recovery (Barbarich, 2002). There is consensus among the literature that there are currently a significant number of therapists working in the field who have themselves a history of an eating disorder (Bloomgarden, Gerstein & Moss, 2003; Barbarich, 2002; Costin & Johnson, 2002; Johnson, Smhurst & Gowers, 2005; Warren, Crowley, Olivardia, & Schoen, 2009). Many of the clients surveyed in the UK-based study by Johnston et al. (2005) reported that, at some point in their treatment, a therapist had disclosed such personal experience. Many of the therapists and professionals surveyed in the studies by Bloomgarden et al. (2003), Barbarich (2002) and Costin and Johnson (2003) have acknowledged that they have used self-disclosure in their treatment approach with eating disorder patients. Existing theories regarding the benefits of such disclosure comes from the perspective of the therapist. The eating disorder client’s experience of therapist disclosure of personal recovery from an eating disorder has never been explored in depth. Given the prevalence rate of recovered professionals in the field and that research suggests that many disclose their personal experience to their clients, more research is needed to examine the impact of such therapist self-disclosure on the client, the therapeutic relationship and the outcome of treatment. Research into this area will provide those working in the treatment of eating disorder clients a deeper and more comprehensive understanding of how their clients experience self-disclosure of personal experience of an eating disorder. As a result, they will feel more informed in effective use of self-disclosure in their work. The current research aimed to begin to give an insight into the eating disorder clients’ experiences.

**The Research Question**

How is therapist disclosure of personal recovery from an eating disorder experienced by the eating disorder client?
Within the next chapter my personal relationship with the research will be explored along with my epistemological position of my research question. My choice of method and research procedures undertaken will be documented.
Methodology

Personal Statement
Throughout this chapter I have used the first person to convey personal accounts towards reflexivity and I have highlighted its use in italics. I hope the reader will see how my personal interests have been influential in the development of this research. I hope this helps with the evaluation of the data and shows readers my attempts to be reflective throughout the research process (Willig, 2001).

Motivation
The aim of this study was to give participants an opportunity to reflect upon and speak openly about their experiences of having their therapist disclose personal experience of an eating disorder to them at some point in their treatment for their eating disorder. Participants were encouraged to speak openly and freely about their experiences, about factors that influenced how it was experienced and how it affected themselves, the treatment, the therapeutic relationship and the therapeutic outcome. This holistic view of the participant experience fits with the practice of Counselling Psychology as qualitative research also places importance on the individual’s subjective experience and the exploring of meanings within it. Qualitative methods have been used many times to investigate counselling phenomena such as counselling practices, counselling process, relational issues between counsellor and client and counselling outcomes (Wertz, 2005).

Phenomenological methods focus on the individual or idiographic experience, the lived world of the participant. This philosophy of phenomenology fits with this study as it provides exciting methods of investigating and understanding one’s experience. It provides a rich source of ideas about how to investigate and understand a person’s lived experience (Smith, Flowers & Larkin, 2009). To be phenomenological we ask that the participant take a step back and consciously reflect, remember and engage with a particular experience (Smith & Osborn, 2008).

Willig (2001) suggests that the objective of qualitative research is not to predict how people experience events; instead, it aims to describe and explain events and
experiences. Interpretative Phenomenological Analysis (IPA) is a qualitative research method that allows the researcher to explore how an individual experiences particular events (Smith & Osborn, 2008). It aims to gain their individual perspective on their experiences. I chose IPA as my method of analysis as I wanted to explore the participants’ experiences of having their therapist disclose personal experience of an eating disorder to them. The study was suited to IPA as the sample was homogeneous and my research question was of significance or special interest to them (Smith & Osborn, 2008).

Epistemology

The epistemological position of the research question should guide the choice of research method. In IPA, we are assuming that the data generated can tell us something about our participants’ understanding of their experience. IPA combines a questioning hermeneutics with an empathic hermeneutics (Smith & Osborn, 2008). The IPA researcher seeks to understand the viewpoint of the participants while at the same time asking critical questions of the data produced. Smith and Osborn (2008) go on to state that both types of hermeneutics or interpretation styles can potentially lead to ‘richer analysis’, which, in turn, better captures the whole of the participant and their lifeworld. Although my research aim was to gain an understanding of my participants’ experiences of the research phenomenon, it would be foolish of me to neglect how my own experiences, identification and felt empathy could influence my interpretation of the data in some way.

I have suffered from an eating disorder in the past and during this time, while receiving treatment for an eating disorder, have had therapists disclose personal experience of an eating disorder to me. As I have personal experience of the phenomenon under investigation, how will this influence the research design, the data collection and analytic process? As this happened to me a number of years ago, I decided to have a colleague who is sufficiently familiar with my research topic interview me in the early stage of this research with the intention of uncovering my views and opinions of the phenomenon. By becoming explicitly aware of my stances on how I experienced my therapist self-disclosure at the time, I hoped it would better position me in being continuously reflexive of how my own opinions and experiences might be influencing how I interpret or apply meaning to the participants’ data. Although I have attempted to
be aware of the influence of my personal perceptions, it is inevitable my interactions, questions and, in turn, my analysis may have been affected by my own views and interests. In addition to this, I am now a recovered professional working in the treatment field of eating disorders. Although I do not now or have never used self-disclosure with my patients, I will be reflecting on my role as a recovered professional and the impact of this upon this research study.

The relationship between the researcher and the participants can be very influential in the research process. Ajjawi and Higgs (2007) state that a relationship between the researcher and participant is necessary in the research process. The level of rapport, how comfortable the participants feel and the context can affect the participants’ willingness to share particular feelings and experiences. Larkin, Watts and Clifton (2006) suggest that participants’ accounts of their experiences of the phenomenon are always constructed by both the participant and researcher. As IPA seeks to capture and gain an understanding of the participants’ experiences, I felt that, given the many areas where it is not only possible but, indeed, likely for my experience and preconceptions to influence the interview and analytic process, it is all the more important to account for this in some way. As Madill, Jordan and Shirley (2000) state, “The effect of the individual analyst on research findings can create a creditability problem for qualitative approaches from the perspective of evaluative criteria utilised in quantitative psychology.” (p1)

I was wondering if I would be looking for my participants to share experiences that were in line or similar with my own. As mentioned previously, I am now a trainee psychologist working with eating disorders and hoping to continue in the area post qualifying; therefore, am I looking at the data searching for something that supports my career choice? As such, I needed to adopt an epistemological stance that allowed this to be acknowledged.

When considering and deciding upon the most appropriate epistemological stance to take, I decided that the theory of contextual constructionism fitted best. This approach takes account of the “inevitability” of the researcher’s personal perspective in the process and it views the empathy experienced by a shared feeling and understanding as a method of connecting the researcher and participant and contributing to the analytic
process (Madill et al., 2000). Contextual constructionism works with inter-subjective meanings by openly acknowledging the researcher’s subjectivities (Pidgeon & Henwood, 1997). It proposes that knowledge is situation-, context- and standpoint-dependent (Jaeger & Rosnow, 1988) and results will vary depending on the context they were sourced from (Madill et al., 2000). As such, all meanings are understood to be subjective but no less valid regardless of whether they appear to be in contrast to alternative perspectives (Madill et al., 2000). It is the researcher’s role to ground the results in the interview data to show that the findings produced are based in the participants’ accounts (Tindall, 1994).

**Philosophical Considerations**
According to Ashworth (2008), qualitative psychology is concerned with human experience and with the perspective of each individual of those experiences. In opposition to the positivist position of testing aspects of human cognitions with the aim of producing externally measurable and observable variables, the phenomenological shift grew with the desire to return the focus to the innate ideographic experience. Since its inception, Phenomenology has evolved since its founder, Edmund Husserl (1859-1938), posited that human experience is not a matter of response to assumed variables, but, rather, is a system of connected meanings within a person’s reality (Ashworth 2003; Moran, 2000). IPA is one of a number of qualitative approaches to research that strives for the psychological meanings of the experience as perceived by the participant. Glorgi and Glorgi (2008) state that phenomenological analysis attempts to establish the essence of the phenomenon from detailed examinations of the real illustrations within the real lives of the participants. IPA is based on three theoretical/epistemological underpinnings; these being phenomenology, hermeneutics and ideography. Each of these will now be discussed in turn.

**Phenomenology**
Phenomenology is discovery-led and so is not intended to prove or disprove existing theories (Bowlby, 2007). Instead, it aims to look closer at what happens or what exists to be discovered (Creswell, 1998). Experience is at the core of phenomenology. According to McLeod (2001), phenomenology seeks to set aside prior assumptions and produce an exhaustive description of the phenomena until its core features reveal themselves. Willig (2008a) states that phenomenology is interested in how human
beings experience the world within particular contexts at particular times. How the phenomenon appears varies depending on the individual’s intentionality, that is, their location, the context, the angle of perception and their desires, wishes, judgements, emotions, aims and purposes (Willig, 2008a).

Husserl, the founder of phenomenology as a philosophical movement (Ashworth, 2008), highlighted the importance of human experience as a beginning point in psychological investigation. He saw human experience, reflection and perception as having fundamental importance and that the meaning or “essences” of experience is bound up in the “lifeworld” of the individual (Willig, 2008a). To be phenomenological as Husserl conceived it was to bracket the taken for granted of the phenomenon and try to establish the core or “essence” of experience (Smith et al., 2009). In IPA, the work of Husserl has highlighted the process of reflection and brought the need of “bracketing” to the attention of the researcher. However, instead of searching for the essence of experience, IPA and the aims of this research seek to capture a particular experience of a particular group of people inclusive of the diversity and variability of the experience (Smith et al., 2009).

Heidegger, who was a student of Husserl, was also very influential in the development of phenomenology. However, in contrast to Husserl, Heidegger’s stance on phenomenology moved to a more interpretative one that was grounded in a person’s life world. He emphasised the importance of reflexive awareness and intersubjectivity, as Heidegger saw our relatedness to the world as fundamental to our ability to understand it and others. Heidegger’s influence in the development of IPA is seen more strongly within the role of hermeneutics, as interpretation of the data is a key aspect in attempts to understand and make sense of the participant’s experience.

Hermeneutics
Ashworth (2008) states that hermeneutics is concerned with the interpretation of texts and the researcher’s role in attempting to understand an individual’s narrative. IPA is double hermeneutic. Participants are trying to make sense of their world and the researcher is trying to make sense of the participant trying to make sense of their world. Ricoeur (1976) differentiated between the hermeneutics of empathy and the hermeneutics of suspicion. The hermeneutics of empathy represents an authentic
account of an experience. It involves the application of the researcher’s understanding and reflexive attempts to ascertain meaning. The hermeneutics of suspicion refers to a more rigorous level of interpretation that involves the application of that which lies outside of the text. Heidegger was a key player in the meeting of phenomenology with hermeneutics. It was felt that “the things themselves” can appear or present themselves in a concealed or covered up manner and meaning needs to be interpreted. With this, Heidegger felt that the researcher inevitably brings their prior experiences, assumptions and preconceptions into the process and, therefore, needs to be continuously aware of their own influence on the process. The bracketing of one’s own preconceptions became a cyclical process that Heidegger felt could only be partially achieved (Smith et al., 2009).

*Given the many identities I hold within this research, this cyclical process becomes a crucial element of the research procedure that has been both challenging and insightful. Please refer to the additional reflective paragraphs in italics throughout this chapter where I talk about this more.*

**Idiography**
Idiography is concerned with the particular. IPA employs idiography in two ways. Firstly, IPA looks for detail and depth in the analysis of the phenomenon and so is systematic and thorough. In addition, IPA seeks to understand how the research event, relationship or process is understood by the participant (Smith et al., 2009). Participant samples for IPA are small and purposively selected for the research topic and, therefore, generalisations are avoided but observations are made cautiously (Smith & Osborn, 2008). The idiographic stance of IPA and its methods of analysis allows for the individual experience of my participants to be made more general but always identifiable back to them (Smith & Osborn, 2008).

**Research Design**
In this study, an exploratory qualitative design was used with the aim of capturing my participants’ experiences of the phenomenon under investigation. Qualitative research is concerned with an individual’s personal experience and the meanings that they attach to their experiences (McLeod, 2001), whereas quantitative research aims to test theories and establish facts. As such, when choosing my methodology, qualitative methodology
best suited my research aims as a qualitative research method would enable exploration
of the perceptions and meanings true to the participant (Ritchie & Lewis, 2004) and, as
such, fitted well with the aims of this research. Semi-structured interviews with a small
homogenous sample were conducted as a method of data collection. The resulting data
was analysed using Interpretative Phenomenological Analysis (IPA).

**Methodological Considerations**

When deciding upon a suitable qualitative research method for this study, various
methods were considered before deciding upon IPA. According to Wertz (2005),
phenomenological methods are scientific in their principles. They are methodical,
systematic, critical, general and potentially intersubjective. They vary in their analytic
procedures, expression and situation. Many core phenomenological characteristics can
be seen between the various methods (Giorgi, 1989).

Grounded Theory shares many characteristics with IPA specifically with regard to
producing and analysing data. Jonathan Smith developed IPA as a means to achieve a
level of insight into the personal psychological world of the participant, whereas
Grounded Theory was originally developed to identify and explain contextualised social
processes. Willig (2008a) suggests that both IPA and Grounded Theory aim to produce
a cognitive map of an individual’s view of the world and both begin with individual
cases which are integrated to gain a fuller understanding of the research topic under
investigation. However, Willig (2008a) also states that they differ in that Grounded
Theory aims to identify and explicate contextualised social processes that account for
the phenomena, whereas IPA aims to gain a better understanding of individual
experiences and achieve insight into an individual’s real lifeworld.

A second alternative considered was Discourse Analysis, of which there are two types:
discursive psychology, which is concerned with what participants are doing with their
thoughts (Potter & Wetherell, 1987; Poter, 2003), and Foucauldian Discourse Analysis,
which asks how discourse constructs subjects and objects (Foucault, 1981; Willig,
2008a). Like IPA and Grounded Theory, it also aims to explore psychological
understanding of the discourse between the researcher and the participant and constructs
meaning from the discourse (Phillips & Jorgensen, 2002). However, Discourse Analysis
requires a more sensitive approach towards language, as its focus is on examining the
words people use. Discourse Analysis tends to be more interpretative than Grounded Theory and IPA because it doesn’t focus on questions of experience and it sees a person’s reality as inaccessible as it is constructed and reconstructed through language. Ultimately, the goal is to shed light on the cultural and linguistic factors that influence ways of thinking, speaking and acting on a given topic. As such, Willig (2008b) suggests that Discourse Analysis is better suited to exploring accountability and stake in everyday settings rather than aiming to explore cognitive processes.

As it is my participants' experiences of the phenomena under investigation that is key and is the main focus of this research, IPA seemed to fit best as it offers a method that gave me scope and permission to openly explore and access their psychological world and to attempt to make meaning of their experience.

Method

Interpretative Phenomenological Analysis
Developed by Jonathan Smith, Interpretative Phenomenological Analysis (IPA) is a research method concerned with understanding the lived experience of the participant and with how the participant makes sense and comes to understand their experiences (Smith, 2008). In IPA, the researcher is responsible for approaching the data in a phenomenological way. The IPA researcher tries to understand how a participant experiences the phenomena under investigation and describe this acquired understanding (Larkin, Watts & Clinton, 2006). Individual experience is influenced by thoughts, judgements beliefs and expectations (Willig, 2008a). As such, an assumption of IPA is that individuals can experience the same event or condition in different ways. As discussed earlier, IPA analysis is strongly influenced by hermeneutics, as the researcher, in the effort to capture what appears of the participant experience, employs interpretative engagement on the part of the researcher. For IPA to be successful it requires a mixture of both phenomenology and hermeneutics. The researcher uses phenomenological insights when trying to uncover the participants’ individual experience and hermeneutic insights when engaging in interpretative analysis in order to understand the experience (Smith & Osborn 2008).
As such, IPA accepts Heidegger’s view that it is impossible to gain direct access to the personal world of our participants and, therefore, the researcher is encouraged to engage with the individual narrative at such a level of depth that they can feel they are gaining privileged access and insight to their participants’ thoughts and beliefs surrounding the phenomenon under investigation (Willig, 2008a). To enable this, Smith and Osborn (2008) recommend that the researcher be aware of how their own perception can influence how they access the participant experience. At each stage of the research design, collection, analysis and write-up I have endeavoured to engage in the process in a reflexive way.

**Analytical Procedure**

IPA has become a widely used method in psychology (Eatough & Smith, 2008), and since its development, detailed descriptions of procedures have been produced (Langdriddle, 2007; Smith & Dunworth, 2003; Smith, Jarman & Osborn, 1999; Smith & Osborn, 2008). Its founder, Jonathan Smith, encourages the researcher to be flexible in adapting the method to their preferred way of working and to best investigate the research topic (Smith, 2004; Smith & Osborn, 2008).

It is an interpretative activity where thematic analysis of the data generates codes and super-ordinate themes from the interview transcripts. Data then moves from the particular of a single case to a more general context as additional data is analysed and early descriptions move to more interpretative meanings later (Willig, 2001; Smith, 2008). The process of analysis takes several stages. A brief description of this process is detailed below:

- Interview transcripts are read several times to gain a general feel for the participant’s views and feelings, etc. Throughout this reading of the text, the researcher makes notes of interesting comments and areas of texts and codes that are anchored in the participant’s words are noted in the left-hand margins. The researcher then rereads the text again and emergent themes are identified using more interpretative accounts from their perspective. These emergent themes are noted in the right-hand margin.
- Individual themes are listed initially from the first interview. A sample of this for one of my participants can be seen in appendix 5. These are subsequently
subdivided into super-ordinate themes where interrelationships between the various themes are identified. A sample of this can be seen in appendix 6.

- This process is repeated for the remaining interviews and are organised into existing super-ordinate themes or, if a new themes has emerged, it is added to these.
- Themes shared across all cases are organised to make consistent and meaningful statements that are grounded in the participant’s account of their experience (Smith et al., 2009: p 79-101). A sample of this can be seen in appendix 7.

**Validity and Reliability**

According to Morrow (2005), the quality criteria in qualitative research are strongly related to the epistemological stance held by the researcher. Contextual constructionist research acknowledges that the nature of the data collected and the analytical process are strongly influenced by the subjectivity of the researcher. For this reason, Morrow (2005) recommends that the researcher brackets their assumptions in order to manage their subjectivity while conducting IPA.

Traditional methods of measuring reliability and validity are based in the positivist quantitative perspective and are not in keeping with the ethos of qualitative research. In response to this, Yardley (2000) suggested the four general principles for assessing the quality of IPA research to be as follows: sensitivity to context; commitment and rigour; transparency and coherence; and, finally, impact and importance.

Sensitivity can be shown by awareness of the related and relevant literature. It is also hoped that the reader will see that the researcher displayed sensitivity throughout the process. In relation to the principles of commitment, rigour, transparency and coherence, commitment refers to the in-depth engagement with the topic, rigour with completeness of data analysis and of the interpretation, transparency being the degree that all aspects of the research process are disclosed, and coherence meaning the “fit” between the research question and the epistemological position taken and the methods used to investigate the research question (Yardley, 2000).

In order to ensure compatibility with the above, a sample of the coded transcripts was reviewed with my supervisor. A sample of some initial coding and emerging themes can
be seen in appendix 8. Additionally, to ensure transparency, a paper trail of all the data concerned in the building of codes, themes and super-ordinate themes for analysis was kept. My personal reflections on the research process have been documented in italics within this thesis.

In addition, in line with the recommendations of Ajjawi and Higgs (2007), I constantly cross-checked my interpretations with the text in order to ensure authenticity and to ground the interpretation in the participants’ data. To demonstrate this, many verbatim quotes are included throughout the results and discussion to provide readers with an opportunity to judge whether the themes presented are consistent and grounded in the data (Smith, 1996). However, this study recognises that IPA acknowledges that the findings presented are only one possible interpretation (Pugh & Coyle, 2000). It is hoped that the researcher’s and participants’ voices are evident throughout the analysis and that this will help to demonstrate authenticity (Denzin & Lincoln, 1994).

Triangulation of data can be used to improve validity, and it usually involves using multiple data sources in an investigation to produce understanding (Ritchie & Lewis, 2004). However, within a contextual constructionist approach to conducting IPA, triangulation was used in this study to ensure that an account is rich, robust, comprehensive and well developed (Madill et al., 2000). For this reason, a quarter of the interviews were reviewed by my research supervisor with the contextual epistemology goal of completeness and not convergence in mind.

Research supervision was also important to the process of reflexivity through this research process (Etherington, 2004). Contextualist analysis accepts the inevitability of the researcher bringing their own personal perspectives to the research process, and supervision proved to be a valuable resource that allowed me to explore my personal position within the research, my relationship to the participants, the research and personal proximity of the subject matter (Pearson & Brew, 2002).

**Data Collection**

When considering a method of data collection I considered my research question, what I hoped to achieve and methods suited to IPA. In qualitative research, interviews are frequently used to obtain knowledge. Kvale (1996) suggests that qualitative researchers
seek data rich enough so that meaningful interpretations can be made. The process of doing IPA requires the researcher to engage with texts and transcripts at a micro level in order to extract the idiosyncratic meaning contained within (Smith et al., 2009). Smith et al. (2009) also suggest that interviews are a suitable way to collect and generate data to be analysed using IPA.

For the purposes of this study semi-structured interviews were utilised as they provide participants with an opportunity to share their experience of the phenomenon being investigated with the researcher. They allow the researcher to interact with the participant, thus facilitating rapport and empathy, which promotes a more flexible and deeper level of exploration of the phenomena of interest. Chan (2005) reports that the data becomes more enriched as a result of the dynamic interaction between the researcher and the participant. In addition to this, I was excited to be able to meet and speak with participants about their experiences of therapist self-disclosure of personal experience of an eating disorder.

As it is the participants’ experience that is of interest, Willig (2001) recommends that the researcher keeps questions open-ended and non-directive. In order to allow the participants the maximum opportunity to tell their own story, I started the interview with an initial broad question to encourage the participant to share their individual experience of the topic. A range of other questions designed to clarify, elicit and probe information surrounding the research topic followed this initial broad question. This form of data collection also allows the researcher to probe and further explore important and interesting areas as they arise, thus helping to ensure depth and richness of dialogue and text. Smith and Osborn (2008) and Willig (2001) recommend that the researcher produces an interview schedule in advance. They suggest the process encourages the researcher to clarify in advance what aspects he/she would like to cover in the interview and provides an opportunity to pre-empt difficulties that might arise. Exact questions were not constructed prior to the interviews; instead, bullet points of areas that were of interest to the researcher were compiled as I felt this would allow for more freedom and flexibility within the interview and allow for the questions to be introduced more organically into the interview. These points of interest for the interviews were stimulated both by the existing literature and by my clinical and personal experience. In line with recommendations by Smith and Osborn (2008), I made myself familiar with
the interview points in advance, which allowed me to concentrate on what the participant was saying and be better attuned to the effect of the interview on the participant.

**Sample**
IPA studies are usually conducted on small purposively selected samples. This study utilised a homogenous purposively selected sample as the research was focused on gaining a better understanding of how a particular group of people experienced the phenomenon as they could provide unique and valuable insight into this particular phenomena and experience. Smith and Osborn (2008:49) state that, “They represent a perspective, rather than a population.” A homogenous sample also enables the researcher to examine the convergences and divergences of experiences within the sample.

**Eligibility Criteria**
To be eligible to participate in the study, participants had to meet the following criteria:
- Be over 16 years of age
- Had received specialist treatment for an eating disorder
- While receiving treatment they had a therapist disclose personal experience of an eating disorder to them.

Participants were excluded if they were currently very distressed or acutely ill or underweight. Participants were also excluded if they were currently in or were less than three months out of individual counselling or psychotherapy. Three interested participants had to be excluded as they were currently in individual counselling. All three participants understood the reasoning for this and they wished me well with the study.

**Sample Size and Demographic Information**
There are no set sample size criteria for IPA research. IPA is concerned with detailed accounts of the participant’s experience. Its focus is quality not quantity. For research undertaken at professional doctorate level, Smith and Osborn (2008) suggest that a smaller number of higher quality interviews are more important than a larger sample size. In order to allocate sufficient time, reflection and dialogue, something that successful IPA research requires (Smith & Osborn, 2008), a sample size of between six
and eight was decided, in this instance, to be sufficient to develop meaningful instances of similarity and differences between participants. The current study had six participants, which is a sufficient number to be able to engage with each transcript at the deep level required for analysis. As IPA is an idiographic mode of enquiry involving painstaking analysis of cases, Smith et al. (2009) suggest a small sample size is more appropriate.

The age of the participants ranged from 18 to 34. All participants were female and white Caucasian. Although one isn’t looking for the sample to be representative, it is worthwhile pointing out that this does fit in with the demographics for eating disorders (BEAT, 2011). Three participants were Irish and three were British; none were married or had children; four were in college or university and two had degrees but weren’t working at the time of the interviews; and all were of normal weight and were functioning well. Vignettes of each of the participants can be seen at the beginning of the following chapter (pg. 94).

**Recruitment**

Recruitment posters (see appendix 9) outlining the aims of the research, participant requirements and researcher contact details were posted in eating disorder support group venues in London and were emailed to gatekeepers of support groups around the country. One British participant saw the advertisement in a S.E.E.D support group venue in Manchester. Assistance was also given by BEAT, the UK National Eating Disorder Association. After explaining the research aims and submission of the ethical approval, the research advertisement and all information and consent documents to their research administrator, BEAT kindly agreed to advertise the research poster on their website free of charge. From this many expressions of interest were received and two of the British participants came via this pathway. Assistance with recruitment was also provided by Bodywhys, the Irish Eating Disorder Association. Information about the research and the research poster was distributed to their research database. The database consisted of members who had identified themselves as willing to be contacted for research purposes. The research advertisement was also included in their bi-monthly newsletter which is emailed to members. The three Irish participants came via this route.
I am happy that my research appeared interesting and relevant to those I was targeting. It was great to receive so much interest and not to feel that I was struggling to recruit. I was feeling anxious in the early days of recruitment that I might have difficulty as my criteria was quite specific. Countless times I have listened to my colleagues say, “Does that actually happen?” My anxieties were pushing me to think of additional ways to recruit and I thought of approaching people whom I had known when I was sick who I knew had experience of my research topic. I soon realised this wouldn’t be appropriate for many reasons ethical and otherwise, including the issue of power dynamics. How would they see me now? Here I am, recovered and fully functioning, doing a Doctorate and leading a relatively “successful” life and, in contrast, they were still battling with an eating disorder. What feeling would this have evoked in them? Thankfully, recruitment of participants never became an issue, but this line of thinking did make me more aware of the myriad of thoughts and emotions that can possibly occur during my meetings with participants.

**Procedure**

All participants made initial contact via email. If a telephone number was provided I made contact with them by phone and explained my research topic in more detail and clarified that they met the inclusion criteria. The voluntary nature of participation was discussed and all participants were given the opportunity to ask any questions they had regarding the research and the proposed procedure. All interested participants were sent an information sheet (see appendix 10), which explained the purpose and outlined the procedure of the interview to read and consider. Prior to the interview, participants were also sent copies of the two consent forms that they would be asked to sign on the day of the interview. These outlined their rights as a participant (see appendix 11) and detailed the use of audio recording (see appendix 12) to read and consider. As none of the participants were London-based, interviews took place at a hotel that was accessible and convenient to the participant. The hotel receptionist directed us to a quiet area where there would be no disruption. Some hotels allowed us to use a meeting room free of charge.

Upon meeting they were asked to sign the consent forms confirming their agreement to participate and consenting to use of audio recordings. GP contact details were also sought from each participant. Once these steps were completed, a semi-structured
interview was conducted. Interviews lasted between 60 and 95 minutes. After the interviews all participants were given the opportunity to discuss any concerns and ask any questions they had. As the interview process involved the participant reflecting on sensitive information, a list of contactable psychological resources and points of support (appendix 13) was given to each participant.

All participants were encouraged to ask questions they had about the study. All of the participants expressed their enthusiasm in the initial email about participating in the study as they felt that therapist disclosure of personal recovery had a big impact on their treatment and they were keen to share their experiences, both good and bad.

*During my research supervision, I discussed the possibility of being asked by the participants if I myself had an eating disorder: how would I respond? It was never my intention to self-disclose my own position to my participants, but both me and my supervisor felt that I should be prepared as it appeared very likely that I would be asked. For this reason, I prepared an answer that I could draw on if the situation arose. We both felt it best not to deny it but, equally, given the subject matter, not to disclose. How would it be for my participants if they happened to be sharing a negative experience or negative effect? My disclosing could at worst cause a negative impact and at best cause them to sensor their sharing of their experience. Surprisingly, none of my participants asked the question. Does this mean anything of note? Was this question even in their awareness or had they presumed I had personal experience from my research topic and the types of questions I asked or the empathy I expressed? Did my appearance have any influence on my participants or their willingness to share? I am of normal weight and I do not feel there is anything remarkable about my appearance that would suggest a history of an eating disorder. Those with eating disorders often pay particular attention to others’ weight and size (Sanderson, Wallier, Stockdale & Yopyk, 2008). This is something I will reflect further on in the discussion.*

**Transcription**

All interviews were digitally recorded and transcribed. All identifying information was changed in the transcript in order to protect the identity of the participants and those who were mentioned during the interview process. In terms of the transcription process I followed recommendations by Smith (2003), as he highlights that, although IPA
transcription does not require prosodic features of talk to be recorded, all words spoken should be transcribed, including false starts, pauses, laughs, crying and other behavioural expressions that are worth recording. A number of example pages of a transcript from an interview with one of my participants can be seen in appendix 14. Transcriptions were done in order of interviews and were given a number to identify the participants (i.e. P1 for participant 1) and the letter R for the interviewer/researcher. As transcripts contain sensitive information, only a sample will be included within this thesis, but they can be made available to the examiners if requested.

_During the transcribing of the interviews, I became aware of times where I had been influenced by own experiences and preconceptions. This sometimes led me to be more directive than I would have liked and seek the participants’ views or opinions on my own curiosities. Although I have adopted a contextual constructionist approach to my research that allows for the inevitable influence of the researcher on the results (Pidgeon & Henwood, 1997), I have tried to keep some sense of objectivity in the analysis. Best (1995) suggests that it is beneficial for the researcher to move between subjective and objective dimensions as it allows for a deeper understanding of the phenomenon under investigation. By bringing my own opinions and beliefs into my awareness, it has helped to enable me to look past my own experiences and see my participants’ meanings and views and ground the results in their experiences._

**Ethical Considerations**

British Psychological Society (BPS, 2009) ethical guidelines were adhered to at all times throughout the research process. I discussed the following with my participants:

- **Informed Consent**
  Information on the aims, procedures and use of findings were provided to all the participants. The consent process was formalised by asking the participant to sign a consent form before the interview took place.

- **No Deception**
  Any questions that the participants had regarding the research were invited and answered fully.
• **Right to withdraw**

I informed the participants of their right to withdraw from the research at any time, even after an interview has taken place. They were aware that no questions would be asked regarding reasons for withdrawal and also that any data already collected (i.e. interview tape and transcript, consent form and pre-interview questionnaire) would be destroyed upon withdrawal. They knew that they could chose not to answer any interview question for whatever reason and that they could chose to terminate the interview at any point.

• **Debriefing**

Time was given to seek the participants’ views of the interview process and content at the end of the interview. I provided all participants with a list of contact details for psychological resources/support agencies.

• **Anonymity**

Before the interviews began, I informed the participants that all identifying information would be removed from interview transcriptions. This helped my participants become more at ease as they knew there was no need to censor their experience for fear of making themselves or others identifiable through details and names shared.

• **Confidentiality**

I informed my participants that all materials would be stored securely and that tapes and transcripts would be destroyed at the end of the study.

Ethical approval was granted from the Psychology Department at City University (see appendix 15). Ethical approval was not required from other agencies.

**Summary**

Within this chapter, I have explored the epistemological position of my research question along with the philosophical underpinnings of my chosen research method, IPA. I have attempted to be transparent with the procedural and analytic processes that I have followed to help the reader understand how the results presented in the chapter that follows have been reached. In addition, I hope to have given an adequate account of the
various identities I hold within the research and how this could possibly have influenced the research process.

In the next chapter I attempt to show the reader what I have found in a way that gives the reader insight into how therapist disclosure of personal experience of an eating disorder was experienced by my participants.
Analysis

Before I present the results and details of the participants’ experience, I will provide the reader with a brief vignette description of each participant’s background in terms of their eating disorder and treatment history. I will then provide a description of the information each participant provided about their therapist who disclosed personal recovery of an eating disorder to them. Information about how the disclosure occurred, the frequency of disclosure and the therapist’s weight as perceived by the participant will be presented. I hope this information will allow the reader to better understand and contextualise the findings subsequently presented.

Participant Vignettes

Lucy
Lucy was 27 and was a qualified teacher, but she was not working at the time of the interview. She was single. Lucy appeared slim but not underweight. After receiving a diagnosis of Anorexia Nervosa at 14, Lucy’s family sought private therapy for her with the therapist who disclosed personal recovery. Lucy reported that around age 16 she began bingeing and purging and developed a bulimic presentation until she was 18. At this time, she managed to stop bingeing, but her purging behaviours continued in response to her strong fear of gaining weight and becoming fat. In this period, she would have met the DSM-IV criteria for EDNOS; however, under the proposed new revisions in the upcoming DSM-5, instead of an EDNOS diagnosis, Lucy would have received a diagnosis of Purging Disorder within Feeding and Eating Conditions Not Elsewhere Classified. Lucy self-induced vomiting until age 22 and she continued in treatment until age 24. Since then, she has considered herself in recovery. Lucy sought therapy with the therapist who disclosed personal recovery until she was 17 and her family was encouraging her to seek treatment elsewhere due to the lack of progress towards recovery. She then worked with her subsequent therapist on and off until she was 24 when she finished treatment.

Holly
Holly was 24 and was at university studying to become a midwife. She was in a relationship. She developed Anorexia Nervosa at age 13 and met the full criteria for
Bulimia Nervosa between the ages of 15-20. Holly had been in and out of treatment for many years. She began working with her therapist who disclosed recovery at age 19. She stopped working with her at age 22 when she moved away for university. Holly appeared to be of normal weight and was functioning well.

Ruby
Ruby was 18 and was doing her A-levels. She started restricting her food intake at age 10 and was diagnosed with Anorexia Nervosa at age 11, at which time she received inpatient treatment. After discharge she maintained her progress for a time but developed Bulimia Nervosa at age 14 when she began binging, vomiting and abusing laxatives. Ruby had two therapists disclose personal recovery to her. The first was at age 12 when receiving follow-up outpatient treatment for anorexia. She worked with this therapist for eight months. The second was at age 15 while seeing a therapist for bulimia. She worked with this therapist until she was 17 and finished treatment. When we met for interview Ruby appeared to be of normal weight and she was no longer in therapy. Ruby felt that she had more work to do in terms of recovery, but she reported that she was happy with her progress.

Chloe
Chloe was 23 and was finishing university. She was not in a relationship and was unemployed. She was diagnosed with Anorexia Nervosa at 14 and described herself as being in and out of treatment until age 18 when she began seeing her therapist who disclosed personal recovery. She continued to work with this therapist until she was 21. She has not been in treatment since and she considered herself to be doing “ok”. Chloe was tall and appeared slim but not underweight.

Emma
Emma was 34 and was in a long-term relationship. She had worked as a cook in her family business for many years, but at the time of the interview she was not working as she was about to begin a college course in Business. Emma began binging and self-inducing vomiting at age 16, but she didn’t receive formal diagnosis of Bulimia Nervosa until she was 19 when she first presented for treatment. She had seen many therapists over the years and began seeing the therapist who disclosed personal recovery at 26. Throughout this time, she had periods that were symptom-free mixed with
episodes of bingeing and purging of varying severity. She worked with this therapist until age 30. At the time of the interview Emma was functioning well and she reported that she had been binge-free for six years and was maintaining a healthy weight for a number of years which she was content with.

Tara
Tara was 18 and was studying for her A-levels. She was single. She started dieting at 13 and then bingeing and vomiting at 14 and was given a diagnosis of Bulimia Nervosa. She began therapy at 14 to please her parents but disengaged after three months. Tara began working with the therapist who disclosed a history of an eating disorder to her when she was 15 and finished treatment with her nine months before we met. At the time of the interview Tara appeared to be of normal weight and she considered herself to be progressing well while recognising she had more work to do.

Details of the Therapist’s Disclosure
The reader should be aware that this information presented about the therapists is a subjective account and will be affected by the lens and fantasies through which the participants experienced their therapist.

Lucy’s Therapist
Lucy knew of her therapist’s eating disorder history before they began working together. Lucy described it as a motivating factor to engage in treatment and it was the primary reason for choosing her as a therapist. Lucy describes her therapist as being very open about her personal recovery in the therapy. It was first discussed in the first session when the therapist was quite specific about having recovered from Bulimia Nervosa. In subsequent sessions Lucy reported that her therapist shared many details about her own experience, some quite graphic. Lucy reported she frequently felt that her therapist was taking up her session time. When they first started working together Lucy’s therapist had recently given birth and Lucy perceived her to be overweight. During the course of treatment, Lucy saw that her therapist lost weight and regained a shape that she perceived as normal. At one point, Lucy described her therapist as becoming very slim, and due to disclosures on the part of the therapist, Lucy was aware that she adhered to a health-conscious lifestyle to the point where Lucy questioned her level of recovery.
Holly’s Therapist
Holly’s therapist disclosed her personal recovery in the first session. Holly reported that it was brief and detail was limited to the fact that she had recovered. Holly felt that this was done to convey understanding and this is the way it was received by Holly. No specifics regarding diagnosis was shared, but Holly detected she also had a long struggle towards recovery. Holly thought this because she perceived her therapist to have a deep understanding of her experience and needs. Holly described her therapist’s weight and shape as similar to that of her own when we met (normal). Of all the participants, Holly’s therapist’s self-disclosure appeared the shortest in duration and her personal history and experiences were rarely introduced into the therapy.

Ruby’s Therapist
During her time in treatment, Ruby had two therapists disclose personal recovery to her. It first happened when she 12 while in treatment for anorexia. Ruby said it happened very early on in the therapy (first or second session). Her therapist disclosed that she had recovered from anorexia and had received a lot of treatment. Ruby reported that during her therapy sessions her therapist would frequently refer back to her experience of treatment and recovery. Ruby remembers thinking her therapist was overweight, but, looking back, she feels that her therapist was of normal weight, but her perception of weight was distorted at the time.

Ruby’s second experience of therapist disclosure occurred at age 15. She reported it happened about five sessions in. Ruby reported feeling stuck in the treatment and she felt the disclosure was done to shift the therapy along. Ruby remembers no specific details being shared and said it was rarely brought up again in the sessions unless she asked the therapist something about her experience. Ruby reports that even when she would do this the therapist would avoid sharing specific details. In terms of the therapist’s weight and shape, Ruby perceived her therapist to be of normal weight.

Tara’s Therapist
Tara’s therapist disclosed her personal recovery in the first session. Although she says her therapist didn’t disclose specific details at that point, she did share that there were times throughout the treatment when she would refer to her specific experience of the
illness and techniques that were helpful. Although Tara’s therapist did not disclose a particular diagnosis, the information shared by her therapist led Tara to believe that it was anorexia. Tara also reported that her therapist disclosed a current BMI of 21 to her as Tara perceived her as being very slim and she was conscious of becoming heavier than her. At the time, Tara’s BMI was lower than this, and she felt that her therapist disclosed this information to serve as a reality check for her distorted body image. Tara was aware of other clients who had also seen the same therapist as her and they were also aware of her therapist’s personal recovery. Tara believed that her therapist disclosed this information to all her clients and it was part of her treatment approach.

**Chloe’s Therapist**

Chloe reported that her therapist disclosed personal recovery a number of sessions into the treatment. She estimates this occurred around the 13th or 14th session. Chloe feels this was a stuck moment in therapy where her motivation to continue was wavering. She felt her therapist disclosure was aimed to help her (Chloe) build trust and move forward. She reveals that, at this time, the disclosure was brief and no specifics were shared. However, after her therapist’s personal recovery was discussed within the sessions, it was there for them both to refer to and this happened throughout their remaining sessions, although she reported that specific details of weight and behaviours were avoided. Chloe described her therapist’s weight as being within the normal range and that there was nothing about her appearance to raise suspicions of an eating disorder past.

**Emma’s Therapist**

During their first meeting, Emma’s therapist disclosed her personal recovery. She reported that she was sharing this information to let her know that she (the therapist) did understand and to show that it was possible to move on from the position that Emma was in. Emma reported that her therapist drew on her personal experience at times throughout therapy to highlight techniques and skills that helped in her recovery. Emma felt that her therapist drew on her experience to highlight recovery but that details about her illness were avoided. Emma’s therapist didn’t disclose what type of eating disorder she had, but Emma believed that it was similar to her own. Emma reported that her therapist was not overweight, but she perceived her to be at the upper end of what she saw as normal.
Overview of Analysis

The analysis of the transcripts was a time-consuming but interesting process. It yielded so much information and insight into each participant’s experience that it was difficult to accept that I wouldn’t be able to include everything. I felt a responsibility to my participants and a pressure to do their words and experience justice.

Throughout each of the participant’s transcripts there was an overriding theme of ambivalence. I thought about making it a master theme in itself, but as it cuts across so much of what will be presented, I felt it best to consider it within each theme instead as I was afraid of losing the other aspects of what their ambivalence pertained to.

I will now try to show my reader how I came to these master and constituent themes by presenting illustrative extracts of my participants’ words. It would be outside the scope of this report to include all possible extract examples that apply to the themes presented, but I do hope to provide the reader with transcript extracts that best represent the theme and the participants’ views as a whole.

It should be noted that each of the master themes have much that overlaps between and within them. I could have chosen to have one overriding theme of “ambivalence” as mentioned previously, or, equally, grouped everything under “oscillating aspects”; however, given the richness of experience shared by the participants, I felt it more appropriate to categorise the themes further in order to present a fuller, more comprehensive picture of the participants’ experience and accept that there may be some overlap along the way.

List of Master Themes and Their Emerging Constituent Themes

Master Theme One: Oscillating Aspects
1. Initial Processing
2. Tempering Conditions

Master Theme Two: The Therapist Embodied
1. The Overweight Therapist
2. The Thin Therapist
3. Coveting
Master Theme Three: Recovery
1. Possibility of Recovery
2. Therapists’ Recovery
3. What is Recovery?

Master Theme One: Oscillating Aspects
The first master theme, “oscillating aspects”, encompasses the initial benefits the participants shared experiencing from their therapists’ disclosure and the additional complex aspects of the experience that unfolded during the course of the interviews that highlight contrasting and conditional views to the overt benefits initially discussed. All participants spoke of having an increased sense of hope that recovery is possible, a deeper level of understanding about and empathy for their experience, an awareness that their therapist “got it” and them having insider knowledge. Participants also felt that having their therapist disclosure prompted reciprocal disclosure from them. All participants reported helpful and unhelpful levels of identification with their therapist. Other aspects reported included feelings of anger and resentment towards their therapist, increased competition and an over normalising of experience. Another negative impact was over-disclosure on the part of the therapist and the sharing of details being damaging or harmful. All participants reported both helpful and unhelpful aspects of disclosure.

Sub-Theme One: Initial Processing
One of the most prominent helpful aspects of disclosure expressed by all my participants was hope. The participants felt that hearing that their therapist had recovered from an eating disorder gave them “hope” and allowed them to believe that recovery might be possible.

1: “It was quite encouraging to kind of see that you can I guess live a normal life and not be completely consumed every moment by thoughts of food or weight or everything else. And like it wasn’t a huge amount of detail but she said that she’d been speaking with therapists for a long time throughout and that it had been a very gradual process but even that to me was better than hearing that there was nothing kind of at all that could be done or so I guess it was sort of reassuring.. yeah”
Chloe describes it as “encouraging”, hearing her therapist share that she has had personal experience of an eating disorder, and through seeing her living a “normal life”, Chloe was able to begin to imagine a different life for herself, one where eating disorder thoughts and behaviours didn’t dominate. However, while reporting finding it “encouraging” and “reassuring”, Chloe also alludes to a less positive side to the disclosure. Chloe had a sense that her therapist’s recovery was hard and took time, which was discouraging, but “even that” was worthwhile for Chloe to hear as it meant that recovery was possible. This sentiment was echoed by Tara, acknowledging a sense of beginning to envisage change and a life beyond her current state.

2. “It made me feel that there is light at the end of the tunnel. Because to see her she had such a healthy relationship with food and like.. because like.. I suppose people think when you have recovered you either eat loads of chocolate and crisps all the time or you live on like salads and stuff but she had like a mix of both because she wants.. She let herself have things that she likes but she wanted to put good things into her body so she’d eat like vegetables and healthy things cause she wanted to look after her body now and that’s different to only eating lettuce because you can’t allow yourself something else.. It’s different”

For Tara, her therapist’s disclosure of her personal experience of recovery, of having been there and done that, was important to her as it allowed her to believe that if she persevered with the difficult battle and struggle she experienced in treatment, there would be “light” there to make it worth it. Most of the participants felt that they had forgotten what life was like prior to their eating disorder and this appeared to make it more difficult to visualise what life without their eating disorder could be like.

3.“I sort of learnt that there is a better life than this, you know there is something else to focus on other than food all your life”
The above extracts give a sense that the participants’ feeling that knowing their therapist had undergone personal recovery from an eating disorder allowed them to see a life beyond their reality at that time and that this was an important element for them. As Tara goes on to say:

4. “To hear my therapist say that ‘I am now well’. Its just inspirational and I know for a fact that I wouldn’t have got well without her. I know for a fact cause just, if you think that you are not going to get well from it there is just no point in battling it, cause its just such a hard battle. Like the stage I’m at now, I can manage my food but I’ve still got a bit further to go and to think that I will be stuck here forever.. I’d rather be ill. Cause it’s too hard, I’d just rather stay ill and live with it. So to know that I can get through to the other side.. It’s really inspirational. .... to know that I can get through to the other side it’s just really inspirational”

(Tara: 4-5:38-50)

The power of hope is summed up nicely by Emma when she says:

5. “My therapist offered me hope and the value of her experience which is huge, like hope in itself can cause somebody to begin on a journey and stay on a journey and believe that things will get a little bit better and a bit easier”

(Emma: 43-589-594)

As is evident in the above excerpt, Emma valued the fact that her therapist has battled and won struggles that were similar to what she was going through. Emma felt that this was a valued extra than what is normal in treatment. She speaks of the sense of hope as being inspiring to “begin on a journey” and motivating to “stay” on it. It allowed her to take the leap of faith required of her and trust that it would “get a little bit better and a bit easier” and seeing what her therapist had done allowed that belief to gain in strength.
Feeling inspired by their therapist’s recovery came through in most of the transcripts. Inspiration and motivation to recover appeared to be a little different than hope. The participants seemed to take a detailed look at what recovery might be and, coupled with hope, this acted as a motivating factor to engage in treatment.

6.“She had a lot of freedom, you can tell she was at peace with herself, yeah she. And you can tell even by the way she walked, the way she holds herself like you can tell... yeah, she gave me hope that when she does. Gives me something to aim for that you don’t need to settle for a certain stage that you can go beyond it. Yeah cause I’ve had a couple of friends who I thought had been recovered and I started spending time with them and its turns out from what I’ve seen of them that they are not actually completely recovered yet. So that kind of disheartened me and I went to therapy and said I don’t know if I can get through this and she was like ‘you can, you definitely can’”

(Tara: 11-12: 129-144)

“Freedom” and “peace” were words used by many of the participants and will be visible to the reader in many themes as this chapter progresses. For Tara, these were qualities or aspects that she perceived in her therapist that encouraged her to feel that there was something to be hopeful for and motivated to achieve for herself. Tara was inspired to try to achieve something beyond what she had believed possible.

All of the participants spoke of the battle that recovery from an eating disorder is. Part of what makes it difficult is feelings of ambivalence. As such, sometimes motivation to engage in that which feels challenging and fearful can be fleeting. Holly felt that working with a therapist who she knew had recovered from an eating disorder provided a reminder of why she made the decision to engage in treatment.

7.“It was a constant reminder and that was every week, that was every week I went up there I could see that it was possible so even I if I sat there, and even sometimes I said to her ‘I’m not going to be able to do it, I’m not going to be able to do it’ and she wouldn’t even say anything, she would just sit there and nod and I knew it was just that common thing that we know this we know that we can go to this space but you know she was sitting in front of me so obviously it was possible and then I kind of went well it
would only ever be possible if I give up you know and bloody hell sometimes you really would want to just go no I’m not doing this, I can’t do this”

(Holly: 61-62: 834-848)

Holly describes her therapist as being a motivator and re-motivator throughout her treatment. When she was feeling like she couldn’t do it, that it wasn’t possible, her therapist was there to remind her that it was possible and, for Holly, the fact that the therapist who she knew had recovered was sitting in front of her provided proof that it was possible. Holly’s ambivalence about engaging fully in treatment and recovery is evident in this excerpt: “Then I kind of went well it would only ever be possible if I give up you know”. Even though Holly had committed to treatment to a certain degree, there is a sense of her going along with it without really knowing if recovery was what she wanted, but her therapist knew this and worked with this. Holly feels this was an unsaid understanding between her and her therapist because of their shared experience: “I knew it was just that common thing that we know”.

For many of the participants, their therapist was the first time they had come across somebody who had recovered from an eating disorder. They described feeling hopeless before this and disheartened that it couldn’t be done.

8. “But you were seeing people sick all the time and you were seeing people who were a lot longer in it than you and a lot worse than you and you were wondering that you know, as time goes by you lose a little bit more hope every time and I really was full sure I was not going to make it.... So yeah with her there was always that thing of hope, it didn’t matter what was going on or how hopeless I felt, when I went there I could not deny the fact that here was this woman who had recovered, who had this you know, fantastic therapist and great business but also her counselling things at the back of her house, this lovely house and her husband and children there and everything you can’t but just go, you know I can’t say that I will never get there so there was that”

(Holly: 60-61: 812-833)
In the excerpt above, there is a sense of Holly needing to see someone that had been successful in beating an eating disorder. Previously, all she had seen was people who had been struggling with their eating disorder for years and had not managed to progress towards recovery. In many ways she was comparing herself to them and was thinking it wasn’t possible. After meeting with her therapist and hearing her disclose personal recovery, this provided alterative possibilities for her. Holly seemed to look at more than the disclosure from her therapist, but also her therapist’s situation as a whole, her “lovely house and her husband and children there and everything”. This all appeared to instil hope in Holly. This reality of never having met someone who had recovered before was also echoed by Chloe:

9.“I had not met anyone who had recovered so it felt is it actually possible.... I keep seeing the same faces and it’s almost like a little community of people who just can’t get out”

(Chloe: 59:685-592)

In Chloe’s extract, there is also a sense of hopelessness, a belief that recovery was something impossible and that this somehow changed after meeting with her therapist and hearing that she had come through it. She likens it to a “community” that exists separate to the rest of the world that people can’t seem to leave, a community where people are bystanders to life but not participants in it. Hearing their therapists describe themselves as recovered, as having been there, provided the participants with proof that it can be done and so might not be a fruitless battle.

10.“Yeah I guess its been kind of proof that it is possible to reach there”

(Chloe: 57:667-668)

11.“I think as well to know that someone has been there and got through it. Its like..”

(Tara: 14:171)
In Chloe’s and Tara’s quotes above, the sense of seeing is believing that came as a result of their therapists’ disclosure, provided them with the “proof” that this thing that seemed so impossible might actually be “possible”.

For all my participants, hope seemed like such an important element of their therapist disclosure of personal experience and it encouraged them to embark on this uncertain road of recovery as it instilled the belief that it will lead to a better place that will make the journey worthwhile.

All participants shared the sense that their therapist had a deep understanding of what they were going through and had “insider knowledge” of their experience.

12. “*It kind of meant that I felt more sort of [pause] I guess less paranoid of making no sense when I was talking because you kind of think well yeah, ok she gets it*”

(Chloe: 10:105-108)

Chloe felt that knowing her therapist had personal experience of an eating disorder made her feel less “paranoid” about what she said and how she said it. She felt her therapist “gets it” because she had been there.

For Tara, the understanding that she felt her therapist showed was “proof” or evidence of her therapist’s personal experience of an eating disorder.

13.“*You can definitely tell she had an understanding of it if she’d definite. She got it like I could say things that other people would think is totally crazy but she got it and I think that’s proof that she has been there*”

(Tara: 9: 96-100)

Tara believed that only someone who has “been there” could understand the “crazy” thinking that she feels is inherent in an eating disorder. For Tara and many of the participants, the understanding they experienced with the therapist who disclosed personal experience was above that of other therapists.
The experience of their therapist “getting it”, getting the madness of what it is to live with an eating disorder and everything that goes with it came through in each participant’s interview. This therapist understanding experienced by the participants allowed them to become more at ease and trusting of the therapist and had the effect of reducing the shame and embarrassment in disclosing their thoughts and behaviours and heightened the feeling of acceptance for all participants.

14. “As I was able to start being really open about it and that came with the trust as well…. It made things an awful lot easier for me I think that I could be actually honest and open and say that this is what’s happening and it was almost like this weight lifting off you when you actually, when you go to some extremes and that, it the secret, it’s the carrying it around with you that actually makes it so dark you know. So even being able to go in there and say, this happened, and I suppose then she knew the extremes that I would go to…. but yeah with her it was definitely an awful lot easier to be open about those things. She never made me feel like it was even wrong, it was just this acceptance of well that’s where this has brought you now. She got it yeah”

(Holly: 48-49:640-658)

Knowing her therapist had personal experience of an eating disorder had the effect of making the therapeutic environment safer for Holly. She describes it being “easier” to be more “honest” about the true nature of her thoughts and behaviours. Holly describes having her experience validated; “She never made me feel like it was even wrong”. Hearing her therapist’s disclosure encouraged Holly to take risks in the treatment that she might not otherwise have been willing to do.

Chloe also felt that her therapist’s disclosure had a positive effect on her own willingness to share honestly about her experience.

15. “I wasn’t sure of how to articulate myself so having that experience [disclosure] was like, I’m not alone in this and somebody else gets it, the feelings and the anxieties and views seem so alien, it’s hard to imagine anyone how anyone else feel that and it can be such a lonely thing, I guess there is quit a sense of shame as well attached to it.
It can seem so trivial to a lot of people ... it [disclosure] encouraged me to open up more which then had positive effects for our other sessions cause I was able to be more open and more honest about things that I was feeling even if I wasn’t proud of what I was thinking or feeling”

(Chloe: 10-11:116-134)

Chloe describes feelings of identification: “I’m not alone in this and somebody else gets it”. This helped reduce feelings of isolation and encouraged her to disclose her true thoughts and feelings, regardless of how “alien” and shameful she believed them to be. Chloe felt that her therapist disclosure of personal experience of an eating disorder had an overall positive affect on the therapy.

In the below excerpt, Tara shared the experience of Chloe. She also speaks about feeling more comfortable and at ease sharing that which feels “abnormal”.

16. “I wouldn’t admit [behaviours] to anybody that I was doing it but getting therapy, I was like yeah I’ve done this and she’d be like yeah I’ve been there, it’s fine. You will get through it and then you don’t feel so abnormal then and then because you feel like you are not abnormal, you feel like you can get through it”

(Tara: 21:240-244).

For Tara, knowledge of her therapist’s personal experience helped normalise her thoughts and behaviours, which encouraged her to believe that it was possible for things to be different. She also gives insight into how her therapist drew on her personal experience in the therapy: “She’d be like yeah I’ve been there, it’s fine”. However, with this there comes a risk of “rebound” abnormality or hopelessness if the participant was to relapse.

Ruby felt hearing her therapist disclosure encouraged reciprocal disclosure from her.

17. “Because she opened up to me I opened up to her, we had like, quite a strong trust level so you know I didn’t feel scared about telling her that I’d had a bad day, I didn’t
feel scared about telling her that I had hidden food because I trusted her, I trusted…. Because she’d know what I was going through”

(Ruby: 55: 634-642)

As a result of Ruby being aware of her therapist’s personal experience of an eating disorder, she felt it easier to be honest and open because “she’d know what I was going through”. Ruby also felt that the act of disclosure helped build trust in their relationship, which also made it easier to share honestly on her part.

This insider knowledge that the participants felt the therapist had was also demonstrated in the participants sharing that they felt their therapist with personal experience of an eating disorder knew the eating disorder mindset and so was harder to fool.

18. “She was the one person I couldn’t trick. She was the one person cause even another therapist said to me that I could trick her very easily but my therapist…. she knows cause she has been there so she knows all the tricks of the trade”

(Tara: 23:279-284)

19. “I had so many little tricks and she knew them”

(Ruby: 63:738)

This knowing “the tricks of the trade” was something that the participants thought could only come from having been there and having had experienced the eating disorder mindset. They acknowledge that an eating disorder can cause them to become manipulative with those around them, but they felt this is harder to do when their therapist had probably thought and done that same thing at one point.

All participants expressed experiencing a deeper level of empathic understanding with their therapist who had personal recovery than with other therapists they had worked with in the past. Many described believing that you have to have been there to really
understand the “madness” and “crazy” thinking inherent in those with an eating disorder.

20. “She’d definitely be able to empathise and in a way it’s good, I didn’t feel so alienated, I didn’t feel so like I’m mad in the head for having done these things or anything like that, there’s no shame around it because I knew she was coming from a similar place”

(Lucy: 16:196-202)

For Lucy, knowing that her therapist had come from a “similar place” allowed her to identify with her therapist and perceive empathy, all of which reduced feelings of shame, embarrassment and alienation that she had felt in the past. However, it is interesting that Lucy begins using the conditional tense. Might this be dependent on particular conditions or be subject to change? The experience of empathy and understanding was also reflected by the other participants.

21. “I really felt it was because the level of understanding was at a different level all together than anything I had come across before. Em that, she just got it [laughs] Do you know there wasn’t that constant fight... there wasn’t that fight to try and make the person understand what it was like or when I was talking or you know even the comfort to be able to say things that sound so crazy to someone else and actually sitting there having never been in that position or never having those crazy thoughts that go on in your head... It was just that there was an understanding that that was the way it was”

(Holly: 1-2: 8-31)

Holly speaks of having to battle with people in the past to try and make them understand her “crazy thoughts”; and her experience with her therapist who she knew had recovered from an eating disorder was easier because she knew her therapist had first-hand experience of “having those crazy thoughts that go on in your head”. Consequently, she felt her therapist’s understanding was at a much deeper level than she had come across before.
22. “She was very good at knowing what to say, what not to say, what to ignore and I guess, I think that level of understanding can only come from experience. I don’t, I think people can try to understand and I think they can understand to an extent but I don’t think people will ever fully understand unless they have been there because it’s such a complex thing. Like I was saying I don’t understand it so I can’t think how other people could begin to unless they have had that experience”

(Chlo: 21:242-252)

Chlo shared the others’ experience that that level of understanding they perceived their therapist to have “could only come from experience”. She acknowledges that outsiders can attempt to understand but will never reach the same level “because it’s such a complex thing”.

23. “I think people don’t generally get it. If they have not been there they can’t understand why you can’t eat a salad and they’re like ‘its lettuce why can’t you eat it’ they don’t get it but she did. She got it”

(Tara: 9:101-105)

Like the others, Tara shared the belief that you have to have been there to “get it”, to truly understand what drives the thoughts and behaviours that seem nonsensical. However, all the participants felt that their therapists “got it” because they experienced their understanding and knew they had been there.

**Sub-Theme Two: Tempering Conditions**

Just as each of the participants experienced many helpful aspects to disclosure as discussed above, each of the participants shared thoughts and feelings that reflected large amounts of ambivalence on what was deemed to be positive and helpful, and some were more explicit about certain experiences being negative.

As highlighted earlier, each of the participants felt that hearing that their therapist had recovered from an eating disorder provided them with hope, inspiration and motivation.
However, at some point during the interview, the participants provided a caveat with regard to the level of disclosure.

24. “The more that was said the more I would want to know and there is always I guess the risk of hearing specific behaviours and then adopting those even if you didn’t use them before... So in that respect I think it felt like the right amount of information to disclose and I know that I’m like, I’m always very aware of everyone else’s habits as much as I am my own and I think it’s best that I don’t kind of pick up on you know anything else that I’m not already aware of and I think as well like, I guess you can spend too long harping on specific behaviours and [pause] so yeah I’m not sure it would have been a good thing for anything else to be disclosed because it could have become competitive”

(Chloe: 17:194-209)

Chloe highlights the danger in hearing specific details about another’s eating disorder. She refers to it as a “risk”, which implies an element of danger and a need for caution. Chloe’s describes a heightened awareness to the behaviours of others, and her experience tells her that when she hears others talk about their behaviours she is likely to adopt or copy them. Chloe believed that knowing specifics about her therapist’s eating disorder would cause her to become competitive with her. Tara also feels that hearing specific details about her therapist’s eating disorder would result in increased competition.

25. “I’d do the behaviours, if she said I was sick this many times a day I’d do it”

(Tara: 56: 560-562)

Like Chloe, Tara felt that she would also adopt the behaviours that her therapist disclosed and this would have an obvious negative impact on her treatment and recovery. Although Chloe and Tara share their thoughts on what they would think and how they would react to disclosure of eating disorder specifics by their therapists, others shared how having their therapist over-disclose on details had a negative effect on them and their recovery.
26. “I would pick up tricks from her like she would tell me all these things but makes jokes you know saying I can’t believe I used to do that but then in the back of my mind I’d think you know wait a minute I can try that and I would”

The experience that Ruby speaks about above occurred very early in her treatment at a time when she didn’t want recovery. She remembers her therapist disclosing specific details about her eating disorder and the types of behaviours she used to engage in. Ruby describes these as “tricks” that she picked up from her therapists and utilised in a destructive way.

Lucy describes her experience of hearing details of her therapist’s eating disorder in more detail and her reaction to it.

27. “She kind of began to tell me em a little bit about her experience of bulimia and how she had kind of em, I suppose how she kind of, the different things that she had done, she had been arrested and she’s stolen and how she blocked up like toilets and everything like that and I was like ‘oh my god hers was so bad you know it all seemed so so bad and being like and wanting to be the best. The type of person that I would be is you know want to be the best at everything and I suppose em like I suppose even to the point of wanting to be the thinnest anorexic, wanting to be the best like wanting to have done everything and I suppose okay well ‘god mine not seem too bad’ like I mean I haven’t stole and I haven’t done any of these things so of course it wasn’t then I went out and stole but I mean these things kept coming back to me and I kind of took them as little tips on how to be the best eating disordered person or whatever it was so em and I suppose in a way I hadn’t gone through bulimia at this stage but em I kind of through listening to her I knew how and there was a way about it you know so on a very negative sense that I knew she didn’t mean that in any way possible, if anything she was trying to scare me away from it but being where I was at it certainly didn’t”

(Lucy 3-5:38-65)
Of all the participants, Lucy appeared to have the most negative experience. Her therapist’s disclosure didn’t stop at disclosure of personal recovery but continued throughout the therapy in regard to many different areas, from disclosure of specifics of her eating disorder thoughts and behaviours to details about her personal life and relationships. It appears her therapist was very open and graphic in her disclosure and it had the effect of making Lucy feel that she wasn’t ill enough yet to be in treatment and that she could take it even further. At this point in her eating disorder, Lucy had an anorexic presentation and her therapist was sharing behaviours related to her experience of bulimia. This was the first time Lucy had been exposed to such behaviours and she describes learning how to do them and picking up “tips” from her therapist that took her down a very destructive path. Lucy feels that although her therapist’s intention may have been to “scare” her and motivate her to recover, the result was very different. The repeated disclosure continued throughout her therapy with this particular therapist and resulted in a heightened level of competition, feelings of jealousy and resentment.

28. “I suppose I was a little jealous and you know she just seemed to like after 10 years or whatever and going back to her and she seemed to be leaps and bounds ahead of me you know I was kind of going ‘oh am I ever going to get to that place’”

(Lucy: 10:125-130)

Her therapist’s use of personalised techniques had the effect of increasing the sense of hopelessness and failure when they didn’t work:

29. “She could give me ways that she used to say, eh prolong the going into the food or something like that or eh to kind of em, she was really good at giving me ways that helped her to overcome a down time or different things like that to life her up but then again I suppose when I tried to use those things and they didn’t work for me I thought, I felt a bit like a hopeless case do you know what I mean so em I thought well why aren’t they working for me and they worked for her well maybe I’m not curable”

(Lucy: 7-8:90-101)
It appeared that Lucy felt that her therapist was unable to be objective and drew strongly on what her experience of recovery was for her:

30. "Sometimes I felt that her treatment just didn’t fit me right do you know what I mean I think a lot of the time she came from a place that helped her and not that place will help everybody”

(Lucy: 14:172-176)

Lucy uses the word “place” a number of times in the above extracts. It is like she is referring to somewhere or something that is separate from where Lucy finds herself or can imagine herself to be or somewhere that she experiences difficulty identifying with and so is increasingly alienated from her therapist.

Ruby, who had two different therapists disclose personal experience of an eating disorder to her, revealed two different experiences. One she deemed helpful and one she deemed unhelpful. One of the aspects that appeared to make her first experience of disclosure unhelpful was disclosure of specifics by the therapist as discussed earlier in this theme and a feeling that the focus of the therapy had shifted from her to the therapist and the use of personalised rationale and techniques in the therapy.

31. “She was just like making it about her, you know saying, I’ve been there, like I’ve done this and I’m like wait a minute this isn’t about you, you’re fine and your recovered...Because I just felt like what works for you doesn’t work for everybody else. Her experiences were different to mine”

(Ruby: 16-17: 160-179)

In the above excerpt, Ruby shares her frustration that she felt towards her therapist. There is a sense of her not feeling heard as a result of her therapist interrupting Ruby’s process with her own experience and perhaps over-identification and loss of objectivity on the part of the therapist.
This experience was in contrast to that of Tara, who portrayed her therapist as being much more reserved and cautious in her approach to disclosure:

32. “She would never try to say well this is how I got well and I think you should do this and this”

(Tara: 64:646-648)

The participants’ ambivalence on the presented helpful and unhelpful aspects of disclosure was evident throughout their transcripts. Many of the helpful aspects also came with contradictions. Just as knowing their therapist had recovered offered hope and inspiration to the participants, it also appeared to be to be unhelpful if details were disclosed. The participants’ stage of recovery and readiness for change was also influencing factors in how the disclosure was received.

33. “A part of me was like you know.. thank god somebody, you know, she gets what I mean I’m not the only one that is, I’ve seen somebody you know she is grown up and she is still alive and so everybody telling me that I’ll die must be wrong and she’s still alive but then there was a part of me that thought you know I can’t trust her, she knows the tricks, she’s lying to me”

(Ruby 7: 61-69)

Just as the therapist having insider knowledge was presented as a helpful element to the therapy earlier, Ruby’s stage of recovery and level of ambivalence was a mediating factor in how it was experienced. When speaking about her second experience of a therapist’s disclosure of recovery that happened at a later stage in her treatment, knowing that her therapist knew the tricks of the trade was experienced as helpful in terms of recovery.

34. “I had so many little tricks and she knew them”

(Ruby: 63:738)
Holly also expressed some frustration and ambivalence with regard to her therapist knowing the eating disorder mindset, but she reflected on this as being a positive aspect overall even if it didn’t feel like it in the moment.

35. “It utterly frustrated me at times because there was times when I was in a bad space and I didn’t want her to know, I didn’t want to be sitting there and I didn’t want her to understand that you know, when you go in and you have that thing where you’re, I was going back down that road, I was going into relapse and all that and you’re trying to put on this smiley face and cover it all up and you know pretend and she’d see the chink every time.”

(Holly: 18-19:264-273)

Holly’s ambivalence about recovery and the insider knowledge and understanding she felt her therapist had is evident above. Although she describes it as a double-edged sword in the moment, in retrospect, she believes it to be an important positive aspect as it offered some protection against her going down the road of relapse as “she’d see the chink every time”. Ruby also shared aspects of her ambivalence about her therapist’s disclosure of recovery and her own recovery and how it can be very changeable depending on her mood, motivation and state of mind.

36. “Sometimes it would be helpful thinking maybe I’m not the only one that’s like this. Other people have been there you know, I’m not some sort of freak. But then there is also the part of me that thought you know the whole recovery thing, she’s fat, and its just depended on what sort of mood I was in”

(Ruby: 21: 212-218)

It appears that some of what it is that makes disclosure helpful or unhelpful is dependent on the context of how it was initially introduced and the detail revealed. The stage or commitment to recovery of the participants at the time all appeared to act as mediating factors in how it was received. Ruby draws attention to how the therapist’s weight and shape – “she’s fat” – can be influential in how the disclosure is experienced. This is explored in more detail in the following master theme.
Master Theme Two: The Therapist Embodied

This master theme explores aspects of the therapist’s visible form, their qualities and spirit. How knowledge of their therapist’s personal eating disorder history influenced the participants’ perceptions of these aspects; the resulting influence on the participants, the therapy and the therapeutic relationship is also examined. All participants were quite up front and honest about the therapist’s appearance being important to how they related to their therapist. How their therapist looked was an important element of all the participants’ experience. All spoke of a fear of becoming “fat” like their therapist if they deemed their therapist’s weight to be above what was acceptable to them. Many equated the therapist’s weight and shape as epitomising recovery and what it means to be recovered. While weight and shape were important, the participants also took notice of other aspects and qualities of the therapist’s life and essence. They shared the view that what they saw needed to be appealing and desirable for the disclosure to be helpful. However, within this theme it should be noted that some of the participants referred to imagined experiences. They sometimes shared how they believed they would think, feel and react to perceiving their therapist who disclosed personal recovery to be overweight or underweight.

Sub-Theme One: The Overweight Therapist

All participants expressed fear about aspects of the work being challenging and made more difficult if the therapist who discloses personal experience and recovery appears to be overweight or heavier than that deemed to be acceptable or excusable.

37.“Like a big fear of mine is that if I eat normally, I will balloon up and I think that would have made me go ‘whoa, I’m not..’ , I think that would have spurred that fear on and I think that could have pushed me in the opposite direction because I would think that’s recovery and if I return to normal eating I’m going to blow up…. “Like if that’s recovery, then I don’t want it, then I’m not doing it”

(Chloe: 29-30:327-336)

Chloe opens up about a fear that was shared by all of the participants, that if she returns to normal eating or loosens the control over her eating she will begin to gain weight uncontrollably. To her, seeing a therapist who has told her that they had an eating
disorder in the past who she perceives as being overweight or unacceptably heavy acts to confirm this fear and, as a result, makes her more fearful of recovery and more reluctant to let go of her eating disorder: “Like if that’s recovery, then I don’t want it, then I’m not doing it”. Chloe was very open about how she would be very fearful of ending up like her therapist is she was overweight or heavy. This is an example of one of my participants imagining how they would feel and might have responded if subject to various situations. Chloe did not view her therapist as being overweight, so this was not her actual experience. Here and in the extract below Chloe is speaking hypothetically.

38. “That’s what this is going to make me end up like and I’m not doing it’ and I think again I would not have taken it as seriously but in a negative, a very negative strain, and it kind of would have been motivation for me to try, act out more frequently on old habits and behaviours and avoidance mechanisms to stop that from happening and I think that could have resulted in a step back as well”

(Chloe: 35-36:401-410)

Chloe imagines fearing that engaging in treatment and trusting her therapist would result in her becoming heavy or overweight like her therapist as they have recovered from an eating disorder and she believes that is what happens when you let go of the control around food and weight. Others also shared imagining these fears and beliefs:

39. “I don’t think that my recovery would have been as good [if her therapist was overweight] but I’d think well if that’s recovery well I don’t want to get like that. Recovery will make me fat, yeah that’s what I would have thought yea I mean now I know that someone has a healthy relationship with food they have a healthy body because some peoples bodies are bigger than others but if someone is overweight then they could have possible gone the other way you know they could have gone from restricting to overeating and that’s what I would have thought”

(Tara: 39-40: 453-465)
In the above excerpt, Tara shares the fears and beliefs expressed by Chloe. Tara imagines that perceiving a therapist who she knew had personal experience of an eating disorder as overweight would have made her disengage as it would have heightened her fear that “recovery will make me fat”. Tara believes that seeing her therapist now as overweight would also have made her doubt if she had actually recovered, or if she had migrated to a different eating disorder.

Whereas seeing her recovered therapist as being overweight would have led Tara to question her therapist’s recovery, Holly questioned the therapist’s credibility in advising or educating on food and healthy eating and lifestyle and this impacting on the trust between them both.

40. “My thing was more so that this person cannot be healthy and therefore cannot be [pause] cannot sit there and provide me with or try and give me a balanced approach to things and help me out if they’re [overweight]. You know I didn’t trust what they were saying, yeah I couldn’t, I couldn’t trust it so em”

(Holly: 43: 582-584)

Here, Holly is speaking about her first experience with a therapist who disclosed personal recovery. She described not trusting what she had to say or trusting that she could help her get to the place she wanted to get to.

Lucy was aware before entering therapy that her therapist had an eating disorder in the past. Initially, this was one of the factors that interested Lucy in working with her.

41.“Yeah absolutely absolutely [was a motivating factor in asking to see her] and I mean just, certainly most definitely gave me hope that it’s recoverable that I mean I can have a life again”

(Lucy: 28:62)

In our interview, the first aspect of her experience that Lucy shared with me concerned her shock and surprise at her therapist’s appearance on their first meeting:
42. “She had just given birth to a baby so I kind of was, her shape wasn’t the shape that I had expected it to be or whatever you know so, em I suppose initially I was kind of saying you know well okay I’m not going to look like that because I’m not pregnant but em you know it just put me off a bit I suppose initially and I just thought she was big and it was a little bit scary for me because that was obviously my fear”

(Lucy: 1:7-15)

As a result of knowing about her therapist’s personal experience of an eating disorder, Lucy had expected something else of her therapist’s appearance. To help calm her fears about looking like her therapist if she engaged in treatment, Lucy tried hard to rationalise and reassure herself that her therapist’s body shape was a result of her recent pregnancy and not due to a loss of control around food and weight as “that was obviously my fear”. To help with this, Lucy looked for other aspects about the therapist and her life to focus on.

43. “She came across as such a lovely person, such a bubbly person and like a person who just seemed so so happy in herself like regardless and she was kind of, everything about her, she wore such bright colours, her whole personality, like her clothes nearly reflected her personality that was with in you know and everything just seemed to be good for her you know and I suppose in that way I kind of built up the trust with her over a little while and I saw that she kind of came back to her normal shape or whatever and it looked like a real healthy shape and she just seemed so energetic and so motivated and had a great drive for life”

(Lucy: 2:17-31)

It appears it was important to Lucy and her perception of her therapist that she saw that her therapist’s weight and shape changed to something that was more acceptable to Lucy as it confirmed that her shape was due to pregnancy and not loss of control. As the reader will see throughout all these themes, Lucy could be very ambivalent in her thoughts and feelings towards her therapist as her views and perceptions tended to change throughout our exploration of her experience.
Ruby illustrates how her therapist’s weight and shape evoked mixed feelings about how she experienced her disclosure.

44. “There was like two sides to it that one part of me would want to open up to her because she understood what it was like but another part of me was sort of cause it was how she looked as well cause she, she wasn’t fat but she were quite slim but still had like curves and I thought well if she’s had a eating disorder and is recovered well that’s what I’m going to look like so it was a bit of both sides at the time.”

(Ruby: 8: 72-81)

Like many of the participants, Ruby had more than one experience of working with a therapist who disclosed personal recovery. In the excerpt presented above, she is speaking of her experience the first time. Although she felt her therapist would understand “what it was like”, she was hesitant about engaging with her as a result of her fear of looking like her. Ruby also demonstrates the no-win situation of the therapist. She could see that her therapist “wasn’t fat” but had curves, and, for Ruby, curves represented a loss of control or failure in her eating disorder efforts and, at that moment, curves were to be feared.

At some point in the transcripts, all participants acknowledged the irrationality or distortedness in their thinking and perception, particularly when it came to their therapist’s weight and appearance. Many were able to laugh at themselves as they said it, but the importance or impact that it had was still present.

45. “When I sat and thought about it like at first it didn’t register and then I though wait a minute if I sit and listen to everything she says, she is going to try and make me fat and I’ll get up like her because at that point anybody above a size 6 I thought was huge.... That was just the main thing that I was thinking about because if I recovered like she had that I’d be the same size and then you know, god forbid that would be the end of the world if I was over a size 6”

(Ruby: 9-11: 83-115)
The fact that their therapists had disclosed personal experience of recovery appeared to make the issue of their weight and shape more prominent. It seemed to have the effect of attracting the participants’ attention or radar to it more than it would if they had not disclosed as it made it personal and gave it meaning. In Ruby’s case, where it appeared that her therapist was a normal weight, it was still above that which was acceptable to Ruby’s eating disorder values. The fact that she knew she used to have an eating disorder gave Ruby more reason to fear it.

46.“I think that it was more the way she looked that I thought I don’t want to be like that; when I’m older I want to be tiny. I want to have such a flat stomach, be a size 0 and everything and seeing her and thinking well she’s had an eating disorder and she’s recovered and she looks like that. She wasn’t fat at all but at that point I saw her as huge”

(Ruby: 26: 279-287)

In the excerpt below, Emma echoes the experience of the other participants. She imagines she would feel distrustful of the therapist and the treatment, as she would fear being made “fat” like her and this fear would have been enough to cause her to disengage.

47.“If I was going to a counsellor and she was saying yeah now you know I had this and now I, say for example plump, now this has nothing to do, it’s my thinking, it’s where I am coming from, I wouldn’t be attracted you know what I mean, I would be like what, you are going to make me fat... So if I thought that somebody was going to make me fat, I’d be like, I wouldn’t trust them cause I would think that they were going to make me fat do you know what I mean.... Yes I don’t want that, I would say I don’t want that and I wouldn’t go anymore”

(Emma: 16-17: 219-233)

Although Ruby and Emma could recognise that their fears were part of an eating disorder mindset, or, as Emma puts it “now this has nothing to do, it’s my thinking”, there would be sufficient anxiety and fear behind them to encourage them to err on the
side of caution. Most felt that the building of trust between themselves and their therapists would be impacted on: “I wouldn’t trust them” (Emma); “I wouldn’t trust what they were saying, yeah I couldn’t” (Holly); and many felt that having a recovered therapist who was overweight was evidence that if they loosened control over their eating and obsessed less about their shape and weight, they would lose all control and become overweight, which, at the time, was one of their biggest fears. For Emma and many of the other participants, if her therapist was disclosing or using her personal experience of recovery, she needed to be offering a version of recovery that she wanted. This is explored further under the next master theme.

Sub-Theme Two: The Thin Therapist
Just as having or imagining having a heavy or overweight therapist evoked an emotional response from the participants, so did having or imagining having a therapist perceived to be very slim or underweight. The participants shared feelings of competition, frustration, jealousy and resentment towards their therapist. Issues of credibility and recovery are also explored.

Ruby acknowledges how, for her, both the skinny and overweight therapist would be equally distracting and unhelpful.

48. “Like a therapist that was tiny you know, all I’d be sat there is thinking how skinny are you, how tiny are you, I’d love to be like that and you’re sat there saying that it’s okay to put on weight, I think that would influence me and having somebody overweight I think would influence me as well because I’d be like you know I can’t, I can’t let myself get to that weight”

(Ruby: 47-48: 543-551)

The thin therapist would evoke feelings of jealousy and envy from Ruby. She imagines having her therapist encourage her to gain weight would cause her to feel angry with her therapist, as she would have felt it was unfair that her therapist could stay slim while she was being asked to gain weight.
When considering working with a very slim therapist Holly feels it would have added more aspects to what is already very difficult work.

49. “I think, I think that challenge would have been too much, I think there is enough of a challenge, for me there was so many issues to get over with trust and, really needing to trust the person I was working with and that they could support me and that you know when I was falling that you know there was that kind of [pause] I don’t know, thing there. If I walked into the room and somebody was really thin and looked fragile, to I think that would have sent a message but also on the weight front, it would have been an additional challenge in something that was already really really really difficult. I don’t think I would have been able to do it”

(Holly: 41-42:552-566)

Holly speaks of feeling that it would have been more challenging as she would doubt the therapist’s ability to support her and contain her fears, but, also, it would have the effect of introducing the issue of weight and shape into the room even more so than it is already. Perceiving the therapist as looking “fragile” seems unnerving for Holly. She feels it would have sent a message that to be very thin is, perhaps, preferred. Holly would have seen it as an additional challenge in terms of not having faith in the therapist, but also being confronted with and reminded of weight or, more specifically, thinness.

Just as in extract 40 when Holly spoke of issues around therapist credibility when discussing the overweight therapist, she highlights the same issue with regard to the thin therapist.

50.“I think if I had a therapist who was, I would find it very difficult if they were very slim or overweight…I had a therapist who was very overweight and I just couldn’t, it wasn’t because I was disgusted by her or anything but I just felt that that in itself is not, is a problem too so I felt how could this person help me erm… normalise my ideas around food and stuff like that, it was too difficult and likewise if someone was very underweight I’d be looking at her and going well this isn’t healthy either, you can’t
really be in a position to sit in front of me and you know be helping me when obviously things aren’t balanced”

(Holly: 35-36: 469-484)

For Holly, imagining having a therapist who was very thin would have reflected to her that the things weren’t “balanced” for the therapist. They were also not healthy and Holly would have questioned her authority and ability to be in a position of helping her and others. Chloe also expresses issues of credibility:

51. “If she was underweight I would have gone ‘well are you doing this, cause if your not I’m not going to’ and I think I would be a lot more sceptical about the whole thing. I think I would be a lot more reluctant to give things a go and I think I would have become a lot more sneaky as I have been in the past and just lied my way through”

(Chloe: 33:373-380)

The above excerpt shows that if Chloe perceived her therapist be underweight, it would have been damaging for her and her treatment. Chloe imagines that had her therapist been underweight, this would have resulted in trust issues between them and would have pushed her further into her eating disorder.

Both Chloe’s and Holly’s extracts above allude to a questioning of the therapist’s recovery. All of the participants did this at one point or another, some more explicitly than others. With regard to the therapist’s weight and shape, this questioning presented itself more frequently when discussing the impact of the underweight or very thin therapist. Here, when imagining how they would react, they state it directly.

52. “It would have made me question whether she was recovered I would have been suspicious”

(Chloe: 30:339-340)
53. “I would have questioned how recovered she actually was [if she was too thin]. Very much so”

(Holly: 43: 569-570)

Perceiving their therapist as being very thin would have caused them to doubt their therapist’s recovery and so impact on their relationship with their therapist and their treatment. In the extract below, Tara explores how she might have been affected by having her therapist who had disclosed personal experience of an eating disorder appear to be underweight.

54. “I would question how recovered she was if she was very skinny and underweight. I’d probably feel more angry with her. I think I’d feel angry because if I thought she wasn’t well then I wouldn’t have the respect for her but if I thought she was well but she was still that thin it would be resentment because I’d feel jealousy yeah it would be like why do you get to eat you don’t need to do all of the things that I have to do but yet you are that size. It would be anger”

(Tara: 46-47: 451-461)

Like Holly and Chloe, Tara feels she would also doubt her therapist’s level of recovery if she was “skinny”. She imagines feeling angry and let down if her therapist who had said she was recovered appeared underweight. Tara feels she wouldn’t have the same “respect for her” and acknowledges that there would be feeling of “jealousy” and “resentment” and a competitive edge would be brought into the relationship. This excerpt by Tara also demonstrates again the no-win situation of the therapist. Being thin and still having an eating disorder might have resulted in loss of respect, but being thin and recovered might still have resulted in feelings of jealousy and resentment from Tara: she imagines feeling angry as, to her, it would have felt unfair that her therapist got to be well, and got “to eat” and be thin.

Feelings of competition with the thin or underweight therapist were also mentioned by other participants.
55. “Instead of being a ally she would have been another person to compete with... I would have been conscious of becoming heavier than she was and I would have hated it, like cause I do that anyway I guess but em yeah I would have found that really really difficult to kind of deal with so I would always have to keep that one step ahead of her continually!”

(Chloe: 31-32: 351-372)

Chloe believes that competition would have been present between her and her therapist if she had perceived her as being very slim or underweight. Chloe feels it could have resulted in a manipulation of the therapy and game-playing and, as such, the therapeutic value of the sessions would be questionable. In the below excerpt, Emma draws similarities with her hypothetical experience of the overweight recovered therapist presented earlier.

56. “If I thought she was very thin, that would be equally disturbing. I could imagine a competitive role between us if she was trying to get me to gain weight and then me seeing her at a certain level, yeah that would be weird and I’d sense that”

(Emma: 18: 245-253)

Emma feels that the therapy would be made more difficult and challenging by having her therapist be very thin. Like the others, Emma believes that weight would become more of an issue and a source of competition between them, and there is a sense that she would become even more sensitive to changes in her own weight as she would be wary of becoming heavier than her therapist. It appears it would also cause trust issues as Emma would be mistrustful of her therapist’s intentions, maybe believing that her therapist was trying to make her “fatter” than she was. Below, Tara is more explicit about sharing the same fears and anxieties:

57. “If she was very slim... I know because of that I couldn’t work with her because I would get competitive…. If they are telling me to do something and I feel that they are not doing it I would feel they are trying to fatten me up or something and make me bigger than they are…. I couldn’t have a therapist that looked like she was still poorly
because I would get ridiculously competitive and it would become a game I think, I think therapy would become a game for my eating disorder”

(Tara: 50-59: 479-501)

Like Chloe earlier, Tara feels that the competition could result in game-playing in relation to her eating disorder and hinder her progress in therapy. There are also issues of questioning the therapist’s credibility when she says “I feel that they are not doing it”. Tara feels the very thin therapist would not be practising what she preaches and this would make her question whether her therapist had actually recovered from her eating disorder past.

These extracts from my participants that have been presented here concerned how the participants did or imagined they would have experienced having their therapist who they knew had an eating disorder in the past appear to them as being underweight or overweight. If the therapist never had an eating disorder or they weren’t aware of it, would their weight have had the same effect on the participants? Ruby addresses this question below:

58. “If she hadn’t have said that she was ill I would have seen her as a totally, her body wouldn’t have been an issue cause like every time I went in it was like, it seemed like she were getting bigger and I was like oh my god have you seen her legs and I couldn’t cope with being like that but I think if she hadn’t told me I wouldn’t have focused on it at all, it wouldn’t have mattered because like walking down the street you see fat people and I never thought of it like that but when somebody said that the had been like that, I was like wait a minute that’s what I’ll end up like”

(Ruby: 27: 288-301)

The other participants to varying degrees shared Ruby’s experience that if she were unaware of her therapist’s eating disorder history, her weight, shape and body would have been less of an issue. It wouldn’t have become something personal and a source of competition, fear, anxiety or jealousy. The identification experienced through having an eating disorder and the familiarity of the workings of the eating disorder mindset has the
effect of making the participants’ suspect of the therapist what they would perhaps suspect of themselves.

**Sub-Theme Three: Coveting**

When exploring what it was that meant their therapist’s disclosure of personal experience of an eating disorder was helpful or unhelpful and the resulting impact on the therapy and the therapeutic relationship, the principal or factor of attraction came through the participants’ experience. A desire for what the therapist had or, equally, not wanting what the therapist had, had power in modulating how the disclosure was experienced.

Holly speaks of seeing her therapist have a level of peacefulness that was something that was attractive and inspiring to her:

59. “There was peacefulness there, yeah there really was [pause] em yeah just a contentment with life, a balance very very balanced and it’s also, it was giving me so much hope to know that this person sitting in front of me that was steady the whole way through and never really wavered for me at all, sitting in front of her week in week out and it does give you hope that, before that I had no hope at all”

(Holly: 59-60: 800-809)

For Holly, she sees that her therapist has something that she deems worthwhile having. She believes in her therapist’s recovery and she has begun to contemplate that there is life after an eating disorder. Her use of words like “peacefulness”, “contentment” and “balanced” reflect how observant she was of her therapist and her way of being. Holly wants the peacefulness, contentment and balance that she sees in her therapist. She also describes her therapist as being “steady” and unwavering. It appears Holly believes in her therapist’s recovery and it offered motivation that helped her to continue on the path to recovery.

Emma also speaks of the need to want or be attracted to what the therapist had or was offering if disclosing personal experience of an eating disorder was to be helpful.
60. “I think for me I was attracted to what they had now that was a big thing like if I was looking at somebody, for me personally right, and they still clearly were a slave to food I think I would be more put of by their sharing their experience because it would not be attractive to me you know for me and with this therapist, the reason I am attracted to her is because she looked like she had a recovery that I wanted and they’re sharing their experience”

(Emma: 12: 164-175)

If Emma views her therapist’s version of recovery as not being something she wanted to aim for, she feels their disclosure would have had a negative effect. This highlights the subjective nature of attraction and how one might receive such disclosure. Emma felt “she looked like she had recovery that I wanted” and so the disclosure was helpful for her. However, what does recovery look like? Emma highlights the personal nature of attraction and how it can be dependant on many things.

61. “At different times I was attracted to different things and I think depending on where I was at, you know I was attracted to you know even a day, anybody who had a day of not binging and purging was just like oh my god I want what you have now and then things would change and that wouldn’t be attractive to me anymore I need somebody who has got real freedom and who is living a productive happy life, happy in their relationship and able to get on with work and you know able to join back into society in some way shape or form. A level of peace on a daily basis you know and yeah you know I think that changes and that’s a very personal thing like yeah and I think that’s the only way, well that is the only way I can work with people like attraction, say this is what I have done you know and this is where I have come from and this is what I’ve done and if you want what I have this is what I have done so that would be a big element to it and I think for me if my therapist was sharing with me their experience of getting over an eating disorder and I didn’t want what they have I would be like”

(Emma: 13-15: 185-209)

The above excerpt helps to demonstrate the need for Emma to want what the therapist had. The therapist’s recovery needed to be believable and appear worthwhile. Emma’s
sharing also reflects that her therapist shared details of her own recovery and Emma wanting to try to follow a similar route to recovery. There seems to be a risk that the therapist’s disclosure of recovery and how they achieved it can be perceived as the way it should be done and possible over-identification that has the potential to be harmful if it fails to meet expectations. In addition, if this doesn’t fit the needs of the client there is a risk of withdrawal from treatment that might not have happened if disclosure never took place. Emma also acknowledges how her perception of what was attractive changed and evolved throughout her eating disorder and stage of treatment and recovery.

Tara also speaks of feeling inspired by her therapist’s recovery and described aspiring to be like her.

62. “Seeing how everything she was doing as a recovered person it was kind of like I might just try it [recovery] you know... She was recovered, she was helping people, she was doing this this and this and I was like that’s what I want to do and it just completely inspired me, completely”

(Tara: 16:193-196)

When Tara looked at her therapist she liked what she saw. As with Emma, there was an attraction to the life her therapist was living. This was enough to encourage Tara to think “I might just try it”. At times, Tara seemed a little in awe of her therapist and the line of wanting to be her and wanting to be like her was a little confusing. In the excerpt below, she describes seeing her as thin, healthy and stunning and thought that if she could look like her therapist she would be happy.

63. “But she just glowed literally you know and just her personality and aura that she gave out, just healthy, she just looked like, like when I was really poorly I was like if I was as thin as her I’d be happy because I saw her as just she was just stunning that’s just what I saw her as”

(Tara: 36: 415-420)
As with all the participants, Tara shows ambivalent feelings towards her therapist, which are demonstrated throughout each of the themes. Here, Tara speaks very highly of her, holding her in high esteem and perceiving her as the epitome of recovery. This is a very powerful and uneasy position for the therapist to hold, and it comes with many risks. Tara was experiencing idealisation towards her therapist that could be quite problematic and result in increased alienation and also increased feelings of inferiority and dependence on her eating disorder. Ruby also speaks of wanting or being attracted to the life her therapist had. For both Ruby and Tara, there seemed to be an attraction to the career and for the first time seeing and believing that they could achieve a different life and provided a goal to aim for.

64. “I learned so much about her as a person rather than her an eating disorder and I sort of learnt that there is a better life than this; you know there is something else to focus on other than food all your life... Seeing somebody else a lot older and recovered and well and helping other people, that’s what made me think you know well I can have that as well and that sort of made me feel like that”

(Ruby: 36/81: 411-413/974-978)

Ruby speaks of wanting a “better life” than the one she was living. For Ruby, knowing that her therapist had recovered and the impression she had of her therapist’s life was appealing to her, drew her in and encouraged her to engage in treatment as it allowed her to imagine what life could be like without an eating disorder.

In the following excerpt, Chloe demonstrates her perception of her therapist and her way of being.

65. “She just seemed to have a real enjoyment for life, which, as sad as it sounds there isn’t time for with like in the mists of an eating disorder. There is no time to kind of take things on and just enjoy life like not properly. On a superficial level yeah but not to the extent that is see other people enjoy life and it’s kind of, I guess it’s reassuring to see that you can get that back and that you can get kind of a gratitude for life back and just a love of it back. To a really kind of honest and through level so that’s really attractive and kind of really encouraging”
Chloe picked up on the “enjoyment for life” that she views her therapist as having. Her therapist’s disclosure of personal recovery and the way Chloe judged her life to be now was “attractive” and “encouraging” to her and put the therapist in a position of role model. There is something about how the participants viewed their therapist’s life in the moment; and if the perception was positive or desirable to them, it had an engaging and motivating affect.

66. “I could see the freedom she has now and it convinced me, just her life and her story convinced me of that and so I was willing to give it a go...I saw her and it wasn’t what she said it was how she was that was so attractive to me and that’s maybe an interesting thing from a therapeutic point of view because I was attracted to what, I don’t even remember what she said okay bits and pieces but it’s how she was that I was like wow, this girl is at ease”

(Emma: 35-41: 471-555-562)

Emma describes being “convinced” by her therapist’s life and recovery; and seeing it as something she wanted for herself encouraged her to engage and shift the balance in favour of recovery: “I was willing to give it a go”. For Emma, it wasn’t about the details of her eating disorder or her recovery, but more about her essence and spit that she picked up on: “Wow, this girl is at ease”.

Just as Tara and Ruby describe aiming for what their therapist has and providing initial motivation and hope, Lucy shares a similar initial perception. However, when her experience of striving for what her therapist had failed to meet expectations, Lucy felt angry, resentful and jealous of her therapist and what she perceived her as having; consequently, this was damaging to their relationship and her recovery.

67. “She seemed so bubbly and so full of life and she had overcome this and that’s what life was like when you overcome an eating disorder and when I realised, like I put back on weight, and I was like I’m not like that you know I’m still feeling really sad inside
then it all crashed down and I was like ‘oh my god, everyday of my life isn’t happy, wow, whu hoo, like you know great, like her life you know and it just drove me further back I like going oh my god, you know, my life is shit and I have this weight on and how come she has it all so good and you know”

(Lucy: 19:238-250)

Lucy’s disappointment is evident in the above excerpt. She felt her therapist had set the bar and expectations too high and portrayed something that wasn’t realistic. Her therapist’s disclosure of recovery appeared to make things very personal for both Lucy and her therapist. Similarities of experience were drawn throughout, and when things didn’t turn out the same for Lucy, feelings of resentment and failure were aroused in Lucy. Although not as explicit as in Lucy’s excerpts, similar risks and dangers could be interpreted from those presented above by Ruby, Tara and Emma.

Unrealistic expectations could have evolved from Lucy knowing too much about her therapist due to over-sharing and Lucy feeling that the therapist was meeting her own needs rather than being for the benefit of the participant.

68.“I think in a way sometimes I felt used for her benefit I suppose. I felt in a way it was all about her becoming this person and this therapist, life coach and all these things she’s doing becoming this amazing person who has overcome this eating disorder but the rest of us are kind of being left behind or been a little bit used at that expense... She always brought it back to her own illness. I knew so much about her you know what I mean and I found with other therapists like I didn’t even know if their mother was dead or alive so just like and I just feel sometimes a little bit overburdened with a lot of her stuff”

(Lucy: 25-29:318-383)

Although all the participants displayed ambivalence about many aspects of their experience of the phenomena, Lucy experienced something stronger than ambivalent feelings towards her therapist, sometimes shifting towards love and hate. At times in the
interview she would speak about her therapist in glowing terms and wanting to be like her, and at other times she would be questioning of her and her motives.

69. “You see she is such a wonderful person and such a magnificent person and really wow you would really look at her twice and be wow she just is amazing you know and all she has and does and is and whatever it is and she is so positive in life and after everything and like I think everybody is really brought in my that, nearly wow like, nearly aspiring to be like her... I mean I didn’t want to be her either I suppose I wanted to be happy like her you know what I mean and I suppose it just all seemed very you know, life is amazing and there were no bad days, but there are bad days and I guess it’s trying to cope with them and get on with it you know”

(Lucy: 45-46:575-592)

Lucy speaks of being attracted to what it was that her therapist has. She describes her as “wow”, “magnificent” and “wonderful”. Lucy was trying to describe what it was about her therapist that would make you look at her twice and, for her, she felt it was this hard to describe essence that attracted Lucy and others to work with her: “I think everybody is really brought in my that. Aspiring to be like her”. This aspiration appears to come from over-identifying with her therapist, the life and recovery Lucy views her to have and wanting that for herself. Lucy acknowledges having difficulty differentiating between wanting to be her therapist and wanting to be “happy like her”. At times, Lucy appeared to feel resentful of the ‘amazing” life her therapist portrayed or she perceived her to have and this seemed unachievable or unrealistic for Lucy from where she was coming from and this sometimes made it difficult for her to identify with her therapist.

**Master Theme Three: Recovery**

The theme recovery encompasses views about the participants’ own recovery and its possibility, and their therapist’s recovery. This was one of the themes where all the participants’ ambivalence was most evident. All the participants started off speaking about their therapist’s disclosure of recovery from an eating disorder in a positive sense in that they believed their therapist’s eating disorder was a thing of the past. As the interviews progressed there were times when the participants seemed less clear about their therapist’s recovery and if their therapist was, in fact, recovered.
Sub-Theme One: Possibility of Recovery

Although all the participants spoke of hope, that hearing that their therapist had recovered provided them with proof that recovery from an eating disorder is possible, many went on to share that they felt that complete recovery was attainable for them and that particular aspects would always remain with them.

70. “I do believe though that it will always be with you to a certain extent and certain things become part of you”

(Emma: 34:456-457)

Emma feels that there are particular aspects of her eating disorder that become ingrained. Some behaviours have become so automatic and thought patterns and responses seemingly enmeshed with her personality that it is difficult to envisage it being any other way.

71. “I will probably be in the middle, you know I’m never going be fully recovered and perfect”

(Ruby: 42: 476-478)

Ruby’s ambivalence about recovery was evident throughout her interview. At this particular point, she appears resigned to her belief that she would never achieve recovery and that she would get to some “middle” or halfway point and be okay or satisfied with that.

72. “I’m still not sure if it’s totally possible cause I think if something has consumed you for so long and I think elements of it are possible”

(Chloe: 4:34-36)

Like Emma, Chloe also had difficulty separating part of herself from her eating disorder. Due to the length of time she had felt “consumed” by her eating disorder, she
had forgotten what life was like before and had accepted characteristics belonging to her eating disorder as being part of herself.

At one point, she was quite open regarding her ambivalence about recovery and one of the advantages she saw to working with a therapist with personal recovery was that she felt her therapist would understand this ambivalence and hesitation to commit to life without an eating disorder.

73.“Yeah cause I guess with recovery there is kind of such a [pause] a split. I know my mind was split so much between one way and the other and it’s like a 50/50 divide and you kind of think you should be saying things to show that you are trying and you are getting better but the think that’s playing on your mind is something that’s completely eating disorder related and has nothing to do with recovery and so [pause] I guess I was more up front about voicing those fears and those feelings afterwards which then enabled me to voice, you know talk about them and maybe find out why I was still feeling them and why I am still feeling them which is something that I didn’t really [pause] I was I guess ashamed and scared to say beforehand”

(Chloe: 12-13:135-151)

Chloe is honest about the “split” she experienced regarding recovery and if, in fact, it was something she wanted. She describes the expectation she feels about what she “should” be saying for the purposes of being seen to want to get well but that she often felt different. After finding out about her therapist’s personal experience, Chloe felt more at ease discussing the split-ness she was experiencing, the shifts in her motivation to engage and her wish to recover versus her connection to her eating disorder and her reluctance to let it go. Once Chloe opened up to her therapist about her conflicting thoughts and behaviours, she was better able to engage with her therapist and in treatment.

Sub-Theme Two: The Therapist’s Recovery
As presented in extracts 68 and 69, Lucy speaks about her therapist having what she sees as an “amazing” life that she wants too. Her ambivalence was evident in her wondering whether such an “amazing” life and recovery was possible. She began to
question and doubt how recovered her therapist was and if everything was as amazing and wonderful as she had first believed.

74 “It just seemed like sometimes what she said she wasn’t living”

(Above, Lucy is questioning her therapist’s creditability in that she feels her therapist wasn’t practising what she preached. This introduces a level of distrust to the relationship and the doubt appears harmful.

Chloe began the interview talking about how her therapist disclosure of past experience of an eating disorder gave her hope that recovery was possible as previously presented. Later, the level of her therapist’s recovery seemed less clear-cut for her.

75. “And there were kind of still moments where she had to remind herself and throughout her life there had been periods where it had been harder and then easier…. She said that she was recovered and this she kind of, this is a very separate part of her life which still kind of is there in the background but very separate to where she is now which I guess sounds realistic from my understanding of recovery. It’s never going to disappear but it can be, hopefully, boxed up and put somewhere else and won’t disrupt life anymore.”

(Chloe: 6:57-58; 25-26:289-297)

Chloe’s expression of how her therapist positioned her eating disorder and recovery has many layers. For Chloe, it appeared more “realistic” that one can never completely recover from an eating disorder but that you can get to a place where it is less consuming and distressing. Not only did her therapist disclose personal experience of an eating disorder, but she also disclosed still experiencing vulnerability and struggle from time to time. This appeared to reinforce to Chloe her belief that recovery from an eating disorder is not possible. Although Chloe didn’t express this as a negative, it did appear to affect the therapy in terms of goals and treatment aims. Chloe seemed resigned to always having aspects of her eating disorder and her therapist appears not to be of help
in challenging this. Shortly after sharing the above views, Chloe expressed an opinion conflicting to it.

76.“From what I’d seen of her and the way that she had spoken about things. I didn’t, yeah there wasn’t really any kind of doubt in my mind that that was the way it was, that she had beaten it and was completely in control in a good way of what she was doing and of the disorder and was recovered. That was very easy to accept and just go okay, it kind of is possible”

(Chloe: 26-27:298-308)

Here, Chloe is saying that she believed her therapist had recovered, that “she had beaten it”. Because her therapist made this “easy to accept”, her disclosure of personal experience of an eating disorder was inspiring for Chloe in that “it kind of is possible”.

77.“She’s always looked healthy, she’s always seemed happy, her weight didn’t fluctuate at all in the time that I seen her well not noticeably and I’m quite eagle eyed in terms of that sort of thing but she just seemed very together, very happy very comfortable, very confident very, I guess it’s more a mentality thing that kind of I take as proof that she is okay with everything”

(Chloe: 43:42-43:492-500)

It seems that Chloe’s perception of many aspects of her therapist made her recovery believable and easy to accept for Chloe. She describes herself as being “quite eagle eyed” for something that might suggest otherwise. Her failing to find it provided her with “proof” that her therapist had recovered. On reflection I am left wondering if, in fact, these excerpts from Chloe are contradictory or if Chloe is referring to what recovery means to her. Perhaps for Chloe to be recovered means accepting that an eating disorder will remain with her, but not to such a degree that it causes a massive level of distress.
Emma shares her experience of a time when she worked with a therapist who disclosed personal experience of an eating disorder and how it soon became evident to Emma that her therapist hadn’t recovered and she describes the impact this had on her.

78.“So that’s the thing with that therapist, I didn’t find [her disclosure] it helpful, I found it more demoralising that they were not in any way over it or recovered… clearly she didn’t have any recovery you know so eventually it just fizzles out it’s like a feeling of more hopelessness. Is there actually a solution, is it possible to get over this you know I come away feeling more demoralized like there is no way out and that’s frightening you know for someone who is offering some sort of solution”

(Emma: 13-29: 367-395)

Emma describes feelings of increased “hopelessness” as a result of knowing her therapist had personal experience of an eating disorder and her perceiving her as not recovered. It made her question further if recovery was possible and she came away feeling demoralised and frightened that the “solution” and the person offering it didn’t meet her expectations. This wasn’t Emma’s only experience with a therapist that she knew had personal experience and the experience that followed this was much more positive. As already described within another theme, Emma perceived there to be helpful aspects to therapist disclosure of personal experience of recovery, but these seemed to be dependant on both the therapist’s recovery and if what her therapist had was something she wanted or was attracted to. She also spoke of a comforting sense of hope and identification experienced as a result of her encounter with the therapist who was, in her eyes, recovered.

79.“There is a sense that they know, that feeling of this person understands me.. Especially for somebody who feels like they are coming from another world that they are different from everybody else in the world that’s how I came in thinking. What planet have I come from you know so being with somebody that has been there it immediately a sense of calm and you feel at ease…. It did help me be more honest about what I was doing, it allowed me to come out more as I identified with somebody”

(Emma: 27-28:360-379)
Even though there was still identification with the non-recovered therapist, it was not helpful from a therapeutic point of view with the purpose of moving forward. Perhaps it is only the recovered therapist that can make Emma feel “calm” and at “ease” because Emma can see she was at ease with her self and had achieved recovery.

The need for the therapist to be recovered was echoed by Tara. For disclosure of personal experience of an eating disorder to be helpful, Tara needs to be able to see that it was a thing of the past.

80. "There is no way that I would have got through it if I thought for one minute she wasn’t recovered, no way. No way at all because I wouldn’t have bothered and I wouldn’t have trusted her because it would be almost like she’s lying to me, I just wouldn’t have trusted her”

(Tara: 26: 306-312)

There is a sense that Tara would have felt her therapist to be a fraud if she wasn’t recovered. She feels that trust and, subsequently, the relationship would be damaged and she would not have “bothered” putting effort into the therapy and have been motivated to work towards recovery.

Like Lucy, Tara raises issues related to credibility if she perceived her therapist as not recovered.

81. “If someone is sitting there saying something to you. You need to work through all this you need to really get well and your thinking well you’ve not done it well then its kind of like well is it really possible and how can I learn from someone that can’t do it themselves”

(Tara: 25-26: 293-299)

Tara feels she wouldn’t be able to trust what the therapist was saying if she felt she was still had an eating disorder. Again, there is that sense of the therapist not practising what
she preaches or following her own advice. Tara also states that it would cause her to further question if it “is it really possible”, her therapist’s non-recovery reinforcing the hopelessness around recovery. There is also a sense of loss of respect for the therapist who is seen to be still struggling with her eating disorder: “How can I learn from someone that can’t do it themselves”. Perhaps there would be less containment and security in trusting that the therapist can work with whatever it is the participant brings and there is also a notion that the therapist cannot bring you past a stage they have been themselves or how can they help someone else if they can’t help themselves. Tara also feels that she could easily tell if her therapist was not recovered.

82. “When you’ve had an eating disorder its so easy to tell if someone is not well. You pick up on the smallest thing”

(Tara: 6: 67-69)

Tara speaks of having an eating disorder radar and this becomes more active after hearing of her therapist’s personal experience and that she would very quickly be able to tell if they were in some way still struggling or had unresolved issues. However, she feels that if the therapist never disclosed and they were fully recovered, she would not necessarily pick up on it.

83. “People say if you have had an eating disorder that you can always tell but I don’t think you can.. Like now to see her around food you would never guess but if someone has not quite made it to recovery you can tell because of the way the are around food. I think once you are fully through recovery its just not a issue to you it just, its like when you have got an eating disorder it is such a big issue its like its just.. Yeah and you can just tell. Em like people said to me that even I can tell by the look on their faces if someone has freedom from food whereas someone that has recovered they don’t have that kind of anxiety around food, so I think if someone is recovered I don’t think I would be able to tell but if it is still there, I can tell, but you could definitely tell she had an understanding of it if she’d definite.. She got it like I could say things that other people would think is totally crazy but she got it and I think that’s proof that she has been there”
Part of Tara’s treatment involved eating a meal or snack with her therapist. This was one of the areas where Tara feels it would be easy to tell if her therapist’s eating disorder was still active or if elements of her eating disorder were still present. She believes that if someone has fully recovered from their eating disorder there is an identifiable “freedom” in one’s actions that the participant is attuned to and is similarly attuned to the absence of this freedom. Tara also alludes to how her perceiving her therapist’s understanding of what seems “totally crazy” in itself in some way discloses her personal experience and provides her suspicious mind with “proof” that her therapist “has been there”. Tara suggests that she might not be able to identify a history of an eating disorder in her recovered therapist by her actions or behaviours, but that the level of empathic understanding she experienced was so great that it could only come from having personal experience.

Tara feels that over-disclosure on the part of the therapist would be a giveaway sign that she wasn’t recovered.

84.“I’d be talking to somebody about my illness then it’s a case of yeah but I did do this this and this and I have to tell people how poorly I was because I’ve always had a thing about well no one has ever noticed my eating disorder so people probably don’t believe me do you know what I mean but you can tell when someone is recovered because they don’t feel the need to do that...She didn’t need to justify her illness anymore cause she was over it”

In the above excerpt, Tara shares her thoughts that if someone is recovered then they no longer feel the need to have to justify themselves or their experience of an eating disorder. She thinks that when still battling a eating disorder one has a need to talk about it, whether it is related to the identity that becomes attached to it or the need she feels to justify her illness and need for help, the need to feel that others believe you and trying to get people to understand where you are coming from and feeling worthy of treatment. Perhaps the therapist’s need to share their experience is related to this
phenomenon of identifying with the illness or the need to justify their interventions and demonstrate understanding.

**Sub-Theme Three: What is Recovery?**

Ambivalence regarding recovery is a thread evident throughout much of the participants’ interviews. What constitutes recovery from an eating disorder is a much talked about topic in the research literature. During her interview, Ruby spoke about her expectations for her own recovery and what she felt about her own recovery.

85. “Her version was just being happy and being able to think about something other than food and being a healthy weight. She never said you have to be perfect. Which took quite a lot of pressure off”

(Ruby: 39-40: 442-447)

Here, Ruby refers to the question of what is recovery and how do you know when someone is recovered. There was no expectation from her therapist to be “perfect” or achieve a recovery that was complete. The recovery goals Ruby and her therapist set were to feel “happy”, to maintain a weight that is healthy and not be completely consumed with thoughts related to food, eating and weight. Ruby felt these goals were realistic from her perspective and this reduced the pressure that she felt to achieve the “perfect” recovery.

In the excerpt below, Ruby shares how she imagines she would feel if she was to find out that her therapist wasn’t recovered but was still struggling with an eating disorder.

86. “I don’t think it would have helped if somebody had of said that they are still struggling and it would also bring back the fact that you know you can’t recover cause there were times you know that I thought that I can’t recover, it’s just not possible cause I had so many people around me in treatment that still had eating disorders and I barely saw people that had recovered, that wasn’t like, what I saw fat, so there was still a part of me that thought it’s not possible so if they had said that to me then it would have made me more thinking you know you’re a grown woman and you’re still struggling with it”
Ruby echoes sentiments expressed by Emma earlier in extracts 78 and 79. They both expressed feelings of hopelessness and despair as a result of perceiving their therapist who disclosed personal experience of an eating disorder to them to be still struggling or battling with it. As mentioned in a previous part of this chapter, Ruby’s therapist was the first person that she had met that described herself as having recovered from an eating disorder. If Ruby were to find out that this was not the case, her belief that recovery is not possible would become stronger than ever and more difficult to shift. There is also a sense that the respect Ruby had for her therapist and trust in her would be damaged; “You’re a grown woman and you’re still struggling with it”. Here, Ruby also alludes to the importance of her therapist’s weight and shape in relation to how she experienced her therapist’s disclosure of recovery: “I barely saw people that had recovered, that wasn’t like, what I saw fat”. For Ruby to believe in her therapist’s recovery, it was important for Ruby that she didn’t see her as “fat” and had a recovery that she wanted to model. However, Ruby’s ambivalence around this is evident in the following excerpt:

87. “She reassured me that she understood and she told me I know everybody is different but she explained like I felt she did understand and that she’s been there and she even said I still struggle every now and again, and that made me think well I can trust her...She’s honest about it, she’s not saying that there is a miracle cure for it but then another part of me also brought it back to the whole I can’t recover, I’m never going to recover cause there is not a life? But I think it was more positive you know it was like reality like other than somebody saying, everything is going to be perfect, when you start eating everything is going to be rosy cause you know deep down I knew that it wasn’t”

Contrary to what Ruby said earlier, here she states that her therapist did tell her that she sometimes “still struggles every now and again” and, as a result, Ruby felt she could “trust her” therapist more because it seemed more realistic to her. While acknowledging
the part of her that felt it “brought back the whole I can’t recover”, she refers to the experience as being “more positive” and, as such, it was easier for her to accept that the road to recovery was not going to be “rosy” and, for Ruby, she felt that this was a more honest disclosure on the part of her therapist and, in turn, she was better able to trust her and share honestly.

**Summary**

In this chapter, I have tried to present the experience of my participants as accurately as possible. I have sought to share with the reader the various aspects of the participants’ actual and imagined experience of having their therapist disclose personal recovery/experience of an eating disorder throughout the course of their treatment. I am grateful to my participants for their honesty and openness in their sharing of their personal experiences. I was fascinated by their experience and I feel their interviews were rich with many aspects worthy of discussion. To allow the reader insight into what I was privileged to be allowed access to, I tried to utilise my participants’ narratives as much as possible to demonstrate the themes under discussion.

Most of the participants had more than one experience with a therapist who disclosed personal recovery to them and, thankfully, all were willing to explore their experiences and its impact on them, their relationship with the therapist and their therapy. Throughout this chapter, I have tried to present and explore what evolved out of the analysis procedure. The first master theme presented was “oscillating aspects”. Facilitating conditions such as hope, identification, understanding, empathy, inspiration and motivation were expressed by the participants as something that made their therapist’s disclosure a helpful experience. Unhelpful aspects identified included picking up tricks from what the therapist discloses, having the focus shift to the therapist and increased feelings of competition, jealousy and resentment. Over-identification on the part of both the therapist and the participant and the therapist using an approach that was personal to her overstepped boundaries, resulting in a loss of objectivity.

The second master theme concerned the therapist’s image, all aspects of their being and its influence on how the participant experienced or how they imagined they would have
experienced their therapist’s disclosure of recovery. Prominent within this was the therapist’s weight and the effect of the participants perceiving their therapists as heavier or thinner than what was acceptable to them. Also explored within this was the matter of coveting. All participants spoke of needing to want what the therapist had in order for the disclosure to be helpful. What the therapist embodied needed to be appealing to the participant. It appeared recovery was judged on how the participants perceived their therapist’s recovery. They looked at their therapist’s life, weight, career, relationships and their attitude towards themselves, food, life and recovery. If the participants liked what they saw, they were more likely to find the disclosure of personal recovery helpful and engage in treatment.

The final master theme explored was recovery. The participants’ expectations or attitudes towards the possibility of their own recovery and how this matched with what their therapist presented were important. The level of recovery the participants deemed their therapist to have was also crucial in determining how the disclosure was experienced. Interlinked with this was the question of what is recovery and how do you know when it has been reached.

Within each of these themes was, of course, ambivalence. Throughout the interviews, each of the participants expressed contradictory thoughts and experiences about what was being discussed. Most of that presented as helpful initially, but later evolved into something less clear-cut, and this continued to develop and change throughout the interviews. I hope that through the many presented excerpts of the participants’ narratives on each theme, the reader will be able to see points throughout that a participant had expressed a view or experience that is in some way contradictory to another by the same participant.
Discussion of Findings

In the previous chapter, I attempted to illustrate how my participants experienced their therapist disclosing personal experience of an eating disorder to them. By this point, the reader will have an appreciation of what made it helpful and what made it unhelpful and the many complexities and aspects that can influence how it is received by the eating disorder client.

All the participants came forward to share their experience as they felt it to be something inherently helpful and they wanted to share this and promote it as something that helped them with their recovery. Nevertheless, exploration of their experience revealed that there were times when it wasn’t entirely positive and helpful. They were able to reflect deeply and honestly on why it was helpful and why it was not, and be open about how they felt about delicate aspects such as their therapist’s body and elements of their own experience that they found embarrassing and difficult to speak about.

The participants’ honesty and openness during the interviews highlighted high levels of ambivalence around certain aspects of their experience. I hope that from the extracts presented in the previous chapter the reader will have seen some of the contradictory views expressed by the participants; these will be highlighted further throughout this chapter within each theme and contextualised within the research literature. Following a discussion of the themes, further unique and original aspects of this study and its findings will be presented. Following this, I explore the implications of these for recovered eating disorder professionals and the profession of Counselling Psychology. Subsequently, I examine the strengths and limitations of this study and explore the possibilities of what I personally can do with what I have learned from the findings. Finally, I leave the reader with some personal reflections on the research process, the findings and my position within it.

1. Master Theme One: Oscillating Aspects

1.1 Hope
For the participants, knowing about their therapist’s recovery from an eating disorder provided them with hope that recovery was possible and motivation to engage in treatment to work towards recovery. Like Costin of Costin and Johnson (2002), the participants shared finding it helpful to see that a “normal life” could be achieved, a life not dominated by “thoughts of food and weight” and that there was “a better life” ahead. Costin believes that recovered eating disorder professionals can offer additional benefits to their clients. She states that recovered professionals can offer hope to their clients that recovery is possible. According to Costin, eating disorder patients are often exhausted, defeated and feeling hopeless after years of battling the illness, and she believes that recovered professionals offer patients proof that recovery is possible and that it is possible to lead a productive life. Costin states that “Clinicians who have successfully mastered recovery become a living, breathing example that recovery is attainable.” (p. 297) Obviously, for this to be the case the patients would need to be aware of the therapist’s recovered status. Costin reported that former patients of the treatment facility of which she is director frequently feedback that one of the most helpful aspects of the programme was “the hope and motivation they experience from the staff members who have been there” (p.297).

Along with hope for recovery, participants also spoke of taking some sort of inspiration from seeing that their therapists were leading successful lives, successful in their career, relationships and family. In the article by Costin and Johnson (2002), Costin reflects this when she suggests that, as a result of thoughts, feelings and actions that feel shameful to them and that they fear will be disgusting to others, eating disorder patients often feel that they will end up abandoned, worthless and defective. However, as a result of seeing their therapist holding a position of status and being valued by others, Costin believes this sends a powerful message to clients as it proves that aspects of themselves can be confronted and overcome which can initiate change in treatment.

1.2 Credibility

Many of the participants made reference to feeling that knowing that their therapist had a personal history of an eating disorder gave them more credibility in working in the treatment of eating disorders. This supports findings by Costin and Johnson (2002). Along with increased credibility, it also permitted the therapist more leeway or, as Costin suggests, greater licence in utilising a tougher approach in calling the
participants “out on my shit”. This was further helped as the therapist was aware of the “shit” on which they needed to be called out on because of their personal experience and knowing the “tricks of the trade” as a result of their “insider knowledge”.

1.3 Understanding and Empathy
For the participants, the therapy seemed to be made easier in some way by the deep understanding and “insider knowledge” they knew their therapist had. Thoughts and feelings that had felt “alien” became less so. In their experience there was an essence of not having to try as hard to battle to explain what sometimes felt unexplainable in the therapy. The participants all believed eating disorders to be very complex, something they themselves struggled to understand at times and, as such, they believed that “outsiders” or people who have never experienced such “crazy thoughts” or “alien thinking” could never truly understand and empathise with their experience as much as they may try. The “knowing” that their therapist “gets it” had the effect of making it easier for them to relax into the therapy and be more at ease disclosing within the relationship. These views expressed by my participants supports the findings reported by Johnston et al. (2005), who found that those with an eating disorder and professionals with a history of an eating disorder believed that recovered professionals had a better understanding of aspects of treatment and would have more expertise in the area than professionals without a history. From her experience, Costin (Costin & Johnson, 2002) felt that recovered staff had the ability to quickly develop a deep level of rapport and trust, which helped reassure patients that the “leap of faith” required for recovery was manageable and didn’t result in something that felt catastrophic. My participants very much shared this view in that they felt it was difficult for therapists who haven’t experienced an eating disorder themselves to fully comprehend the fear and battle that recovery poses for patients.

In the study by Rance et al. (2010), recovered eating disorder therapists felt that the main benefit of their personal experience was their increased understanding and empathy towards their client’s experience. Similarly, eating disorder sufferers surveyed by Johnston et al. (2005) felt that the therapist with personal experience would be more understanding, sympathetic and empathetic. Another advantage of working with a recovered professional as reported by Johnston et al. (2005) was that they would act as an encouraging and positive role model and recovery success story. These reported
beliefs from recovered therapists in Rance et al. (2010) and from eating disorder sufferers in the survey by Johnston et al. (2005) was shared by the participants during the interviews.

1.4 Ability to Draw on Personal Experience
Some of the participants in my study felt that knowledge of their therapist’s personal experience helped to normalise their thoughts, feelings and behaviours, but this appeared to be a fine line. While some felt that it was helpful to hear their therapist say, “I’ve been there, it’s fine”, others felt that their processing of their experience was cut short by the therapist’s attempts to draw on their own personal history to normalise and reassure. Over time, this led to them not feeling heard and their experience was becoming more about their therapist than them. Costin, in Jacobs et al. (2010), highlighted that recovered eating disorder therapists are at risk of taking on the role of “expert” too much and assume that they understand what the client is trying to say because they have “been there”. Because of their personal history, they need to be more careful not to let their personal experience overly influence their understanding of each client and miss out on crucial aspects that are unique to them.

Many of the participants in the current study shared ambivalent feelings in regard to their therapist drawing directly on their personal experience of recovery to make recommendations and give advice within the therapy. For example, Lucy shared that it was at times helpful to hear strategies that her therapist used “to delay going into the food”, but later shared feelings of frustration, jealousy and resentment when she was unsuccessful with these same strategies. Although Costin (Jacobs et al., 2010), who is a recovered eating disorder therapist herself, recommends the recovered therapist to use their personal experience to share resources they used to combat their illness, in Costin and Johnson (2002) she also states that the passion or belief they feel for a particular strategy or technique can also be a weakness in their treatment. Costin (Jacobs et al., 2010) states that recovered therapists must be cautious not to place treatment expectations on their clients because they are using an approach that worked for them or based on what was manageable to them, and she recommends they don’t impose these on clients solely on this basis.
My participants Lucy and Ruby felt that at times their therapists drew too heavily on their experience of what worked for them and, consequently, they felt angry, disappointed and hopeless when these same techniques didn’t produce the same positive results for them. Many of the participants expressed not feeling heard as a result of their therapist’s rigidity in adhering to their personal version of treatment and recovery. When the participants did look at the therapist utilising strategies and techniques they found helpful in their own recovery, they did state that this was best presented as one way or technique and not the only way. Costin and Johnson (2002) also acknowledge that, as a result of having personal experience, recovered therapists can become “narrow and inflexible” in their treatment strategy, and focus on the strategy that worked for them. In addition, although the participants in this study felt that it was helpful to hear that their therapist had recovered, most shared not wanting to know specifics about their therapist’s illness, as it would be triggering to their own eating disorder. The participants spoke of specifics evoking feelings of competition and jealousy. Specifics around weight appeared to elicit feelings of competition and it would result in comparisons and have the potential to motivate them to try and “beat it” in their quest to be “the best”, as one participant put it.

In Jacobs et al. (2010), Costin reveals that she tells her patients about her eating disorder history to demonstrate that she “got it”, but also to share things that she found helpful in her own recovery. Costin believes this to be one of the unique benefits that recovered therapists can offer their patients, but still highlights the need for caution with this technique. She states that it is not necessary for the recovered therapist to share details about their own illness, but rather focus on resources used to get better.

1.5 Identification

Some participants felt that their therapist overly identified with them and vice versa. Ruby shared that she felt her therapist identified too much with her eating disorder and looked at them as both being the same, which was frustrating to Ruby. At many points throughout the interviews, each of the participants shared thoughts and feelings about their therapist and how they saw them, which indicated that there was over-identification on the part of the participants also. Bowlby (2007) highlights concern over the risk of interference and over-identification between the therapist with personal history of an eating disorder and those they treat as a result of their similarity and proximity. DeLucia-Waack (2000) states that a key countertransference issue when
working with eating disorder clients is overidentification. Here, the author is referring to the experience of all those who work with this population, so it seems reasonable to assume that the likelihood of this is increased further with a therapist with a history of an eating disorder, given the similarities of experience. DeLucia-Waack (2000) suggests that such overidenification presents challenges to the treatment as it can interfere with the therapist’s ability to remain objective and “serve as a reality check” for their clients when needed. DeLucia-Waack (2000) also draws attention to the pros and cons of identification in that in the beginning stages it can help build connection between therapist and client, but, later on, can begin to hamper the therapy process.

2. Master Theme Two: The Therapist Embodied

2.1 The Therapist’s Physical Appearance

Each of my participants felt that their therapist's appearance, in particular, their body and weight, strongly influenced how they experienced their therapist’s disclosure of personal recovery from an eating disorder. It seems that listening to their therapist’s personal experience further heightened their awareness and sensitivity to this as it had the effect of making it personal to them as their therapist’s weight now had meaning. If the participants perceived their therapist to be “fat” or overweight, it made them fearful as, for them, it provided confirmation of what they feared happens when you loosen the control of your eating disorder. For some, it was difficult to envisage a recovery that might be different to that of their therapist as, in many ways, they felt destined to look like their therapist, as their therapist now became their representation of recovery. Warren et al. (2009) state that, as a result of eating disorder patients’ overevaluation of appearance and body to interpret the world, they are likely to be hyperaware of their treatment provider’s appearance. In addition, Vocks et al. (2007) reported that the therapist’s figure was more important to clients with eating disorders than it was to clients with other disorders. According to Burka (1996), overweight therapists have reported that their eating disorder clients have felt frightened by their body, as they feared they would end up looking the same. For my participants, this appeared to be more powerful because their therapist had disclosed a personal history that is true of their current experience, which, to them, made their fears more likely to become reality. In the case of both the thin and overweight therapist, the participants questioned the therapist’s credibility and their level of recovery. With the therapist they deemed to be
overweight, some of the participants wondered if they had migrated to another type of eating disorder. They didn’t see the overweight therapist as being healthy and tended to dismiss any advice or psychoeducation they would give on diet and lifestyle. With the thin therapist the participants felt they were not “practising what they preach” and, as a result, the participants were more reluctant to engage with them and their treatment. Some of the participants shared their belief that the skinny therapist with a history of an eating disorder would be too “fragile” to be able to help them and they would have had little faith in the therapist’s ability to support them.

2.2 Impact of Therapist’s Appearance on Relationship
Although all my participants’ shared feeling that their recovered therapist’s weight and shape strongly influenced their relationship with their therapist and their experience of their therapist’s disclosure of personal recovery from an eating disorder, this was something that was never addressed in the therapy room. If it had been discussed, it may have eased some of the participants’ uncomfortable feelings that they experienced and protected the therapeutic relationship. With both the overweight and thin therapist, all participants felt that their ability to trust the therapist would be compromised, which seems understandable given the various aspects of how the recovered therapist’s body shape and weight was perceived by the participants. According to Lowell and Meader (2005), the female therapist can become an object of comparison, and they have brought attention to the need for therapists to acknowledge this and speak about their body with the client in session. They suggest that how the eating disorder client perceives their therapist’s body and the assumptions they make about it can impede the therapy and its progress. Similarly, Picot et al. (2010) suggest that recovered therapists disclose to their clients through their appearance, weight and size whether they actively choose to or not and so recommends that the therapist allows time to explore reactions to their physical appearance in the therapy as it helps to address trust and insight.

2.3 Ambivalence in Regard to Therapist’s Body
There was no consensus on an ideal body shape for a recovered therapist to have. For all participants, perceiving their therapist as being “fat” or “skinny” tended to be experienced negatively. However, in the case of the “skinny” therapist, although the participants questioned their therapist’s credibility and recovery, some also acknowledged hoping that they could learn from the therapist about how to recover but
stay skinny. However, the hope seemed to fade when the participants began to pick up on aspects of the therapist and their behaviour that suggested that their eating disorder was still active. In addition, where the overweight recovered therapist induced feelings of fear and anxiety in the participants, the skinny therapist evoked feeling of jealousy, competition and anger. Similarly, Lowell and Meader (2005) reported that they have had eating disorder clients say that they wanted to work with them because they were thin and this was something their clients wanted to achieve themselves. It appeared that the participants were very observant of any changes in their therapist’s body. Depending on the stage of recovery, some of the participants acknowledged that their view of the therapist’s body was distorted and that the therapist who they at one time viewed as being overweight on reflection may just have been “normal”. “She wasn’t fat at all but at that point I saw her as huge” (Ruby). Given this, it seems all the more important that the therapist explore the pertinent aspect of their shape and weight in the therapy.

Despite the fact that it appears that the importance of the therapist’s body is known amongst those who treat eating disorders (Lowell and Meader, 2005; Jacobs et al., 2010; Vocks et al., 2007), surprisingly little has been written about its influence. Although the experience presented within the current research concentrates on the experience of eating disorder clients with therapists with a history of the same illness, it seems reasonable to suggest that the therapist’s body is also significant in the therapy provided by non-recovered professionals and should still be discussed as part of the treatment. However, the participants did communicate that they became more aware of their therapist’s body after hearing of their therapist’s personal history.

2.4 Coveting

A prominent theme evident in the participants’ transcripts was that of attraction, or to use a stronger term, coveting. It was related to that just discussed in terms of the therapist’s body, but in many ways it extended beyond it to other aspects of the therapist’s essence. Not only did the participants view their therapist’s body as epitomising recovery but also their existence in general. They tended to look at all aspects of their therapist’s life, including their appearance, weight, career, home and relationships. It appeared that it was important for the participants to want or be attracted to what they perceived their therapist to have. The therapist’s disclosure of a
personal history of an eating disorder increased the similarities between them and the participants and, at times, the participants had difficulty separating their identity and recovery from that of their therapist. In Bowlby’s (2007) study, therapists with personal history of an eating disorder shared finding it difficult to create and negotiate aspects of identity separate to their eating disorder. What my participants saw their therapist to have needed to appear worthwhile and appealing to them; if not, they tended to be put off by their therapist’s disclosure, thus, making the participants feel that the life they saw their therapist leading was the same kind of life that they would have if they continued to work together. Therefore, if it wasn’t inviting to them, they disengaged from the therapy and the therapist. However, if they did find what they perceived their therapist to have as attractive or appealing, trust was increased, they engaged in the treatment better and were more open to recovery. Many of the participants spoke of finding the “peacefulness”, “contentment”, “balance” and “enjoyment” that they saw in their therapist appealing and wanted the same for themselves. They believed that their therapist could help them achieve it because they had done it too. Again, this puts the client, the therapist and the therapy in a risky position as the positive identification may fade after the treatment had ended, with possible false positive outcomes at discharge and then the possibility of a dangerous uncontained relapse. A discussion around expectations is important in order to protect the participant from feelings of increased hopelessness if what they had envisaged never materialised. Indeed, some of the participants spoke of having feelings of anger, jealousy and resentment towards their therapist due to feeling that their therapist’s life was so much better than theirs and their therapist had achieved what the participants felt was impossible for them.

3. Master Theme Three: Recovery

3.1 Importance of Recovery
In each of the themes discussed thus far, the benefits and helpful aspects of having their therapist disclose a personal eating disorder history seemed to be dependent on whether the therapist was recovered or not. Indeed, Costin & Johnson (2003) state that their hiring of recovered staff for the eating disorder treatment at the clinic where she is director is conditional upon the fact that they have made peace with food and their bodies and that they describe themselves as recovered, as opposed to in recovery. Bowlby (2007) summarises that existing literature suggests that recovered eating
disorder professionals have the potential to offer valuable input and advantages for those to be treated, but this is dependent on their level of recovery. As mentioned in the analysis chapter, the issue of recovery was something that all the participants appeared to be ambivalent about. Ambivalence surrounded their views on what it means to be recovered, their own recovery and also their therapist’s recovery.

3.2 Participant’s Recovery
At the time of the interviews, none of the participants considered themselves recovered from their eating disorders, but all had returned to a healthy weight and appeared to be functioning well in their lives. They described still feeling fear and anxiety around food and weight and they had yet to get to a place where they had a normal, healthy relationship with food. Some found it difficult to envisage themselves ever getting to this place completely as they felt that complete recovery in these terms was not realistic for them and that particular aspects of the illness would remain with them. These participants’ views supports those of Garfinkel et al. (1977), who have suggested that a large proportion of those who do “recover” from an eating disorder continue to experience impairments in physical, social and psychological functioning even after normal weight and menstruation have been restored. Similar views to my participants’ were also expressed by all 13 participants in the study by Bersesin et al. (1998), who agreed that recovery is a lengthy, slow process that even after recovery, particular fragments of the disorder remain. Participants within the current study tended to view their recovery more in line with that suggested by Root (1990) and Bowlby (2007) in that recovery is possible to a certain extent but the individual will continue to experience residual elements of their eating disorder, such as body image issues and food distortion. Perhaps the participants’ views presented here are normal given their stage of recovery. It is likely that if the same question had been asked earlier in their treatment they may have presented a more pessimistic view and, equally, as they hopefully continue on their road to recovery they will come to a position where they are no longer struggling with their weight, food or body image as they have reached a stage where issues which led to the onset of their eating disorder has been resolved (Weaver et al., 2005; Bowlby, 2007; D’Abundo & Chally, 2004).
3.3 Therapist’s Positioning of Recovery

It is also possible that the participants’ views on recovery were influenced by their therapist’s disclosure of recovery to them. As discussed earlier, the participants shared the feeling that their therapist’s disclosure provided them with hope that recovery was possible and they could achieve a better life for themselves beyond that of their eating disorder. However, as the interviews progressed many of the participants acknowledged doubting that their therapists actually had the complete recovery that they were first presented with. Their doubts arose as a result of various aspects of their therapist’s presentation, such as their weight and shape, their hypersensitivity to their therapist’s actions and behaviours and how they perceived their therapist to relate to themselves, their body and food. Some of the participants shared that at some point in their treatment their therapist acknowledged still struggling with aspects of their eating disorder from time to time; this could have reinforced the belief that you can attain a certain level of recovery and function well in society, but particular aspects of the disorder will remain although at a less distressing level. When the participants did start to doubt the therapist’s level of recovery they also began to question their credibility as an eating disorder therapist, feeling that they were not “practising what they preached”; as such, they became distrustful of their therapist’s actions. This may have been because their therapist now became another person with an eating disorder to compete with, which drew the focus from the treatment and recovery. The participants’ ambivalence was very much evident again in relation to this aspect. Although they questioned their therapist’s credibility after becoming suspicious that their therapist wasn’t completely recovered from their eating disorder, some spoke of finding this more realistic given their understanding of recovery; this led the participants to think that they were being honest with them and so these participants felt they could trust them.

3.4 The Non-Recovered Therapist

All the participants felt they would be unable to work with a therapist who they suspected was still struggling with their eating disorder. Many spoke of feeling demoralised at this realisation and shared feelings of increased hopelessness. The hope that was initially experienced as a result of the disclosure soon shifted to disappointment and despair as they felt the person they thought would help them now didn’t seem in a position to do so. Moreover, all the participants felt they would be able to tell if their therapist was not recovered and couldn’t be fooled by their therapist, as
their “ED radar” was always active. Some of the participants also felt that they would have known that their therapist had an eating disorder in the past because of the understanding and “insider knowledge” they portrayed.

In Johnston et al. (2005), three of the professionals surveyed reported that they had an active eating disorder, as did eight of those surveyed by Shisslak et al. (1988). It is likely that more therapists than is acknowledged in the literature have active eating disorder symptomology and that their eating disorders are not a thing of the past. Indeed, as mentioned earlier, it is argued that many of those who recover from eating disorders may still carry strong residual beliefs and attitudes about eating, weight and shape (Johnston et al., 2005; Shisslak et al., 1988). According to Bowlby (2007), recovered eating disorder professionals interviewed in her study reported that they see many colleagues in their field who, to them, did not seem recovered from their eating disorder. Some of her participants reported that they had seen therapists look worse than their clients and exhibit eating disorder behaviour. One of Bowlby’s (2007) participants described feeling sorry for the clients being treated by these not recovered therapists as she felt they were being “cheated” by being treated by someone that is unaware that recovery can happen. Participants in the study by Bowlby (2007) acknowledged doubting the competency of those they felt hadn’t recovered from their eating disorder but didn’t want to raise the issue, as no guidelines existed around determining the extent of an individual’s eating disorder and they highlighted that it is an awkward and challenging issue to deal with. This view was also shared by Jacobs et al. (2010), whose article was written in response to a member of the Academy of Eating Disorder requesting advice on a listserv about addressing a colleague who they felt to be dangerously underweight. Responses demonstrated that this was a contentious and sensitive issue with many looking for some clear guidance on this issue as a means, perhaps, to manage their anxiety around it. Bowlby (2007) suggests that the lack of professional protocols to regulate and define acceptable levels of recovery for treatment professionals compound the problem, as many of the participants in Bowlby’s (2007) study reported feeling uneasy about informing their colleagues and place of work because they didn’t want to be associated with members of the eating disorder treatment community who obviously still suffered with an eating disorder. However, some of her participants described a desire to disclose to be authentic and honest and better collaborate with the colleagues and challenge perceived stereotypes.
Master themes two and three perhaps show the reader the most original material moving beyond the previous literature outlined in this study and reveal the importance and quality of the participants’ accounts. I would also like to draw the reader’s attention to how the participants and, therefore, clients constantly negotiate and renegotiate their thoughts. The reader will notice that there are, perhaps, aspects of master theme one may read as more positive; however, it is not that the participants start this way and reveal their experience to be something opposite, but rather, the participants constantly negotiate around these aspects of their experience.

**Advancing the Literature**

Therapist self-disclosure of any kind is a complex, delicate and intricate process. The insights into my participants’ experience have demonstrated that it should be done thoughtfully with an intended purpose. This study has demonstrated that therapist disclosure of a personal history of an eating disorder to their eating disorder clients can provide hope that recovery is possible, and is inspiration and motivation to begin on the road to recovery. It can help build rapport with difficult to engage clients and make clients more at ease and comfortable in the therapy as it lets the client know they are understood and enhances the clients’ perception of empathy in the relationship. It can encourage reciprocal disclosure from the client and increase identification between therapist and client, as such, helping the client engage and helping reduce the power differential in the therapy. Given these potential benefits such disclosure can bring to the therapy and the client, it would be easy to assume that it has a worthy place in the recovered eating disorder therapist’s repertoire, and it may well have. Nonetheless, this study has also demonstrated that all recovered therapists thinking of utilising this specific type of self-disclosure should also give careful consideration to the many ways in which their clients can negatively experience hearing this information. The amount and frequency of disclosure appears to be an important modulating factor in how it can be received. If therapists decide to disclose their history or an eating disorder to their client it should be kept short and specific details avoided. Clients should be asked for feedback on how it feels to know this information and their responses discussed in the room. In line with the recommendations of Lowell and Meader (2005), Vocks et al. (2007) and Picot et al. (2010), the therapist must explore the influence of their own body in the therapy with their eating disorder clients, and this becomes increasingly
important after a disclosure of a personal eating disorder history. Feelings of jealousy, resentment, anger and competition can be evoked in the client. From my participants’ accounts, it appears that one of the most important factors that influenced how disclosure can be experienced by the client is the recovery status of the therapist. The eating disorder clients’ “radar” becomes even more sensitive after such a disclosure and they will be quick to pick up on the smallest thing that might suggest that their therapist is not recovered. Working with a therapist who they suspect or perceive not to be recovered can be very damaging for the therapist and their clients’ outlook on recovery. This study highlighted that such an experience can have the effect of increasing the clients’ ambivalence about recovery and increase feelings of hopelessness, disappointment and exacerbation with treatment.

A review of the literature suggests that this study has been the first to highlight the concept or theme of coveting as an influential factor in modulating how disclosure of personal recovery can be experienced by the eating disorder client. One of the previously unexplored aspects in the eating disorder literature that this study drew attention to is to that of “coveting”, or the idea of needing to want what the therapist has, or the importance of finding the therapist’s life appealing.

Taken into consideration are the therapist’s body, shape and weight. The influence of this appeared so strong and such an important aspect of my participants’ experience that I deemed it to warrant a theme in itself. However, in terms of coveting, it relates to much more than the therapist’s body, shape and weight. The participants in this study took careful consideration of their therapist’s essence and life in a very holistic way. As a result of their knowledge of their therapist’s personal eating disorder history, the participants very much saw themselves as similar to their therapist and had difficulty separating their eating disorder and envisaging a recovery and life that was different to that of their therapist. This was motivating for them to engage in treatment, providing they liked what they saw and found it appealing; if not, they appeared to be discouraged or put off and were more reluctant to engage as they envisaged recovery as unattractive or something not worthwhile battling for if what they perceived their therapist to be and have was not what they wanted. At times throughout the interviews, some of the participants spoke of their frustration that they felt their therapist couldn’t see that they were different from them. However, in many ways the participants also lost objectivity
on their separateness, their uniqueness and individuality, and this inevitably led to blurred boundaries and difficult to manage dynamics in the therapy.

It is difficult to say whether the same type of coveting issues exist in regard to therapists without a history of an eating disorder who work with eating disorder clients, and future research on this would be interesting. Nonetheless, given the influence that their therapist’s disclosure of a personal history of an eating disorder had on how the participants perceived and engaged with their therapist, it would be reasonable to suggest that knowing of their therapist’s personal experience increased the proximity between the participant and their therapist and, thus, made the view they had of the therapist more immediate and probable to them.

Although the existing literature presents mixed opinions as to the advantages and disadvantages of therapists working in the field of eating disorders when they themselves have in the past suffered from an eating disorder, there is consensus with regard to the reservations expressed within the literature about those practising with active eating disorders and these reservations tended to be concerned with the vulnerability of the therapist, rather than that of the clients (Johnston et al., 2005; Bloomgarden et al., 2003). However, the current study did highlight many risks to the clients’ welfare as a result of receiving treatment from professionals who are seen to be still practising aspects of their eating disorder and it has been one of the first studies to take explorative account of the clients’ perspectives. Implications of these findings will now be discussed. This is something that professionals with a past history of an eating disorder who now provide treatment services to the eating disorder population while feeling vulnerable themselves should be aware of and strive to work in the best interests of their services users.

**Implications for Recovered Eating Disorder Professionals**

Although it appears that many therapists with a personal history of an eating disorder don’t routinely disclose this to their place of work for fear of stigmatisation and their uncertainty about questions around fitness to practice being raised, it appears it would be both in their own and their clients’ interest if their clinical supervisor was aware of it. The earlier review of the literature on recovered eating disorder professionals treating eating disorder clients highlighted the potential risk to therapists in terms of increased
vulnerability and relapse. Also highlighted was the potential for harm to clients as a result of countertransference and unattuned disclosures from the therapist. Hence it seems clear that the field needs to look at the protective role clinical supervision has to play in the protection of both the therapist and client.

In this way the therapist would have a place to explore whether such an intervention would be in the best interests of their client given the complexity surrounding its use. In line with the findings of this study and that of Rance et al. (2010), therapists with a history of an eating disorder should be aware of the possibility of enmeshment and over-involvement with their eating disorder clients. Again, having a clinical supervisor or colleagues who are aware of their eating disorder past would be very helpful in managing these risks. Given the stigmatisation that currently exists around recovered therapists working in the field of eating disorders, this group of professionals should begin to further open up dialogue about these issues in the workplace, which will allow service managers and colleagues to witness professionals who promote a positive image for those with a history of an eating disorder now working in the treatment and to work on reducing the stigma that surrounds this. Fitness to practice procedures can produce a culture of fear and it is important, whilst recognising them, to create a supervisory space where it is acceptable to discuss personal history, as not discussing this can be dangerous.

Evident in some of my participants’ accounts of their experience is the important issue of therapist abuse of power in relation to disclosure and the violation of therapeutic boundaries. Particularly in the case of my participant Lucy, her account of how her therapist used self-disclosure is an example of the therapist meeting her own needs within the therapeutic relationship. Lucy described a role reversal taking place and feeling burdened as a result of the quantity and detail of her therapist’s disclosure. Therapists reading this who may be considering using self-disclosure with their clients should take caution from Lucy’s experience. In this study, it was apparent that self-disclosure of personal recovery from an eating disorder can have a positive influence on the therapy of eating disorder clients and it has a place in the recovered therapist’s repertoire. However, it is the therapist’s responsibility to ensure that it is done with the client’s welfare in mind and with clinical purpose. Therapists must give careful
consideration to their intent and the resulting impact of the disclosure on the client. Clinical supervision would be an appropriate space for such reflection.

In addition, recovered eating disorder therapists using disclosure with their clients should seek feedback from their clients on how it felt for them to hear it and continue to be aware of the many ways that it can influence how it feels for their clients to know this information.

**Wider Implications for Counselling Psychology**

This stigma highlighted above is encouraged by suspicions or doubts around the recovered status of some professionals in the field and the questions this raises around one’s fitness to practice. As the existing literature has highlighted the uncertainty about a “recovered” professional’s competency as being something awkward, uncomfortable and uneasy to have to deal with, the therapists themselves need to take responsibility and use their own judgement as to when they are feeling triggered, vulnerable and moving toward relapse. In Costin and Johnson (2002), Johnson commented that in his time as programme director at the eating disorder service where he employs therapists with personal recovery, he has had three members of staff experience “wobbles” in their recovery, one a moderate relapse and one a severe relapse. The three staff members who were feeling psychologically vulnerable but who didn’t relapse behaviourally had their supervision intensified and, as a result, their vulnerability abated within several weeks. The staff member with the moderate lapse received outpatient therapy and the lapse was remedied in several weeks. The staff member who had a severe relapse required residential treatment and it was mutually agreed that they would not return to the programme. It should be highlighted that the environment in which Johnson works is open and supportive and so staff members were able to discuss their feelings of vulnerability and receive support through their “wobbly” moments. This is something the field of Counselling Psychology can play an important role in. As the profession grows, there exists a Counselling Psychologist in most eating disorder services across the UK and a growing amount of mental health services in general. Also, in line with the recommendations of authors such as Johnston et al. (2007), Bloomgarden (2000) and Rance et al. (2010), as a profession we must use our influence on policy to work towards developing guidelines and policy regarding the employment of recovered professionals in these services and open up discussion regarding what stage one is
considered adequately recovered to work in the treatment of eating disorders and introduce some sort of protocol around this for the protection of both those using the services and the recovered therapists themselves.

Human resource departments across the public and private eating disorder sector should introduce policy that stipulates that therapists who have experienced an eating disorder within the last five years must disclose this information to their employers or clinical supervisors. It would be unnecessary to request such disclosure if the therapist experienced an eating disorder a number of years in the past and they had been maintaining their recovery successfully since. With this information, appropriate levels of clinical supervision and other protective resources could be made to ensure that both the therapist and client remained protected. While guidelines like this can be helpful, it must not become punitive. I am reminded of the wounded healer archetype and how people who have experience of a particular problem can have the potential to be the most dangerous but also the most effective therapists (Grapp, 1992; Stone, 2008; Dunne, 2000; Timm & Blow, 1999).

If an unambiguous and open environment existed, recovered therapists considering disclosing their experience to their clients would feel better able to use recourses and outlets available to them to engage in exploration around their motivation to disclose. They should be encouraged to give appropriate space and consideration to the possible implications of this for their client, their relationship, the therapy and also the implications of this for themselves and their position in the therapy.

**Strengths and Limitations of this Study**

This study was based on the experiences of six women who had their therapist disclose personal experience of an eating disorder to them while they were receiving treatment for their eating disorder. Given the small sample size, the experiences shared by the participants cannot be generalised to all those who have had their therapist disclose personal recovery to them. However, IPA is interested in how a particular phenomenon has been experienced by the individual but allows the researcher to look across cases and examine what is shared and also unique (Flowers & Larkin, 2009). Furthermore, Smith and Osborn (2003) state that IPA findings can give indications of the likely experiences of others in similar situations. In addition, although this study was open to
males and females, only females requested to participate and it is possible that the experiences of men could have been different to that of my female participants. However, as this study aimed to be exploratory in nature, this small sample size did allow for the dialogue on the clients’ experience of this specific area of disclosure to be opened and it has highlighted areas worthy of investigation in future projects.

All the participants were reflecting on experiences that happened in the past and it is possible that their experiences in the moment may have been different to that reported with hindsight. It would be difficult, if not impossible, to get more in-the-moment client experiences of the phenomena under investigation given that the client would be engaged in therapy with the therapists and it could potentially impede their treatment and would raise a number of ethical implications.

Furthermore, although the sample size was small and the research question specific, it has provided insight and clues into a neglected perspective of therapist disclosure. Still, as this is the first piece to ask this research question, those that work in the treatment of eating disorders would value further exploration of this phenomenon.

What Next?
After reflecting on the findings of this study and its implications for recovered professionals and the field of Counselling Psychology, I am left contemplating what I am to do with what I have found. Having a history of an eating disorder and being a trainee Counselling Psychologist nearing qualification currently working in the treatment field of eating disorders, that which has been discussed in this study has direct implications for the way I work. In addition, in this chapter, I have attempted to bring the reader’s attention to various aspects of the clients’ experience and made recommendations as to what can be done within the community of eating disorders to influence change for the better; therefore, it seems important that I attempt to do these myself.

Upon qualification I hope to be in a position where I can bring awareness of these findings and implications to those who would benefit from it. Initially, I would like to submit this study for publication to one of the prominent counselling and psychotherapy journals and present this study at a conference where my target population would be in
attendance. It is important to highlight that research suggests that between 1 in 3 and 1 in 4 eating disorder treatment professionals have personal experience of an eating disorder themselves (Bloomgarden et al., 2003; Babarich, 2002; Costin & Johnson, 2003). Yet, for fear of stigmatisation and lack of clear guidelines around the issue, few feel comfortable enough to inform their place of work or colleagues about it and so feel unable to use these supportive resources when an issue pertaining to their own history is influencing the treatment they provide to their clients. Self-disclosure of their eating disorder histories to those they treat is one such issue. This study has brought awareness to the possible benefits of a recovered therapist disclosing their experience to their clients, but it has also given insight into important risks and harmful consequences to the client and the therapy. It is important that all recovered professionals are aware of the risks if the opportunity to self-disclose arises within the therapy.

Most services hold clinical improvement groups, and within the service I work in I plan to take the opportunity to discuss my findings and open the issue up for discussion amongst those treating eating disorders and service managers. I would also be open to the possibility of doing presentations in other eating disorder services. At the service where I work, my clinical supervisor is aware of my personal eating disorder history and this has been very beneficial to my practice. Although my personal experience is rarely mentioned within supervision, I know the space is there if I needed to discuss anything in relation to it and my supervisor can also direct my attention to it if she felt it was relevant to my clinical work; for this reason, I would encourage others to do the same.

Personal Reflections

I am grateful that the participants felt comfortable enough in my presence to share as openly and honestly as I feel they did. I felt a good level of rapport was established in the interviews and I felt they were at ease sharing. Their insight and honesty has unquestionably informed the way I will practice in the future and I hope many therapists and clients will benefit from the insights and aspects of experience highlighted in the study.

None of the participants were very ill or underweight when we met, most very much in recovery mode with the shared feeling that exploring their experience was helpful and
therapeutic for them. Some shared the feeling that they had gone past the stage where
they felt embarrassed or uncomfortable taking about it and now in many ways liked
doing so because they got “something” out of it. Many acknowledged that this need to
talk about their eating disorder experiences was connected to the identity or attachment
to their eating disorder. I am left reflecting on how perhaps these same identity and
attachment processes have influenced their therapist’s decision to disclose their
personal experience of an eating disorder.

This research highlighted that therapist disclosure of personal history of an eating
disorder to their eating disorder clients is a complex issue with many aspects needing
consideration. Given the many identities I hold within this study and the relevance of
the findings to how I might practice, it is important for me to consider whether self-
disclosure is something I might use in my practice. Although risks of such self-
disclosure have been highlighted, I do believe there is a place for it at particular times
with particular clients. It is definitely not a one size fits all approach. As previously
highlighted, careful consideration must be given to the reasons and intended purpose of
the disclosure and how the particular client might receive it. That being said, at this
point in my career I don’t think I would use this intervention just yet. However, after
gaining more experience in the field with this population, it would be something I would
consider using in the future if deemed helpful and appropriate. Until I reach this point,
I will strive to achieve similar benefits with alternative interventions.

In the write-up of this study I am aware I am making disclosures about my experience
and myself. As the interview and analysis evolved through this study, I began to
question whether it was necessary and appropriate to do so. I wondered whether I
being naïve in sharing as much as I have. After all, I have also highlighted to the reader
how clients’ knowledge of their therapist’s personal eating disorder history can be
damaging to them and their recovery. I spent time exploring this with my research
supervisor and, in the end, I concluded that it would make the process difficult if I felt I
needed to hide or cover up my motivations for this research and why I truly felt it
relevant and worthy of exploration. In addition, since I conceived this study, each time
someone asked me what I was doing my research on, I have felt my research question
raises the question of my own eating disorder history in the mind of those hearing it and
I felt this would also be true of those reading it. For this reason, I felt it appropriate to
reflect on my experience so that the reader is not left with unanswered questions. Although I believe self-disclosure is acceptable, if and when I submit this study to a journal for publication, my disclosures would not be included. This would be done for practical reasons, as methodology word limits would not allow for the reflexive accounts included in this study but, importantly, also for increased personal control and choice in whether I choose to disclose such information to my clients. I am aware and understand that those who read this study will have knowledge of my history. Should they be or become clients of mine, as a result of this research, I am confident in my ability to manage what this brings to the relationship for therapy advancement.

For clients who come to me with knowledge of my personal history or those who request such information from me, perhaps the issue may not be whether to disclose or not, but rather, if this comes across in a fused “this is important to me” manner in the therapeutic relationship. Perhaps it is this “I do/I don’t have an eating disorder history” which is important in allowing the meanings it holds to be explored.

I have enjoyed this research experience and I found it to be personally and professionally valuable. I hope to have done justice to my participants’ experience and I have attempted to make each of their voices heard in the excerpts presented. I am left feeling grateful and privileged to have met with each of them and for being allowed to enter and explore their experience with them.
References


Henretty, J. R., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy:


470–475.


Appendices
Appendix 1

DSM-IV (2000) criteria for Anorexia Nervosa

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

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

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

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

Specify Type

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

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).
Appendix 1b

Proposed Revisions in DSM-5
Anorexia Nervosa

A. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

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

Specify current type:

Restricting Type: during the last three months, the person has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge-Eating/Purging Type: during the last three months, the person has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).
Appendix 2

DSM-IV (2000) criteria for Bulimia Nervosa

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

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

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

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

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

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

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

Specify Type:

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

Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.
Appendix 2b

Proposed Revisions in DSM-5

Bulimia Nervosa

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

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

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

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

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

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

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.
Appendix 3

DSM-IV (2000) criteria for Eating Disorder Not Otherwise Specified (EDNOS)

The Eating Disorder Not Otherwise Specified category is for disorders of eating that do not meet the criteria for any specific Eating Disorder. Examples include.

1. For female patients, all of the criteria for Anorexia Nervosa are met except that the patient has regular menses.

2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the patient's current weight is in the normal range.

3. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur less than twice a week or for less than three months.

4. The regular use of inappropriate compensatory behaviour by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).

5. The patient has normal body weight and regularly uses inappropriate compensatory behaviour after eating small amounts of food (e.g., self-induced vomiting after consuming two biscuits).

6. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.

Appendix 3b

Proposed Revisions in DSM-5

The category Eating Disorder Not Otherwise Specified is to be replaced by a section termed Feeding and Eating Conditions Not Elsewhere Classified.

Brief descriptions of several conditions of potential clinical significance are provided so that the problems of individuals with feeding or eating problems not meeting criteria for currently recognised disorders can be more appropriately described and categorised.

Atypical Anorexia Nervosa

All of the criteria for Anorexia Nervosa are met, except that, despite significant weight loss, the individual’s weight is within or above the normal range.

Subthreshold Bulimia Nervosa (low frequency or limited duration)

All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than for 3 months.

Subthreshold Binge Eating Disorder (low frequency or limited duration)

All of the criteria for Binge Eating Disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than for 3 months.

Purging Disorder

Recurrent purging behavior to influence weight or shape, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, in the absence of binge eating. Self-evaluation is unduly influenced by body shape or weight or there is an intense fear of gaining weight or becoming fat.

Night Eating Syndrome

Recurrent episodes of night eating, as manifested by eating after awakening from sleep
or excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better accounted for by external influences such as changes in the individual’s sleep/wake cycle or by local social norms. The night eating is associated with significant distress and/or impairment in functioning. The disordered pattern of eating is not better accounted for by Binge Eating Disorder, another psychiatric disorder, substance abuse or dependence, a general medical disorder, or an effect of medication.

**Other Feeding or Eating Condition Not Elsewhere Classified**

This is a residual category for clinically significant problems meeting the definition of a Feeding or Eating Disorder but not satisfying the criteria for any other Disorder or Condition.
Appendix 4

Eating Disorders Not Currently Listed in DSM-IV

Binge Eating Disorder

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

1. Eating, in a discrete period of time (for example, within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances

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

B. The binge-eating episodes are associated with three (or more) of the following:

1. Eating much more rapidly than normal

2. Eating until feeling uncomfortably full

3. Eating large amounts of food when not feeling physically hungry

4. Eating alone because of feeling embarrassed by how much one is eating

5. Feeling disgusted with oneself, depressed, or very guilty afterwards

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for three months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging) and does not occur exclusively during the course Anorexia Nervosa, Bulimia Nervosa, or Avoidant/Restrictive Food Intake Disorder.
Appendix 5: Sample List of Participant Themes

Identification “weren’t on your own with it” 3/23
Easier to be open “a lot easier” 4/27
Timing, not being ready for treatment “reluctant to get better” 6/48
Pushing therapist to disclose “you don’t get it you can’t tell me what to do because you’ve never been there” 6/51
Therapist wanting to show she get it “I have been there, I get what you mean” 6/53
Boundaries “we won’t make this all about me” 6/54
Ambivalent about disclosure “a part of me” 7/61
Understanding “she gets what I mean” 7/62
Identification “I’m not the only one” 7/63
Harder to trick/manipulate recovered therapist “she knows the tricks” 7/69
Ambivalence “like two sides” 8/71-72
Understanding “she understood what it was like” 8/74
Therapist’s appearance “how she looked” 8/75
Fear of looking like therapist “that’s what I’m going to look like” 8/80
Distrustful of intentions “she is going to try and make me fat” 9/86
ED mindset “at that point anybody above a size 6 I thought was huge” 9/88
Readiness to change “I didn’t want to get better” 10/103
Trust “I trusted her more because she had been there” 10/105
Normalising of feelings “she showed me that it was normal” 10/100
Not wanting therapist’s body/recovery “if I recovered like she had that I’d be the same size” 11/112-113
Acceptance “I acknowledged that I was ill” 13/132
Frustration “she thought we were both the same” 15/148
Feeling dismissed “oh well I did that” 15/150
Over normalising of feelings “oh it’s fine I did that” 15/151
Too much about therapist’s experience “she was just making it about her” 16/160
Therapist meeting own needs “this isn’t about you” 16/163
Questioning therapist’s recovery “it was just whether I believed what she was saying” 23/247
Over disclosure “quite a bit saying what she used to do” 17/171
Not feeling heard “my issues are different” 18/182
One size fits all approach “I just felt like what works for you doesn’t work for everybody else” 17/178-179
Angry with therapist/frustration “I just felt like saying it’s not about you” 18/181
Fantasising about therapist’s ED “was it anorexia, bulimia?” 19/198
Unhelpful knowing too much “what she used to do, how she used to feel” 20/207-208
Spiltness of experience “it were like split into two” 20/210
Reduced isolation “I’m not the only one” 21/213
Disclosure unhelpful if therapist overweight “the whole recovery thing, she’s fat” 21/217
Details being destructive “I would pick up tricks from her” 21/219
Timing “wasn’t in recovery mode” 21/225
ED mind frame “I’d latch on to anything” 22/233
Competition “one step ahead” 22/237
Contradictions “saying that you could get better, that’s what I didn’t believe” 23/248
Fearful of therapist’s recovery “the way she looked that I thought I don’t want be like that” 26/280-282
Recovery means fat “well she’s had an eating disorder and she’s recovered and she looks like that” 26/285-286
No-win situation “She wasn’t fat at all but at that point I saw her as huge” 26/286-287
Influence of disclosure on how therapist’s body was perceived “it wouldn’t have been an issue” 27/290
Timing “I’m ready for this” 30/326
Attracted to what therapist had “fine, healthy and happy” 30/336
Focus remaining on client “she didn’t make it about her” 31/348
Strong therapeutic relationship “such a good relationship” 32/357
Relatable experiences “she could relate to it” 33/367
Ambivalence “looked fine like a normal woman” 35/393-394
Hope “I sort of learnt that there is a better life than this” 37/411
Questioning recovery “her version” 39/442
Ambivalence regarding recovery “I’m never going to be fully recovered and perfect” 42/477
Awareness of therapist’s weight “looked a lot thinner” 43/485
Questioning therapist’s recovery “something clicked inside me” 43/480
Increased hopelessness “bring back the fact that you can’t recover” 45/518
Inspiration “I rarely saw people that had recovered” 46/523
Wanting what therapist had “that I thought you know want that” 50/584
Motivation “give me all these reasons not to give up” 52/604
Separating client from ED “knew me more as a person” 53/615
Reciprocal disclosure “I opened up to her, she opened up to me” 55/634-635
Empathic understanding “she knew what I was going through” 55/641
Outsiders not understanding “why can’t you just eat” 57/643
Was therapist recovered ”she said I still struggle every now and again” 58/676
Understanding how difficult recovery is “she’s honest about it” 60/700
Increased hopelessness “brought back the whole I can’t recover” 60/703
Disappointment “deep down I knew it wasn’t” [recovery] 60/709
Honest/thought love “she just said it how it was” 61/722
Insider knowledge “I had so many little tricks and she knew them” 63/739
Tailored approach “she understood not everybody’s the same” 67/785
Not feeling heard “as soon as I said something it was like I used to do that” 68/798-799
Disclosure helped remove barriers “you have been there I trust you” 73/865
Sense of humour/playfulness “she would make jokes” 74/886
Disclosure speeding up of relationship development “she actually did understand” 75/898
Appendix 6: Sample of Super-ordinate Themes

Cluster 1: Therapist’s body, weight and shape
- Therapist’s appearance “how she looked” 8/75
- Fear of looking like therapist “that’s what I’m going to look like” 8/80
- Distrustful of intentions “she is going to try and make me fat” 9/86
- ED mindset “at that point anybody above a size 6 I thought was huge” 9/88
- Not wanting therapist’s body/recovery “if I recovered like she had that I’d be the same size” 11/112-113
- Disclosure unhelpful if therapist overweight “the whole recovery thing, she’s fat” 21/217
- Fearful of therapists’ recovery “the way she looked that I thought I don’t want be like that” 26/280-282
- Recovery means fat “well she’s had an eating disorder and she’s recovered and she looks like that” 26/285-286
- No-win situation “She wasn’t fat at all but at that point I saw her as huge” 26/286-287
- Influence of disclosure on how therapist’s body was perceived “it wouldn’t have been an issue” 27/290
- Ambivalence “looked fine like a normal woman” 35/393-394
- Awareness of therapist’s weight “looked a lot thinner” 43/485

Cluster 2: Helpful aspects of disclosure
- Identification “weren’t on your own with it” 3/23
- Easier to be open “a lot easier” 4/27
- Understanding “she gets what I mean” 7/62
- Identification “I’m not the only one” 7/63
- Understanding “she understood what it was like” 8/74
- Trust “I trusted her more because she had been there” 9/68
- Normalising of feelings “she showed me that it was normal” 10/100
- Reduced isolation “I’m not the only one” 21/213
- Attracted to what therapist had ‘fine, healthy and happy’ 30/336
- Strong therapeutic relationship “such a good relationship” 32/357
- Relatable experiences ‘she could relate to it” 33/367
- Hope “I sort of learnt that there is a better life than this” 37/411
- Inspiration “I rarely saw people that had recovered” 46/523
- Wanting what therapist had “that I thought you know want that” 50/584
- Motivation “give me all these reasons not to give up” 52/604
- Empathic understanding “she knew what I was going through” 55/641
- Understanding how difficult recovery is “she’s honest about it” 60/700
- Harder to trick/manipulate recovered therapist “she knows the tricks” 7/69
- Disclosure helped remove barriers “you have been there I trust you” 73/865
- Disclosure speeding up of relationship development “she actually did understand” 75/898
- Honest/thought love “she just said it how it was” 61/722
- Insider knowledge “I had so many little tricks and she knew them” 63/739
- Relatable experiences “she could relate to it” 33/367
Cluster 3: Negative impact of therapist disclosure

- Frustration “she thought we were both the same” 15/148
- Feeling dismissed “oh well I did that” 15/150
- Over normalising of feelings “oh its fine I did that” 15/151
- Too much about therapist experience “she was just making it about her” 16/160
- Therapist meeting own needs “this isn’t about you” 16/163
- Over disclosure “quite a bit saying what she used to do” 17/171
- Not feeling heard “my issues are different” 18/182
- One size fits all approach “I just felt like what works for you doesn’t work for everybody else” 17/178-179
- Angry with therapist/frustration “I just felt like saying it’s not about you” 18/181
- Details being destructive “I would pick up tricks from her” 21/219
- Timing “wasn’t in recovery mode” 21/225
- ED mind frame “I’d latch on to anything” 22/233
- Competition “one step ahead” 22/237
- Unhelpful knowing too much “what she used to do, how she used to feel” 20/207-208
- Spiltness of experience “it were like split into two” 20/210
- Contradictions “saying that you could get better, that’s what I didn’t believe” 23/248
- Tailored approach “she understood not everybody’s the same” 67/785
- Not feeling heard “as soon as I said something it was like I used to do that” 68/798-799
- Timing, not being ready for treatment “reluctant to get better” 6/48
- Ambivalent about disclosure “a part of me” 7/61
- Readiness to change “I didn’t want to get better” 10/103

Cluster 4: Protective factors on how disclosure was experienced

- Focus remaining on client “she didn’t make it about her” 31/348
- Strong therapeutic relationship “such a good relationship” 32/357
- Timing “I’m ready for this” 30/326
- Boundaries “we won’t make this all about me” 6/54

Cluster 5: The non-recovered therapist

- Increased hopelessness “brought back the whole I can’t recover” 60/703
- Disappointment “deep down I knew it wasn’t”[recovery] 60/709
- Was therapist recovered “she said I still struggle every now and again” 58/676
- Questioning therapist’s recovery “something clicked inside me” 43/480
- Increased hopelessness “bring back the fact that you can’t recover” 45/518
- Questioning recovery “her version” 39/442
- Ambivalence regarding recovery “I’m never going to be fully recovered and perfect” 42/477
- Questioning therapist’s recovery “it was just whether I believed what she was saying” 23/247
Appendix 7

Sample List of Shared Themes

Body shape and weight: therapist

“She had just given birth to a baby so I kind of was, her shape wasn’t the shape that I had expected it to be or whatever you know so, em I suppose initially I was kind of saying you know well okay I’m not going to look like that because I’m not pregnant but em you know it just put me off a bit I suppose initially and I just thought she was big and it was a little bit scary for me because that was obviously my fear” (Lucy: 1:7-15)

Attraction to what therapist had:

“She came across as such a lovely person, such a bubbly person and like a person who just seemed so so happy in herself like regardless and she was s kind of, everything about her, she wore such bright colours, her whole personality, like her clothes nearly reflected her personality that was with in you know and everything just seemed to e good for her you know and I suppose in that way I kind of built up the trust with her over a little while and I saw that she kind of came back to her normal shape or whatever and it looked like a real healthy shape and she just seemed so energetic and so motivated and had a great drive for life and I suppose in a way I aspired to be liked her” (Lucy:2:17-31)

Towards the end she looked fabulous absolutely amazing yeah and I saw she looked really really healthy and I didn’t see as much the fear in looking healthy. Absolutely I really felt you know she did look very healthy and really kind of comfortable with herself, most definitely she was you know and you I know I suppose in a way it put my mind at ease about looking healthy or looking well” (Lucy: 40:501-509)

Overweight therapist

“Like a big fear of mine is that if I eat normally, I will balloon up and I think that would have made me go ‘whoa, I’m not..’, I think that would have spurred that fear on and I think that could have pushed me in the opposite direction because I would think that’s recovery and if I return to normal eating I’m going to blow up” (Chloe: 29:327-335)

“Like if that’s recovery, then I don’t want it, then I’m not doing it” (Chloe: 30:336)

Skinny therapist

“It would have made me question whether she was recovered I would have been suspicious” (Chloe: 30:339-340)

Competition with thin therapist

“Instead of being a ally she would have been another person to compete with” (Chloe: 31:351-353)
“I would have been conscious of becoming heavier than she was and I would have hated it, like cause I do that anyway I guess but em yeah I would have found that really really difficult to kind of deal with so I would always have to keep that one step ahead of her continually”! (Chloe: 32:366-372)

Less credibility respect for underweight therapist

“If she was underweight I would have gone ‘well are you doing this, cause if your not I’m not going to’ and I think I would be a lot more sceptical about the whole thing. I think I would be a lot more reluctant to give things a go and I think I would have become a lot more sneaky as I have been in the past and just lied my way through” (Chloe: 33:373-380)

Overweight therapists/fear-inducing

“That’s what this is going to make me end up like and ‘I’m not doing it’ and I think again I would not have taken it as seriously but in a negative, a very negative strain, and it kind of would have been motivation for me to try, act out more frequently on old habits and behaviours and avoidance mechanisms to stop that from happening and I think that could have resulted in a step back as well” (Chloe: 35-36:401-410)

“I was attracted to people who were skinny because that was the way my head was thinking. Now if I was going to a counsellor and she was saying yeah now you know I had this and now I, say for example plump, now this has nothing to do, it’s my thinking, it’s where I am coming from, I wouldn’t be attracted you know what I mean, I would be like what, you are going to make me fat (yeah) whereas the what I was attracted to you know so if I thought that somebody was going to make me fat, I’d be like, I wouldn’t trust them cause I would think that they were going to make me fat do you know what I mean….Yes I don’t want that, I would say I don’t want that and I wouldn’t go anymore” (Emma: 16-17: 219-233)

“Even if it was that my therapist was visibly eating disordered, say on the anorexic side, and I thought she was extremely thin, that would be equally disturbing. I could imagine a competitive role between us if she was trying to get me to gain weight and then me seeing her at a certain level, yeah that would be weird and I’d sense that” (Emma: 18: 245-253)

“I think if I had a therapist who was, I would find it very difficult if they were very slim or overweight.” (Holly: 35: 469-470)

“And had a therapist who was very very overweight and I just couldn’t, it wasn’t because I was disgusted by her or anything but I just felt that THAT in itself is not, is a problem too so I felt how could this person help me em normalise my ideas around food and stuff like that, it was too difficult and likewise if someone was very underweight I’d be looking at her and going well this isn’t healthy either, you can’t really be in a position to sit in font of me and you know be helping me when obviously things aren’t balanced” (Holly: 35-36: 473-484)

Effect of thin therapist

“I think, I think that challenge would have been too much, I think there is enough of a challenge, for me there was so many issues to get over with trust and, really needing to trust the person I was working with and that they could support me and that you know when I was
falling that you know there was that kind of [pause] I don’t know, thing there. If I walked into the room and somebody was really thin and looked fragile, to I think that would have sent a message but also on the weight front, it would have been an additional challenge in something that was already really really difficult. I don’t think I would have been able to do it” (Holly: 41-42:552-566)

“I would have questioned how recovered she actually was. Very much so” (Holly: 43: 569-570) (if too thin)

“My thing was more so that this person cannot be healthy and therefore cannot be [pause] cannot sit there and provide me with or try and give me a balanced approach to things and help me out if they’re.. You know I wouldn’t trust what they were saying, yeah I couldn’t, I couldn’t trust it so em. Yeah it would have been the same thing if I had walked in and she was very fragile I wouldn’t think that she was doing what she was telling me to do yeah and you can’t you know it would be such an easy thing to walk out of a session and dismiss everything that had been said in that session or anything that they said or whatever’s gone on because at the back of your mind it will always be there” (Holly: 43-44: 582-597)

Attracted to what therapist has

“But she just glow literally you know and just her personality and aura that she gives out, just healthy, she just looks like, like when I was really poorly I was like if I was as thin as her I’d be happy because I say her as just she is just stunning that’s just what I saw her as” (Tara: 36: 415-420)

Importance of appearance

“It was definitely a major part definitely was. And I know that because my thinking is still quite poorly and I can manage my food but I’ve still got a lot to work on so even now the way I respond to people and to therapists is very much on how they look” (Tara: 37: 430: 435)

“I got on really well with her so it’s down, it’s definitely a lot related to how people look definitely. An it’s not in a judgemental way its not cause I would never judge anyone by there looks” (Tara: 38:446-449)

Overweight therapist

“I don’t think that my recovery would have been as good but I’d think well if that’s recovery well I don’t want to get like that. Recovery will make me fat, yeah that’s what I would have thought yea I mean now I know that someone has a healthy relationship with food they have a healthy body because some peoples bodies are bigger than others but if someone is really overweight then they could have possible gone the other way you know they could have gone from restricting to overeating and that’s what I would have thought” (Tara: 39-40: 453-465)

“And it’s a major fear because with the weight gain it’s the same as rejection, being a failure, a terrible person and all that. Its like its not just about weight gain, its about everything that come with it, its like if you are overweight you are literally going to fail in life your just not going to succeed at al. that what it feels like. If she was overweight it would scare me yeah it would, eh I’m not sure how I would feel now em I don’t know how I would feel about it now but like I said I’m not completely recovered yet but em I don’t know but I think it would scare
me because there is this major fear and like with eating disorders people want to get the psychological well like you want to feel good about yourself but you don’t want to put the weight on” (Tara: 40-41: 468-482)

**Thin therapist**

“That would be a case of well you don’t understand because you want me to eat and your slim so you can eat and I said that to hr when I was really poorly lie ‘o your so slim you can eat but I can’t cause I cant afford to put anymore weigh on” (Tara: 44: 514-519)

**Credibility**

“I would question how recovered she was, not just thin but very very skinny and underweight. I’d probably feel more angry with her. I think I’d feel angry because if I thought she wasn’t well than I wouldn’t have the respect for her but if I thought she was well but she was still that thin it would be resentment because I’d feel jealousy yeah it would be like why do you get to eat you don’t need to do all of the things that I have to do but yet you are that size.. It would be anger” (Tara: 46-47: 451-461)

**Thin therapist equals competition**

“I’ve seen a few therapists, well I’ve not seen personally but I’ve seen them around and they work with eating disorders and they are so slim and I know because of that I couldn’t work with them because I would get competitive” 50: 479-484)

“I couldn’t have a therapist that looked like she was still poorly because I would get ridiculously competitive and it would become a game I think, I think therapy would become a game for my eating disorder” 59-60: 487-491)

“If they are telling me to do something and I feel that they are not doing it I would feel they are trying to fatten me up or something and make me bigger than they are” (Tara: 51: 497-501)

**Ambivalence re hopes and body shape**

“There was like two sides to it that one parts of me would want to open up to her because she understood what it was like but another part of me was sort of cause it was how she looked as well cause she, she wasn’t fat but she were quite slim but still had like curves and I thought well if she’s had a eating disorder and is recovered well that’s what I’m going o look like so it was a bit of both sides at the time” (Ruby: 8: 72-81)

**Scared of looking like therapist**

“When I sat and thought about it like at first it didn’t register and then I though wait a minute if I sit and listen to everything she says, she is going to try and make me fat and I’ll get up like her because at that point anybody above a size 6 I thought was huge” (Ruby: 9:83-89)
Recovery means fat

“That was just the main thing that I was thinking about because if I recovered like she had that I’d be the same size and then you know, god forbid that would be the end of the world if I was over a size 6” (Ruby: 11: 111-115)

Scared of recovery

“I think that it was more the way she looked that I thought I don’t want to be like that, when I’m older I want to be tiny. I want to have such a flat stomach, be a size 0 and everything and seeing her and thinking well she’s had an eating disorder and she’s recovered and she looks like that. She wasn’t fat at all but at that point I saw her as huge” (Ruby: 26: 279-287)

Influence of disclosure on therapist’s appearance

“If she hadn’t have said that she was ill I would have seen her as a totally, her body wouldn’t have been an issue cause like every time I went in it was like, it seemed like she were getting bigger and I was like oh my god have you seen her legs and I couldn’t cope with being like that but I think if she hadn’t told me I wouldn’t have focused on it at all, it wouldn’t have mattered because like walking down the street you see fat people and I never thought of it like that but when somebody said that the had been like that, I was like wait a minute that’s what I’ll end up like” (Ruby: 27: 288-301)

Heightened awareness of therapist’s shape/recovery

“Like she was going on holiday for a few weeks and she got really toned up and she came in and I said you look a lot thinner and something clicked inside me and I was you know, …but she was just like no I just got in shape for holiday but I think in the back of my mind I thought she is not going to tell me if she is still ill because she knows how I’d react. But there was something’s that made me question was actually recovered” (Ruby: 43:482-497)

Thin therapist/overweight therapist

“Like a therapist that was tiny you know, all I’d be sat there is thinking how skinny are you, how tiny are you, I’d love to be like that and you’re sat there saying that it’s okay to put on weight, I think that would influence me and having somebody overweight I think would influence me as well because I’d be like you know I can’t, I can’t let myself get to that weight” (Ruby: 47-48: 543-551)
Appendix 8

Sample of coded transcripts

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<td>therapy came out as outcome</td>
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P: the first time I can't remember everything, cause I just blocked it out. I can't think of it like I can't remember but I think I was about ten and I had been seeing her for about three or four months and I'd go in and at this point I was just so reluctant to get better or acknowledge that I was poorly at this point and I just sit and say 'oh you don't understand, you haven't been there, you don't get it if you can't tell me what to do because you've never been there' and she said 'I have been there, I got what you mean, we won't make this session all about me but I've had an eating disorder I've been there and I've come out the other side'. I think that is the
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Appendix 9

Recruitment Poster

Exploring the Client’s Experience of Therapist Disclosure of Personal Recovery from an Eating Disorder.

While in treatment for an eating disorder, have you ever had a therapist disclose personal experience of an eating disorder to you?

Are you over 16 years of age?

If the answer is yes, would you be willing to share your experience?

I am conducting research into how therapist disclosure of personal recovery from an eating disorder is experienced by the client. The study aims to gain an understanding of your experience of its impact on you, the therapeutic relationship, the therapeutic process and outcome. I am interested in all aspects of your experience, including whether you find it helpful or unhelpful and what was it about the experience that made it so.

The research would involve an interview with me, which should last no longer than one hour. Confidentiality will be assured and you can opt out of the process at any time.

If you are interested in taking part in the research, please contact me by email on gabrielle.brady.1@city.ac.uk or on my mobile on 07850056623. If I am unable to answer, please leave a message giving your name and contact number and I will return your call as soon as possible.

Insight gained from this research will be of interest to the many therapists and counsellors with personal experience of an eating disorder that now work in the treatment of eating disorders. Your sharing of your experience will offer treatment providers valuable insight into the possible advantages and disadvantages of such self-
disclosure. As a result, they will feel more informed of effective use of self-disclosure in their work, which will be of benefit to them but, more importantly, will benefit the client!
I look forward to hearing from you.

Gabrielle Brady
Researcher: Gabrielle Brady
Research Supervisor: Dr Jay Watts
Professional Doctorate in Counselling Psychology - City University
Appendix 10

Information Sheet for Participants

INFORMATION SHEET FOR PARTICIPANTS

Research Project
• The proposed research plans to explore your experience of having a counsellor or therapist disclose to you that they have had personal experience of an eating disorder.
• The study aims to gain an understanding of your experience of its impact on you, the therapeutic relationship, the therapeutic process and outcome.

Procedure
• Upon meeting you will be asked to sign a consent form confirming your agreement to participate. You will also be asked to sign a consent form regarding the use of audio recordings. Both of these forms will have been sent to you in advance of the interview for you to read and consider.
• You will be asked to participate in a loosely structured interview that should not last more than one hour. In the interview you will be given the opportunity to share your experience of what it was like to have a therapist tell you that they themselves have had personal experience of an eating disorder. At some points during the interview I may ask some questions to clarify and explore some details of your experience a little further. You can decide not to answer any questions you are not comfortable with without providing a reason for doing so.

Possible Risks of the Research
Should you have any questions or require any information relating to the issues raised by the study, please do not hesitate to let the researcher know. It is recognised that the interview process could be distressing to some participants as sensitive material may be addressed. Should any of the material in the study cause you any anxiety or distress, please feel free to discuss this at any time with the researcher, both during and after the
interview. However, while acknowledging these possible risks it is fair to say that the majority of participants tend to enjoy the research experience! You will be provided with details of appropriate counselling services and other eating disorder specific services that can be contacted if necessary. Lastly, as stated on the Consent Form, should you at any point in the research process wish to withdraw you will be at liberty to do so without giving reason and you will in no way be compromised.

Professional Doctorate in Counselling Psychology - City University
Researcher – Gabrielle Brady Research Supervisor – Dr Jay Watts
Telephone: 07850056623 Telephone: +44 (0)20 7040 0143
Email: gabrielle.brady.1@city.ac.uk Email: jay.wats.1@city.ac.uk

City University
Department of Psychology
City University
Northampton Square
London EC1V 0HB
Appendix 11

Consent to Participate

CONSENT FORM

I consent to participate in the research project entitled ‘The Client’s Experience of Therapist Disclosure of Personal Recovery from an Eating Disorder’ conducted by Gabrielle Brady, a trainee Counselling Psychologist in the Department of Psychology at City University, London, and supervised by a member of staff of that Department (Dr Jay Watts, Department of Psychology, City University, Northampton Square, London EC1V 0HB, Telephone: +44 (0)20 7040 0143). The research will be conducted in all respects according to the Code of Ethics and Conduct of the British Psychological Society (2009).

The purpose of this study is to explore how participants experienced therapist disclosure of personal recovery from an eating disorder. The study aims to gain an understanding of the resulting impact on the participant, the therapeutic relationship, the therapeutic process and outcome. I understand that the only requirement will be for me to participate in a loosely structured interview that will take approximately one hour.

I understand that the results of this research will be coded in such a manner that my identity will not be attached to the information I contribute.

I understand that the results of this research may be published in psychological journals, but that I will in no way be identifiable in any such publication.

I understand that my participation is voluntary; that there is no penalty for refusal to participate; and that I am free to withdraw my consent and discontinue participation at any time without providing reasons.
I understand that this project is not expected to involve any risks of harm any greater than those involved in daily life, and that all possible safeguards will be taken to minimise any potential risks.

If I have any questions about any procedure in this project, I understand that I may contact the researcher via email at gabielle.brady.1@city.ac.uk or via telephone on 07850056623.

In the case of wanting to make a complaint, my research supervisor can be contacted as follows:

**Supervisor for Doctoral Research:**
Dr Jay Watts
City University
Department of Psychology
City University
Northampton Square
London EC1V 0HB
Telephone: +44 (0)20 7040 0143
Email: jay.wats.1@city.ac.uk

Signed (Participant)
........................................................................................................Date..........................

Name (Block Letters)
..........................................................................................................................

Signed
(Psychologist)........................................................................................................Date...............
Appendix 12: Consent to Audio Recording of Interview

CONFIDENTIALITY AGREEMENT ON THE USE OF AUDIO RECORDING

This agreement is written to clarify the confidentiality conditions of the use of audio recording by Gabrielle Brady for the purposes of psychological research.

The participant gives Gabrielle Brady permission to audio record the interview on condition that:
- The permission may be withdrawn at any time
- The tapes are used solely for research analysis by Gabrielle Brady
- The tapes will not be heard by any other person other than Gabrielle Brady unless shared in confidence with the research supervisor or the DPsych Examiner
- The tapes will be stored under secure conditions and destroyed at the appropriate conclusion of their use
- This agreement is subject to the current Code of Conduct and Ethical Principals of the British Psychological Society and adherence to the law of the land in every respect

I have read and understood the above conditions and agree to their implementation.

Signed (Participant)
.................................................................Date..........................

Name (Block Letters)
.................................................................

Signed
(Psychologist).................................................................Date...............
**Appendix 13**

### Psychological Resource List

**RESOURCE LIST**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Contact Details</th>
</tr>
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<tbody>
<tr>
<td>Keith Chopping</td>
<td>Fleet Street Practice 89 Fleet Street London</td>
<td><a href="mailto:kchopping@aol.com">kchopping@aol.com</a></td>
</tr>
<tr>
<td>Gill Dunbar</td>
<td>32A Llanvanor Road Childs Hill Barnet London (North) NW2 2AR England</td>
<td>020 8201 9062 <a href="mailto:gilldunbar@aol.com">gilldunbar@aol.com</a></td>
</tr>
<tr>
<td>Carolyn Hall</td>
<td>175 Portland Road Kensington and Chelsea London (North) W11 4LR England</td>
<td>020 7229 2132 <a href="mailto:carolynhall2000@yahoo.co.uk">carolynhall2000@yahoo.co.uk</a></td>
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<tr>
<td>Caroline Goldblatt</td>
<td>4 Holt Close Muswell Hill London N10 3HW England</td>
<td>0208 350 3784 <a href="mailto:caroline@thesafespace.co.uk">caroline@thesafespace.co.uk</a></td>
</tr>
<tr>
<td>Matthew Campling</td>
<td>Campling Therapy Islington London (North) N1 1HR England</td>
<td>07949831005 <a href="mailto:macamffll@tiscali.co.uk">macamffll@tiscali.co.uk</a></td>
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<tr>
<td>Rachel McGuire</td>
<td>CCPE, Beauchamp Lodge 2 Warwick Crescent London W2 6NE England</td>
<td>07960672838 <a href="mailto:rachmc70@yahoo.co.uk">rachmc70@yahoo.co.uk</a></td>
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<tr>
<td>Amy Alexander</td>
<td>Muswell Hill Haringey London (North) N10 1PB England</td>
<td>07837627234 <a href="mailto:greendoortherapy@gmail.com">greendoortherapy@gmail.com</a></td>
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<tr>
<td>Francesca Hall</td>
<td>4, Marty’s Yard 16, Hampstead High Street Hampstead London (North) NW3 1QW England</td>
<td>07792 857118</td>
</tr>
<tr>
<td>John Colverson</td>
<td>14 A, Annette Road, London N7 6EH England</td>
<td>07957318423 <a href="mailto:jajcolverson@aol.co.uk">jajcolverson@aol.co.uk</a></td>
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<tr>
<td>Diana Battle</td>
<td>108 Jeddo Road Hammersmith and Fulham London (North) W12 9EG England</td>
<td>020 8740 6216 <a href="mailto:dianabattle@gmail.com">dianabattle@gmail.com</a></td>
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<tr>
<td>Laura Farleigh M.A</td>
<td>35 Windermere Avenue Finchley Barnet London (North) N3 3QX England</td>
<td>020 8346 5507 <a href="mailto:lfar@windermere.demon.co.uk">lfar@windermere.demon.co.uk</a></td>
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<tr>
<td>Helen Hayes</td>
<td>81 Diana Road Waltham Forest London (North) England</td>
<td>07790 330514 <a href="mailto:helen_hayes098@yahoo.co.uk">helen_hayes098@yahoo.co.uk</a></td>
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<td>Email: <a href="mailto:help@b-eat.co.uk">help@b-eat.co.uk</a></td>
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Appendix 14

Sample Transcript Extract

R: What was your attraction when you saw my research topic? What kind of prompted you to get in touch?

Just because em.. I’ve been ill for a very long time and the changes that have happened in my recovery are just unbelievable, like I literally cant believe the changes and its through the changes that I’ve made that has made me want to go into being a therapist for people with eating disorders and its research about what I want to do cause I will be recovered and I hope that that will help people. So it was just that really..

R: So, what has your experience of therapy been like overall? You said you have been sick, very sick for a couple of years, so it’s been an ongoing thing.

I started to, I was ill when I was eight, I’m now 23 and I didn’t get any treatment until I was 21. Em when I was 11 people started to find out about it but nothing was done about it, I wasn’t given any treatment eh so when I asked for help I was 21 and I have funded my own treatment since then and eh my therapist disclosed that she had an eating disorder in the past but she was now well and that to me was amazing that cause, when people, people having found out that I had an eating disorder when I was 11 and then kind of like, it was just something that I did you know what I mean.. It was just me identity, I was just the girl that didn’t eat and things like that and then it gradually got worse and I started being sick and everything and I got more poorly but nobody really noticed it was just, I had just faded into the background em.. And then when I disclosed that I had an eating disorder when I was 21 and I said I needed help and end everyone was like you never get well from an eating disorder, you can never abstain from food. If you’re an alcoholic you just don’t drink you don’t go to pubs but you have to face food every single day so everyone was saying to me you won’t get well, you will manage it but you won’t get well. And em so to hear my therapist say that “I am not well’.. Its just s inspirational and I know for a fact that I wouldn’t have got well without her, I know for a fact cause just, if you think that you are not going to get well from it there is just no point in battling it, cause its just such a heard battle. Like the stage I’m at now, I can manage my food but I’ve still got a bit further to go and to think that I will be
stuck here forever.. I’d rather be ill. Cause it’s too hard, I’d just rather stay ill and live with it. So to know that I can get through to the other side.. It’s really inspirational.

R: So, it gives you hope that it is possible.

Yeah definitely, yea

R: And did you ask her had she been ill or were you suspicious of anything or was she very open from the start?

She introduced herself as an ex sufferer, so didn’t go in for like loads of detail em she’d sort of say if I expressed that I was feeling a certain way she would say its normal I felt like that, other people have felt like that but em she doesn’t go in to great detail. But em.. She ran a support group and private therapy and she introduced herself in the support group as an ex sufferer and so everyone could kind of see that she was well and you could see it as well you can tell because there is other people that I know have had eating disorders and say that they are well but you can still kind of tell that they are not all the way there but with my therapist you can tell, you could just tell.

R: How could you tell?

Things like.. Its just when you’ve had an eating disorder its so easy to tell if someone is not well. You pick up on the smallest thing, like the way people are around food, the way they look at it, the way.. Even like their body posture around food they way they try to feed other people and she is just really normal around food and especially if you have got an eating disorder or have had one, put in with other people cause its that competitiveness that you have got to eat less than them.. so you can pick it up really easy.

R: Do you think that if she didn’t disclose from the start that she was an ex sufferer that you would have been able to pick it up from her?

Eh.. See I don’t know. I think.. People say if you have had an eating disorder that you can always tell but I don’t think you can.. Like now to see her around food you would never guess but if someone has not quite made it to recovery you can tell because of the way the are
around food. I think once you are fully through recovery its just not a issue to you it just, its like when you have got an eating disorder it is such a big issue its like its just.. Yeah and you can just tell. Em like people said to me that even I can tell by the look on their faces if someone has freedom from food whereas someone that has recovered they don’t have that kind of anxiety around food, so I think if someone is recovered I don’t think I would be able to tell but if it is still there, I can tell, but you can definitely tell has an understanding of it if she’d definite.. She got it like I could say things that other people would think is totally crazy but she got it and I think that’s proof that she has been there..

R: So, that would have given it away that she knows. Where is she getting this from? How does she know that?

Yeah.. Cause I think people don’t generally get it. If they have not been there they can’t understand why you can’t eat a salad and they’re like ‘its lettuce why can’t you eat it” they don’t get it but she did.. She got it.

R: Did she tell you what kind of eating disorder she had?

Yeah em. She disclosed that to me because when I was in therapy with her she was kind saying what I’d been through cause when I was eight I had binge eating disorder then anorexia to bulimia and she was saying to me that she had been through the same stages em so she was just sort of saying how she could relate to what I was saying em so yeah..

R: How did that make you feel?

It made me feel that there is light at the end of the tunnel, because to see her she had such a healthy relationship with food and like.. Because like.. I suppose people think when you have recovered you either eats loads of chocolate and crisps all the time or you live on like salads and stuff but she had like a mix of both because she wants.. She let herself have things that she likes but she wanted to put good things into her body so she’d eat like vegetables and healthy things cause she wanted to look after her body now and that’s different to only eating lettuce because you can’t allow yourself something else.. It’s different.

R: So, she had a freedom around food?
Yeah she had a lot of freedom, you can tell she was at peace with herself, yeah she. And you can tell even by the way she walked, the way she holds herself like you can tell of someone got really low self esteem and she just.. yeah, she gave me hope that when she does.. gives me something to aim for (Yeah) that you don’t need to settle for a certain stage that you can go beyond it.. Yeah cause I’ve had a couple of friends who I though had been recovered and I started spending time with them and its turns out from what I’ve seen of them that they are not actually completely recovered yet. So that kind of disheartened me and I went to therapy and said I don’t know if I can get through this and she was like ‘you can’ you definitely can. And she is just really brave, what she been through and its such a common, like people. Everybody thinks that you can’t come through an eating disorder and that as soon as a problem happens.. Like you’ve relapsed but that’s not true because if you work through all the emotional stuff properly and you get through it then just because something happens you are not going to want and go self-destruct, you are not going to want punish yourself and its different you deal with it in different ways and its very much about like the way you think, the emotions and stuff so if you work through that properly and get actually to recovery then you won’t...

R: So, she has really given you hope that it is possible and you can do this...

Yeah cause I’d only been in treatment 18 months and even 18 months ago I was very very poorly and like now I’m a completely different person. Like I couldn’t even hold a conversation with people cause I was too poorly I didn’t get any chance to, she just gave me that goal and its literally her recovery that has done that for me and its really disheartening to look at my friends when they tell me they’re recovered and then I find out that they are actually not. That’s really disheartening and I think as well to know that someone has been there and got through it.. Its like.. If I had a therapist that had never been there I’d be like you don’t get it, cause you have never been there you don’t know what it is like

R: Because you think it’s such a hard thing to understand unless you have been there?

Yeah like cause my friends say to me if they’ve not been there they can’t understand it, like they don’t get it and I suppose its understandable because I don’t really understand why people do drugs and stuff and so everyone can’t understand it but I think its definitely
definitely helps me now and like I’m volunteering for a support group now and it seeing all the help that she given people that inspired me to go into nursing because I used to be a dancer em but I went into dancing to loose weight as part of the illness, for all the wrong reasons and I pushed myself to the max, like I went to full time dance school, I qualified I this this and this, basically I did everything and then I went to the support group, she was recovered, she was helping people, she was doing this this and this and I was like that’s what I want to do and it just completely inspired me, completely and I know that as one of my goals if I want to help other people through it I need to be well. Whereas if I wanted to stay as a dancer I wouldn’t need to be well, cause I’d been dancing for years and years while I was ill and no one noticed that I was ill so I got away with it but it gave e like a goal for the future as well. As well as like recovery and being well, she gave me like for my career, my future my life..
Appendix 15: Ethics Release Form

Ethics Release Form for Psychology Research Projects

All trainees planning to undertake any research activity in the Department of Psychology are required to complete this Ethics Release Form and to submit it to their Research Supervisor, together with their research proposal, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- Trainees are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff.

Section A: To be completed by the student

Please indicate the degree to which the proposed research project pertains to:

BSc □ MPhil □ MSc □ PhD □ DPsych □ N/a □

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project
   Exploring the Client’s Experience of Therapist Disclosure of Personal Recovery from an Eating Disorder using IPA.

2. Name of student researcher (please include contact address and telephone number)
   Gabrielle Brady, 221 The Ridgeway, North Harrow, Middlesex, HA2 7DA

3. Name of research supervisor
   Dr Jay Watts

4. Is a research proposal appended to this ethics release form? Yes

5. Does the research involve the use of human subjects/participants? Yes Np
   If yes,
   a. Approximately how many are planned to be involved? Six to eight
b. How will you recruit them? Through posters at support venues, BEAT and Bodywhys websites, word of mouth.

c. What are your recruitment criteria?

To be eligible to participate in the study, participants will have to be over 16 years of age, have received specialist treatment for an eating disorder and while receiving treatment they will have had a therapist disclose personal experience of an eating disorder to them. Participants will be excluded if currently very distressed or acutely ill or underweight. Participants will also be excluded if they are currently in or are less than three months out of individual counselling or psychotherapy

(Please append your recruitment material/advertisement/flyer)

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent? No

e. If yes, will signed parental/carer consent be obtained? Yes No

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Participation in a semi-structured interview lasting approximately one hour.

7. Is there any risk of physical or psychological harm to the subjects/participants? No

If yes,

a. Please detail the possible harm? ------------------------------------------

b. How can this be justified? ------------------------------------------

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details? Yes

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person’s treatment/care be in any way compromised if they choose not to participate in the research? No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research? Yes

(Please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)
Audio recording and transcript of interview. Consent form.

12. What provision will there be for the safe-keeping of these records?

All audio files and transcripts will be stored in a pin protected folder on a personal password protected laptop. All consent forms and any other printed material will be stored and locked in personal filing cabinet.

13. What will happen to the records at the end of the project? 

All audio files and records will be destroyed at the end of the project.

14. How will you protect the anonymity of the subjects/participants?

Any identifying information will be changed in the transcript to ensure anonymity.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

All participants will be given the opportunity to speak with me (the researcher) to discuss any concerns or questions they have both before and after the research. All participants will also be given a list of contactable psychological resources at the end of interview.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in bold print, please provide further explanation here:

The participants full name and GP contact details will be sought from all participants prior to the interview. A confidentiality contract will be discussed with all participants where they will be informed that confidentiality will be breached if I believe that they are a harm/risk to themselves or others. If a participant discloses high levels of distress or suicidal thoughts, contact will be made with their GP and who will involve the practice crises team as necessary.

Signature of student researcher: Gabrielle Brady Date 22 March 2010

Section B. To be completed by the research supervisor

Please mark the appropriate box below:

☐ Ethical approval granted
☐ Refer to the Department of Psychology Research Committee
☐ Refer to the University Senate Research Committee

Signature _____________________________ Date 7/4/16
Section C. To be completed by the 2nd Department of Psychology staff member
(please read this ethics release form fully and pay particular attention to any answers on the
form where bold items have been circled and any relevant appendices.)

☐ I agree with the decision of the research supervisor as indicated above

Signature: ___________________________ Date: 10/14/10
Section D: Combined Client Study and Process Report

Collaboratively Uncovering Core Beliefs that Inhibit Change in Behaviours
Introduction

Bennett-Levy and Thwaites (2009) suggest that critically reflecting on one’s therapeutic practice is an important aspect of a therapist’s therapeutic training and is central to the development of their therapeutic skills. Through this report, which combines features of both a case study and process report, I hope to show my reader the macro and micro elements of my practice with the patient presented and demonstrate my development in working collaboratively with my clients in acknowledging and incorporating new relevant information and reformulating when necessary, which are elements central to Cognitive Behavioural Therapy for Eating Disorders (CBT-E) (Fairburn, Cooper & Shafran, 2008). In addition, I hope to show my ability to work with complex case presentations, link relevant psychological theory with my clinical practice and demonstrate awareness of the therapeutic process.

Along with presenting a progressive stage-by-stage view of the therapy, I will also include and reflect on a ten-minute segment from one of our sessions. Before commencing therapy, the client was informed of my role as a trainee Counselling Psychologist, the service’s confidentiality policy and consent to digitally record our sessions was obtained. In order to maintain client confidentiality, all identifying information was changed. The pseudonym Sam has been given to the client.

The Therapeutic Model

Adapted forms of CBT are recommended by the National Institute for Clinical Excellence (NICE) for the treatment of Bulimia Nervosa and binge eating disorder patients as it has shown to be the fastest, most effective form of psychological intervention for these presentations (Fairburn & Harrison, 2003). It is now well recognised that the eating disorder patients tend to migrate across diagnosis (Fairburn & Harrison, 2003) and, as such, the most effective clinical approach is to focus on cognitions, emotions and physical states that relate to the individual’s restrictive and bulimic behaviours, as they may have both forms of eating pathology and commonalities in their interaction. In response to this, Fairburn, Cooper and Shafran (2003) developed the “transdiagnostic” CBT model of eating disorders. It is based on the understanding of the core pathology of patients presenting with a wide range of disturbed eating patterns (Waller Cordery, Corstophine, Hinrichsen, Lawson,
Mountford & Russell, 2010). It centres on the beliefs relating to the overevaluation of shape, weight and eating and other cognitive, emotional, physical and behavioural aspects of eating disorders how these are understood in terms of how they lead to and maintain these cognitions (Waller et al., 2010). It links cognitions, emotions and behaviours regardless of the diagnosis (Waller, 1993; Fairburn et al., 2003).

Central to CBT-E is the formulation of the processes that maintain the client’s psychopathology and it plays a crucial part in treatment as it identifies elements that need to be targeted for change to occur and be maintained (Fairburn, 2008). As such, the therapist aims to construct a customised formulation at the beginning of treatment that is adjusted and revised to include additional factors and information when necessary.

In its broadest version CBT-E addresses mechanisms that are “external” to the core of the eating disorder but still play a key role in its maintenance (Fairburn et al., 2008). Attention in treatment is also given to clinical perfectionism, low self-esteem and interpersonal difficulties. It has much in common with other empirical supported forms of CBT as it is concerned with the processes that maintain the psychopathology, with importance given to the cognitive processes. It uses cognitive and behavioural strategies and procedures combined with the necessary psychoeducation (Fairburn et al., 2008).

Geller, Williams and Srikameswaren (2001) advocate the “curious clinician” stance when working within a CBT-informed approach with eating disorders. They suggest the relationship should foster self-acceptance, be active rather than passive, involve curiosity and a willingness to learn from the client, be transparent and be collaborative and based on the premise that the client is responsible for change.

Organisational Context and Referral

Sam was referred by her GP to the NHS multidisciplinary specialist eating disorder service where I work. She was initially assessed by one of our psychiatrists who then referred her to the psychology team for assessment and, if deemed helpful and appropriate, treatment. My sessions with Sam took place in our outpatient wing. Sam attended monthly reviews with one of the service’s specialist medical doctors throughout her time in the service. In addition, Sam attended two outpatient appointments with one of the service’s dieticians.
Client Profile
Sam was a 27-year-old white British woman. Her parents separated when she was 16. Her mother is a medical doctor and lived in the midlands and her father was self-employed and lived in the North of the country. She has one sister who is two years younger. Sam described her relationship with both her parents as “superficial”. She is close with her sister, but describes feeling “jealous” and “envious” of her. Sam lives in a flat-share in North London with two others. She was not in a relationship. She described herself as having many friends but no best friend. Sam is working as a newly qualified primary school teacher in a challenging school. She found the job extremely stressful and had been working 12-hour days. Before commencing teacher training, Sam studied science at university and after graduating she spent some time working in a laboratory for a pharmaceutical company. She described feeling unfulfilled and let down by the role and hoped teaching would help her feel more “satisfied”.

Presentation
Sam attended our session punctually and was always smartly and fashionably dressed. She appeared stressed and anxious and was initially apprehensive about adding to her workload by taking a morning a week off to attend our meetings. However, she relaxed as the sessions progressed and maintained good eye contact. I felt we built a good rapport and she was engaged in our sessions.

Initial Assessment and Presenting Problem
The initial focus of our work together was to carry out an extended assessment to work towards a psychological understanding of her difficulties and address her commitment to change. In line with what Fairburn (2008) suggests, this allowed me to create a bespoke tailor-made treatment to fit with the individual patient’s evolving psychopathology and flexibly change with it. The service I worked in allowed for four assessment sessions, which we utilised to assess and formulate her difficulties and engage in some motivation enhancement work. The outcomes of these sessions will now be detailed.

Sam had an 11-year history of Bulimia Nervosa. At the time of the initial assessment she was bingeing two to three times per week. If she thought she would be unable to restrict or exercise in order to compensate for the binge the following day, she would
make herself sick, so “it’s done with”. Reasons for bingeing included boredom; if she had the opportunity; if she was feeling tired, unhappy, or negative; or feeling rejected by others. We also acknowledged that restricting her diet leaves her at risk of bingeing. She described eating quickly during a binge and being “zoned out” and not aware of anything. She would eat until the food runs out or until she “cannot eat anymore”. After bingeing Sam described feeling ashamed, guilty, dirty, hopeless and antisocial and would shut herself off from “everyone and everything” until she was “over it”.

Sam had significant weight and shape concerns. Her weight at assessment was 59.5kgs and her height is 1.76m, giving her a BMI of 19.2, which was slightly in the underweight range (Healthy BMI 20-25). Sam reported she was menstruating normally. She was accepting of this weight, although she was anxious that she was close to the top end of what feels acceptable to her. She was anxious not to go above 60kgs. To manage her anxiety, she had been regularly weighing herself and repeatedly checking her body in the mirror. She felt she looked “hideous” after an episode of bingeing and she would become irritable and snappy with those around her. This helped to reinforce her belief that she is not a good person and increased feelings of guilt.

Sam found social situations difficult because she felt preoccupied and distracted by her eating problems. She felt unable to relax as she felt she was always “putting on an act”. She was very concerned about what other people thought of her and believed she was “boring”, “not funny enough” or “not good enough”. Her fears of being judged negatively or being rejected meant that she shared little information with others and therefore found it hard to get close to people and form relationships, which left her feeling somewhat lonely and isolated. Sam felt she had not learnt how to relate to others and had missed out on “normal development” as a result of her difficulties with eating.

Sam was feeling unsatisfied with many areas in her life. She recognised that she was continually striving for something that is unachievable. Because of her preoccupation with her own shape and weight, and her own perceived flaws or inadequacies, Sam was vigilant about these in others too. This made her feel that she is not a nice person, who is “selfish, jealous and judgemental”. She found it hard to have more realistic standards and expectations and to be kinder and more accepting of herself and others.
History and Development of Problems
Sam’s eating difficulties began at the age of 16 whilst studying for her GCSEs partly in relation to her anxiety about her studies and pressure to do well and partly in relation to an increasing dissatisfaction with herself and her weight. Initially, she was very restrictive and lost a lot of weight quickly. She reported that her weight dropped to 44kgs and her periods stopped. This episode lasted a few months before she began bingeing and vomiting and developed a bulimic presentation.

Sam felt that her mother and sister had always eaten in a controlled way which had the effect of making her feel that she was eating too much and was being greedy. As she felt ashamed of her appetite, she controlled her eating when around them but would overeat in secret whilst at school or away from home. Sam felt that being slim and attractive was always important to everyone in her family and that they always tried to project the perfect image.

Sam felt abandoned and rejected by her father when he moved to the Czech Republic when she was 11 years old. She would strive to please him and make him proud so he would “value” her. In many ways she continued to seek his approval and was often left feeling disappointed and as though she hadn’t done well enough. Sam reported that her father was abusive towards her mother and then her when she would try to intervene. She felt uncared for and unprotected by her mother and feels that her mother favoured her “perfect” sister. Sam sought a close relationship with her father but felt she didn’t live up to his expectations.

Formulation
Bulimia had served some powerful psychological functions for Sam. Bingeing and compensating through dieting and vomiting served as a way for her to try to manage difficult thoughts and feelings and to escape temporarily from life, responsibilities and relationships. Her eating disorder became a way for her to try and escape feelings of being unlovable and to protect herself from rejection and loneliness, but had resulted in her ultimately becoming more isolated and feeling worthless. It had also been a way for her to try and feel better about herself, more confident in her appearance and gain approval from others. As Sam valued her self-worth on her weight, shape and control of these, she was often left feeling disappointed and as though she had failed. As a result
of her preoccupation with food and eating, her over-evaluation of the importance of food and weight and her over-evaluation of achieving and striving, other areas of her life have become marginalised and interpersonal deficits had developed which had further reduced Sam to seek safety in her eating disorder, leading her to feel caught up in a cycle. Although her eating disorder provided Sam with comfort and security, it had come at a huge cost. She was keen to make changes and develop more adaptive coping mechanisms and strategies. Psychologically she was insightful and had made good progress. At the end of our assessment Sam was feeling motivated to develop a healthier relationship with food and eating and her weight and shape.

**The Therapeutic Plan**

Sam’s initial goals of treatment were as follows:

- To develop and maintain a regular pattern of eating
- To stop bingeeing
- To learn more adaptive ways of managing her emotions.

In our assessment sessions we had discussed a goal of reducing bingeeing as opposed to stopping completely as she stated. I didn’t want her to dismiss any progress made if this goal wasn’t achieved. Sam understood this but explained that she needed to strive to be binge-free as she felt that having a goal to reduce would permit her to continue to binge. As such, we agreed to leave her goal as she wanted and we agreed to proceed with psychological treatment using a CBT-informed approach, meeting for a maximum of 20 sessions with a review after six to assess progress.

The cognitive behavioural theory of the maintenance of Bulimia Nervosa suggests that if treatment is to have a lasting impact on a patient’s binge eating and purging, treatment also needs to address the patient’s extreme dieting, their over-evaluation of shape and weight and any tendency for their eating to change in response to adverse events and negative moods (Fairburn, 2008). As such, when developing the initial therapeutic plan that would act as a preliminary structure for our sessions together, Sam, my supervisor and I agreed that it would be aimed to target these elements of Sam’s presentation.
Figure 1: Formulation Diagram

Over-evaluation of shape & weight and their control

Strict dieting & exercise

Events and associated mood changes

Binge eating

Compensatory vomiting & exercise

Over-evaluation of achievement & striving

Pursuit of personally demanding standards in valued areas of life

Marginalisation of other areas of life
Main Techniques Used
In the beginning stages of my work with Sam it was important to formulate the development and maintenance of her difficulties, which I have presented above (Fairburn et al., 2003). Psychoeducation on the various elements of her bulimia along with the cognitive approach to bulimia and its treatment was incorporated (Cooper et al., 2000; Garner, 1997). Self-monitoring was introduced to help identify precisely what was going on for Sam throughout each day. This was useful in helping to assess her current eating patterns and her thoughts and feelings around her bingeing and vomiting episodes and proved very helpful in identifying the link between mood states and bingeing (Fairburn et al., 2003; Fairburn, 1997). Meal planning and regular eating was introduced, as Fairburn (2008) suggests that it is a reliable method for quickly reducing the frequency of binge eating. Self-monitoring around regular eating also helped highlight thoughts, beliefs and values that were contributing to the maintenance of her bulimia. I introduced Sam to “cognitive biases” and she was able to recognise her tendency to think in distorted ways, e.g. all or nothing terms (Salkovskis, 2002). Cognitive restructuring techniques were used throughout our sessions to help Sam develop healthy, balanced thoughts. Sam found the use of thought diaries helpful in challenging the thinking that maintained her overevaluation of eating, weight and shape and the thoughts that directly triggered binge eating and purging. Episodes of bingeing and purging were explored to identify points where Sam could have intervened or done things differently. A list of alternative activities to bingeing was also developed (Cooper et al., 2000).

As our assessment and formulation identified that Sam’s bingeing and purging behaviours serves to help her manage her emotions, time was spent introducing her to emotional management and its various stages and techniques (e.g. self-soothing). Behavioural experiments were collaboratively devised to challenge her food avoidance and support work on Sam’s eating behaviours, perfectionism, self-esteem and emotion regulation (Fairburn et al., 2008; Linehan, 1993).

The end stages of the therapy involved the bringing together of the work done and techniques learned, with the focus shifting to the future to help ensure changes were maintained and to minimise the risk of relapse (Fairburn, Cooper & Shafran, 2008).
The Pattern of Therapy Leading up to Segment and Key Content Issues

Sam engaged well in our sessions and there were no unexpected breaks in the treatment. She was quickly able to get into a routine of regular eating. This appeared to have an immediate effect in reducing her urge to binge as Sam found she was no longer coming in from work “starving”. Sam was also reassured by the in-session weekly weighing which helped in directly challenging her fears regarding eating and weight gain (Cooper et al., 2000).

It was evident early on that Sam had difficulty in recognising and regulating her emotions, as events and moods were contributing to the maintenance of her eating disorder. Her binge eating and vomiting were acting to help her cope with negative events and moods. Along with binge eating acting as a distraction for her troubling thoughts, along with vomiting this had a direct mood-regulating effect as they dampened down her intense mood states (Fairburn et al., 2003). Sam’s diaries and monitoring sheets showed she often felt overwhelmed, stressed, anxious and angry. Sam was doing well and remained binge-free for a period of over two months. This had been her longest period binge-free since her bulimia began. During this period, we noticed an increase in emotional outbursts directed at those around her. This further highlighted the need for Sam to learn and practice emotional regulation skills. As such, we began to work towards the goal of helping Sam to deal with events and moods directly and effectively without their influencing their eating (Fairburn et al., 2003).

With this, Sam’s perfectionist tendencies could be seen in the expectations she was placing on herself at work. Feelings of failure and not being good enough came through strongly. As she was a newly qualified teacher, she underwent regular evaluations and Sam was hyper-vigilant to perceived lapses or slips in her standard of work. This constant striving and fear of failure caused Sam a lot of stress and anxiety and drove her to work very long hours and spend an excessive amount of time preparing lessons. This left Sam with very little time for pleasurable activities, which was also impacting negatively on her moods. As Sam’s negative mood states were often influenced by stress she experienced at work, I hoped an improved work/life balance would benefit Sam in many ways. Behavioural experiments allowed Sam to test her negative predictions about just being “good enough” (Shafran et al., 2002). Sam was encouraged
by a noticeable lift in mood, and having more time to spend with friends allowed her to experience feedback which positively affected her self-esteem.

Fairburn et al.’s (2003) “self-evaluation pie chart” was useful in highlighting the importance Sam placed on her eating, weight and shape and her ability to control these. Sam was aware that these areas were important to her but was less aware of how this led to a marginalisation of other areas in her life. Socratic questioning helped me show Sam how her current means of self-evaluation lead her to put “all her eggs in one basket” and that the use of eating, shape and weight as her main means of self-evaluation was costly, difficult to achieve and maintain (Waller et al., 2010) and that others means or strategies are necessary for a healthy concept of self-worth (Fairburn et al., 2003; Waller et al., 2010). Cognitive restructuring techniques and behavioural experiments were used to modify her cognitions regarding eating, weight and shape and associated behaviours. In addition, as the over-evaluation of eating, shape and weight and ability to control these are core psychopathology underlying eating disorders (Fairburn, 2003), progress in these areas was reviewed on a regular basis.

**Practice and Process**

**Lead Into Segment**

The segment presented below is taken from our 11th treatment session together. In our previous session, the fact that we were half way through the treatment was highlighted. It was half term, so Sam had returned home for the week, therefore there was a break of one week before the session presented. As I mentioned earlier, Sam had been managing to remain binge-free over the last two months. During our review of how things had been since we last met, Sam informed me that she had had a difficult time over the break and she had binged and purged on three occasions. She was upset and described feeling disappointed. While validating her feelings of disappointment I explained that lapses can and do occur. We spent time reviewing her logs and diaries with her for the purposes of doing a “binge analysis” to reflect on what had triggered the binges and what could be learned from them (Cooper et al., 2000). This led to an emotional discussion around her relationship with her mother and how she felt unloved and unprotected by her when her father was physically abusive towards her. The following segment begins in the 38th minute of the session. It had been an emotional and difficult session for Sam and we had begun reviewing thought diaries she had completed.
between sessions. The segment begins with us exploring a situation and particular thought she struggled to evaluate and challenge.

**Transcript and Commentary**

CL.1: It’s almost like I didn’t want to put anything there *(Yeah)* you know cause..

CP.1: **It does seem like you like punishing yourself, like that you wanted to make yourself feel bad, you wanted.**

Comm.1: *I wanted to express empathy and convey to Sam that I was “with” her. Hardy, Cargill and Barkham (2009) and Grant, Townend, Mills and Cockx (2008) suggest that empathy and accurate attunement to the clients experience is an important element in CBT as it contributes to strengthening the therapeutic relationship and improved therapeutic outcome. At CP.1 I tried to do this by providing Sam with my sense of what she was doing using my own words (Gilbert & Leahy, 2009). However, on reflection I am frustrated with myself for interrupting here. It would have been better to stay with Sam’s experience before giving my reflection of the situation. A part of me does regret using the word “punishing” here as I feel it was too strong a word. But I do feel my reasoning or motivation was correct and I don’t feel that Sam received it as being harsh.***

CL.2: It was almost like “Oh look it’s true, I am going to end up alone” *(uh hu)* which is not helpful obviously but..

CP.2: **But it’s useful to recognise that, the fact that you kind of almost didn’t try as hard for something in this column? And I guess it would be useful to spend some time reflecting on why you think that it?** (Pause)

Comm.2: *I am glad Sam was able to continue with what I think was her original that I cut short at CP.1. Here, it might have been helpful to highlight to Sam that she was engaging in some of the unhelpful thinking styles we had discussed in previous sessions *(e.g. catastrophising)* (Westbrook, Kennerely & Kirk, 2007). However, I sensed from Sam’s tone and delivery that she was already aware of this and I wanted to stay with what we were discussing, and I was realising that this had the potential to be an*
important moment in the therapy as we were beginning to uncover something that has
been acting as a block to change.

CL.3: Yea probably so.. Sometimes I feel like if I’m not… [Sigh] like in. if I’m not, if
I’m fine.. People will just think I’m fine (mumm) and they won’t think about me or
care about me..

CP.3: So, then, you have to, there has to be something wrong for people to notice
(Umm) or you have to be upset to get care and attention (Yeah) okay.

Comm.3: Again, I feel I came in too early. It would have been better to leave more time
for Sam to stay with her own process. I could see Sam was struggling a bit here and my
interpretation of her experience was in part to check that I was understanding her
correctly, and Sam’s responses assured me I was. On reflection I also feel that my
intervention at CP.3 was in part my need to rescue her a little bit and try to make things
easier for her (Greenberg, 2009). This was an important time in the therapy as we were
identifying a secondary gain that was acting as a maintaining factor for her eating
disorder. As such, I wanted to encourage Sam to stay with her current process.

CL.4: Umm that’s what I think cause that’s..

CP.4: I think that’s a really important realisation to make, important thing that
you have just identified and I kind of want to hold on to that for a little while and
kind of hold on to that feeling this week, think in terms of where that will get you
and why.. Where did that belief come from that you need to be.. You need to be
sick or ill or something wrong to get peoples attention to get somebody to care for
you? (Long pause) I know it is a big question to answer, so I’m not expecting you to
answer it in the next 15 minutes..

Comm.4: My first part of my intervention at CP.4 was aimed at highlighting to Sam that
I felt what we were discussing was important and encouraging Sam to stay with it even
though it seems painful and difficult for her. Westbrook et al. (2010) suggest that for
treatment to be successful it is important that any secondary gains related to the client’s
presenting difficulties are identified and tackled and, as such, I wanted to highlight that
this was something that was making it difficult to change and let go of her eating disorder.

In the second part of CP.4 I hope to further the process a little bit to get Sam thinking about how this belief developed. However, I recognise I could have done this using a much shorter intervention than I did. It seems clumsily done. During the silence, I could see that Sam felt under pressure to provide me with an answer and my breaking the silence was my attempt to ease the pressure, but after I had said it I realised it was unnecessary and perhaps coming from my own need more than that of Sam’s. Also, Gilbert (2010) suggests that therapists should be careful about interrupting periods of silence as it can feel intrusive and dominating and can hamper the clients learning how to tolerate certain emotions. This is something I will be more mindful of in future, as I believe it would be helpful for Sam given her difficulty in tolerating distress.

CL.5: I know.. I just feel (sigh) if I’m fine I won’t have things like this and I can’t do it on my own (becoming tearful)

CP.5: There is almost a fear of being okay..

Comm.5: Beck (1995) states that it can be useful for the therapist to suggest thoughts or feelings to their clients and ask for confirmation or disproval. I felt connected to Sam in this moment and felt that my accurate interpretation of her feelings helped me empathically connect to her. I felt I was attentive and positive in my body language and my tone of voice was soft and empathic. I wanted to communicate to Sam that I knew this was difficult for her and she was being brave. Gilbert and Leahy (2009) highlight the importance of therapists’ non-verbal communication, as this acts as a valuable tool in conveying to the client that they are being heard and can also be used to encourage them to continue. I do feel that Sam perceived this and she was open to exploration of her difficulties.

CL.6: (Sobbing) Cause it only.. My own.. And I don’t know..(taking more tissues) I’m scared of not having support (un hu) (sniffles) (pause) I don’t know… (blows nose) (moves forward in chair) em anyway em..

CP.6: Just want to brush over that..
CL.7: Well I just feel like we haven’t got much time left (uh hu) em.

CP.7: It’s true we don’t have much time left in the session and it probably is, it is coming to an end but, it’s a really, I don’t want you to brush what you just said under the carpet, that it doesn’t matter because I feel it was a really important moment and a really important reflection that you just made, the feeling that you need to have to have something wrong to get care back from people or to get support and that fear of losing the support and if you’re not feeling supported, okay what do I do? You almost sabotage yourself in an aim to get it.

Comm.7: At both CP.6 and CP.7 I was attempting to highlight to Sam that I felt she was being dismissive of her feelings. I felt connected to her and was very aware of the emotion in the room and that it was difficult for her to stay with it. I also wanted to validate and acknowledge her feelings around the remaining time. Discussion with my supervisor helped me become aware of the possibility that when Sam referred to not feeling like there is enough time remaining, perhaps she could have also be thinking in terms of the therapy as a whole and the pressure she was feeling to make use of the remaining session. This was plausible to me given the anxiety I saw in Sam’s face at our last session when it was mentioned that we were halfway through the treatment. This proved to be a useful reflection to be mindful of throughout our remaining sessions. When I later reflected this to Sam she agreed with it and also shared that she had hoped I would offer to extend our sessions together as she was anxious about not being able to manage things on her own. At CP.7 I also wanted to communicate to Sam that I felt she had taken an important step and made important insights in acknowledging a secondary gain and an important maintaining factor of her eating disorder. Curwen et al. (2007) recommends that the therapist recognises any positive movement made by the client no matter how small. I am aware that my use of the word “sabotage” could have been challenging for Sam if she wasn’t in agreement with my hypothesis and I am pleased that she was. I felt myself and Sam had formed a strong therapeutic alliance throughout our sessions together and I was confident that it could withstand challenges to it.

CL.8: Yeah.
CP.8: And in one way it’s understandable that you do given that’s what you believe you need to do. That if you hold on to the belief that the only way you can get care and attention and support from somebody is from something being wrong or you being unhappy or something,. unwell, well, it’s like I have to make myself unwell to get these emotions that I crave from people. so then what do you do with that?

Comm.8: I felt it important to communicate and normalise things to Sam and that her beliefs could be seen as understandable given her learned experience. According to Curwen et al. (2007), normalisation helps to alleviate the distress that surrounds the client’s experience of their difficulties and therapy process. I was also aware that for the last few minutes I had been more vocal than Sam and I wanted to return the process to her to see if she was able to envisage it being different or changing.

CL.9: Well I just need to learn how to get it without, how to have attention and care without being,. without being ill (uh hu).

CP.9: Can you remember getting it a different way?
(Pause)

Comm.9: Here, the content of Sam’s speech appeared hopeful in that there was a solution to the problems we were discussing and that it was solvable. However, Sam’s body language and tone of voice presented a different story. To me, this was indicative of the ambivalence that is so common in clients presenting with eating disorders (Fairburn et al., 2008). My question at CP. 9 was aimed at eliciting if Sam can remember a time when she experienced love and attention without being ill. Waller et al. (2010) recommend using guided discovery to explore key aspects of the client’s experience that might lead to the uncovering of information that can be used in support of alternative thoughts.

CL.10: Erm.. Not really.. not really.. I think I feel most cared for and most loved when I’m (pause) I don’t know, I’m just em. (sniffles) feeling depressed and unhappy or really hurting myself, I feel like that’s when my mum actually noticed (Uh hu) and I just don’t get a reaction from her unless I’m doing something like extreme..
CP.10: *It’s almost like there needs to be a crisis.*

Comm.10: *Persons (1989) recommends therapists pose questions with the formulation in mind. At CP.10 I was tentatively testing my hypothesis and I was looking for information or evidence to support or refute my hypothesis (Leahy & Holland, 2000). Here, I felt we were uncovering one of Sam’s core beliefs, that she was unlovable and that being sick or in a crisis was a way to feel and receive care, attention and love from those around her as she believes she cannot get it any other way. Geller et al. (2010) recommend the therapist helps the client identify and challenge their core beliefs so that the cognitive and emotional triggers to behaviours can become more manageable. As Sam had difficulty experiencing and effectively expressing emotions that seem difficult I felt this was an essential step towards this.*

CL.11: Yeah

CP.11: *Do you feel like that’s the only time you deserve it?*

Comm.11: *Here, I had a genuine interest to learn more about Sam’s beliefs. Waller et al. (2010) suggest that, when working with eating disorder clients, the therapist should adopt the “curious clinician” stance in uncovering the client’s beliefs. Often, eating disorder clients can feel undeserving of treatment and love from those around them (Garner & Garfinkel, 1997), so at CL.12 I feel justified in posing my tentative hypothesis.*

CL.12: (Pause) No *(Uh hum)* I got (inaudible) I don’t know.. I’d just like to have it all the time really (Uh humm)

CP.12: *I guess from what you said it’s the only way you know how to get it and this is what you call on.*

Comm.12: *Here, I was trying to be empathic and validating towards Sam and her experience. Geller (2002) and Linehan (1993), suggest the patient’s willingness to change is enhanced through validation of their problems in the context of the past and current situation.*
I also remember feeling a little off guard at Sam’s response to my question at CP.11, as although she didn’t refute it, I had assumed she would be more definitive in her agreement with it. In supervision I reflected on this and it highlighted the importance of not presuming I am correct in my perception of my client’s experience. This was a useful lesson given that I work at a specialist eating disorder service and all my clients’ primary presenting problems are eating disorders, sharing the similar underlying pathology. It is important that my work with one client is not overly influenced by my work with another. Although my response at CP.12 did act to validate and normalise Sam’s experience, I feel it was partly my effort to hide some time and regroup!

CL.13: I think I.. I think I do that with my mum, with partners.. Like there has to be a drama (Uh Humm) and it’s “oh yeah I do care about you”.. I feel like I have to test them because I don’t really believe that they care about and they like.. I have to do something really extreme and really self-harming to see if they actually do..

CP.13: So, you need that reaction from them.. (Yeah) you need that as proof that they do love me.. They do care about me..

Comm.13: I was attempting to reflect my understanding of what Sam had just said back to her. This was aimed at checking I understood her correctly but also at helping Sam to better understand her experience. I felt connected to Sam in this moment. I really felt that this session contained significant moments and highlighted an aspect crucial to our formulation that if unacknowledged could inhibit Sam’s progress in the treatment and significantly increase the likelihood of relapse post treatment.

CL.14: yeah (sniffles)

CP.14: I think that is really interesting and I think bearing in mind the time, I think it is something that I would like to carry through to next week because it’s… I think it is an important thing that we have picked up on and it is important to focus on how you can behave differently, how can you think differently, how can you get, know you can get care in different ways, how can you care for yourself, how can you assert your needs to other people for what you need from them and I think that is important and I would like you to reflect on what you just said this
week because I think it’s hugely important and it was kind of a really brave thing if you to.. and insightful of you come up with and realise, I think it’s an important step.

Comm.14: At this stage I was aware of needing to begin bringing the session to a close. At CP.13 and CP.14 I was attempting to synthesise some of the important aspects of the last ten minutes while acknowledging the importance of what we had explored and accrediting progress to Sam to help make it more meaningful to her and foster her responsibility for change (Waller et al., 2010). I also wanted to positively reinforce to Sam that I felt she had been brave during this session and offer her praise in acknowledgement of her discussing and reflecting on emotions and thoughts that were difficult and challenging. Safran and Kazow (2009) suggest this kind of positive feedback helps strengthen the therapeutic relationship and Newman (2009) highlights that it also encourages clients to continue to disclose further painful aspects about their lives and explore further aspects of their psychological experience and strive to make constructive changes.

CL.15: Humm

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The Therapeutic Process and Its Changes Over Time

Waller et al. (2010) suggest that the central goal of CBT is for the patient to become their own therapist and the journey towards recovery in patients attending specialist services is likely to continue past active treatment. Some of the therapy techniques outlined earlier in this report (e.g. psychoeducation, advice on meal planning, weighing) required me to take a directive role at times. With the goal of Sam becoming her own therapist in mind, as the therapy progressed I was conscious of making the responsibility of change more of a shared endeavour. There were many times when I felt Sam looking to me for answers, particularly around times where she felt she was having a “wobbly moment” as between sessions 10 and 11 as discussed earlier. Before this halfway point in the therapy, Sam had reported feeling confident in what she was doing, had expressed feeling more skilful at recognising her problem ways of thinking and behaving, which was encouraging to us both. This was demonstrated in her being
successful in remaining binge-free for two months and putting techniques such as binge-postponement, mindfulness, distraction, pleasurable activities into practice and experiencing the benefits. This enabled my role to evolve to help Sam develop more adaptive ways of coping with life, its stressors and emotions. As I had been pleased and motivated by Sam’s progress, it was important for me to remind myself that the recurrence of bingeing, although disappointing, is normal and it was important for us to reflect on what happened and what could be learned from it. Although Sam’s confidence in her ability to recognise and control her urges to binge had been affected, the exploration of what was going on for her allowed her to see that she had the resources to manage them.

At this time Sam also became dismissive of the progress she had made, which Fairburn et al. (2008) and Waller et al. (2010) suggest is not uncommon with this client group. A discussion around expectations and review of initial goals and reflection on the changes across various areas of her life that have taken place during the therapy reminded Sam of her initial motivation and encouraged her to take more responsibility within the therapy and be more active and forthcoming with what she wanted out of our remaining sessions. I took this as a sign that Sam was taking steps to becoming her own therapist, which, in itself, is a goal of treatment (Waller et al., 2010; Fairburn et al., 2008).

The segment presented above encouraged us both to be mindful of her anxiety around our session’s together coming to an end. Sam acknowledged that she felt if she was no longer symptomatic she would be left on her own both in terms of support from our service and care and attention from those around her. This did make me question whether we needed to renegotiate our ending based on the extended formulation as suggested by Waller et al. (2010). However, reflection in supervision helped me realise that this would be unhelpful and I would be guilty of “colluding” with Sam’s fears by doing so (Westbrook et al., 2008). In response to this and Sam’s fears of abandonment and anxiety about not coping, I encouraged Sam to think of her long-term goals and dedicated time in our sessions to relapse prevention strategies and reminding Sam of skills and techniques learned over the course of treatment.
In support of Sam becoming her own therapist and helping prepare her for treatment coming to an end, our last five sessions were spaced out to fortnightly, which is in line with the recommendations of Fairburn et al.’s (2003) model of CBT-E.

**Difficulties in the Work and Use of Supervision**

Regular supervision with a supervisor experienced with the client group has been incredibly valuable and has had a very containing effect on me. Within it I have felt comfortable discussing and reflecting on both process and content, along with being honest about how I was finding the work challenging and feeling pressure from Sam and myself to “make things better”.

Waller et al. (2010) suggest that it is not uncommon for therapists to over-invest in the likelihood of patient change. As Waller et al. argue, “This seems to be partly the product of seeing oneself as being a ‘white knight’ arriving on the scene to rescue the patient from this ‘terrible disorder’.” (p113) I will admit that this is something that I need to be mindful of, and consultation with my supervisor has also helped me keep my expectations of both my client and myself in check.

At times throughout our work I got the sense of a borderline pattern from Sam and I raised and discussed this with my supervisor and the psychiatrist in charge of Sam’s care within the service. She told me that she had assessed Sam for a personality disorder but did not make the diagnosis. Nevertheless, I kept this possibility in the back of my mind and it was helpful in my understanding of Sam’s core presentation.

**The Therapeutic Ending, Evaluation of Work Done and Learning from the Case**

Sam’s understanding of the function of her eating disorder was enhanced further throughout the treatment. As one of its primary functions was in managing her emotions, effort was invested in Sam becoming better at identifying, tolerating and attending to difficult emotions rather than “numbing” them through the act of bingeing and vomiting. At the end of treatment Sam had been binge-free and had developed a regular healthy eating pattern and was able to incorporate foods she had deemed “triggering” into her diet while feeling confident that her previous feared outcome would not become reality.
The behavioural experiments utilised to test her predicted fears of losing control and weight gain proved much more effective than the cognitive restructuring techniques that were very effective in other areas. Given that Sam held on to these beliefs for a long time, it was motivating for both Sam and I to see these beliefs decrease in strength relatively quickly. Success and progress in this area also encouraged Sam to take greater risks in the experiments and in other areas of the therapy. My experience of using behavioural experiments with Sam has also encouraged me to make more use of them in my work with other clients and has made me more aware of the need to work collaboratively with the client in elaborating on them in keeping the process moving.
References


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