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The Therapist's Emotional Experience: A Compass to Navigate Therapy with Eating Disordered Clients

Portfolio for Professional Doctorate in Counselling Psychology (DPsych)

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City University Declaration

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Preface

There has been a movement towards research on the therapist and their capacity in providing treatment for eating disorders (Garner, 1985; Thompson & Sherman, 1989). This Doctoral Thesis Portfolio attempts to provide insight into therapy with the eating disordered population from therapists' subjective experiences. It attempts to approach eating disorders from both a scientific and practitioner perspective using counselling psychology philosophy to understand and enlighten the therapeutic process when working with these clients. Rizq (2005) said that counselling psychology concentrates on two aspects in therapy, as it promotes the use of the therapist's self as a tool for therapeutic change alongside adopting psychological theory for the enquiry of this experience. This portfolio will focus on the integration of these two aspects.

Therapy with eating disorders was analysed from a theoretical, personal, and professional perspective. This will be explored in this portfolio via three individual components. Firstly, research is presented that investigated therapists' emotional experience after sessions with a client being treated for anorexia. Secondly, the literature on alexithymia in anorexia is critically reviewed with particular reference to inform counselling psychology and to develop understanding of the therapeutic process with this client group. In the final section a case study will be presented in relation to the concept projective identification in order to illustrate the inter-subjective nature of therapy with a bulimic client.

Part 1: The research

Food for Thought: Female Therapists' Emotional Response to Anorexic Clients in Specialist Eating Disorder Services.

This component is a novel piece of research that captured the therapists' emotional experiences in their reflections on a session with a client being treated for anorexia. Written and verbal accounts of eight therapists were analysed using Interpretive Phenomenological Analysis (IPA) to provide an in-depth understanding of their emotional experiences. The therapists worked in specialist eating disorder services and conceptualised their experience of their client using psychodynamic ideas. The therapists' experiences suggested that their feelings in therapy are analogous to food in anorexia. It found that they felt force fed feelings - symptoms akin to starvation - and that they embarked on a process of digestion in order to make sense of their experience.

The research highlights how powerful the emotional experience can be when working with this client group. It uncovers how the therapists use psychodynamic interpretation to make sense of their experiences which was understood as a way of them managing their feelings, as well as dealing with power dynamics. This research shows how important self reflection is on one's own emotional experience in therapy, in order to process and relieve feelings, as well as to help the client. The findings were provided in conjunction with existing literature and some implications for the clinical practice of counselling psychology are presented regarding promotion of the therapist's use of their subjectivity, taking responsibility for their emotional responses and thinking about issues related to transference and countertransference. It is also acknowledged that further work needs to take place for a greater understanding of this topic.

Part 2: Critical literature review

A Critical Literature Review: A Counselling Psychology Perspective on Alexithymia in Anorexia Nervosa.

The purpose of this section is to present a critical appraisal of the research on alexithymia in anorexia, and to review, evaluate and critique the usefulness of diagnosing someone with anorexia as alexithymic. Alexithymia means "no-words-for-feelings" and its presence alongside anorexia is an indication of someone who has suppressed their emotional experience (Skarderud, 2007b). The review explored this from a counselling psychology perspective, which critiques the medical model and diagnoses, favouring a subjective approach, yet counselling psychologists are working in settings where the medical approach prevails. The review highlighted how there may be some positives to recognising alexithymic qualities in anorexic clients working in therapy but that this should be in a way that empowers clients in therapy and does not limit access to therapy. The review presents two models of therapy that address both anorexia and alexithymic issues in therapy but the underlying theme is that counselling psychologists should stay true to their subjective focus.

The portfolio theme

My enthusiasm for treating eating disordered patients is at the core of the portfolio as is my development as a counselling psychologist. The main focus is the role of emotions in therapy with particular reference to the therapist.

The portfolio documents my journey as a counselling psychologist which has involved my development as a therapist and a researcher. The use of counselling psychology philosophy in this portfolio has allowed for a deeper understanding of three important areas; the qualitative research process, the dynamics that occur in therapy with eating disordered clients and my development as a therapist.

Based on the premise of counselling psychology the portfolio illustrates a process in which I have integrated the use of my 'self' as an instrument alongside the application of psychological theory. Using my own experiences as part of this portfolio has been very fruitful. Although my natural inclination has been to turn to psychological theory to help my understanding, I found that embracing my emotional experience has made my understanding of an individual richer and improved the therapy and research process. This has contributed to a greater appreciation of integrating these aspects and to what it means to be a counselling psychologist.

The portfolio promotes the importance of digesting one's emotions which have been evoked in therapy with an eating disordered client. Due to the powerful nature of these experiences they may be difficult to face. I hope that my learning and understanding normalises this experience for other therapists and reinforces the importance of owning their feelings.

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Food for Thought: Female Therapists' Emotional Responses to Anorexic Clients in Specialist Eating Disorder Services

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Abstract

This research explored the emotional experiences of therapists working with clients being treated for anorexia nervosa by conducting a qualitative investigation into eight female therapists' emotional experiences after providing therapy sessions to clients in specialist eating disorder services. The phenomenon of interest was captured in a reflective diary, as well as in a semi-structured interview. The data collected from these accounts was analysed using Interpretative Phenomenological Analysis (IPA). Analysis suggested that the therapists experienced powerful and difficult emotional responses. These were categorised into three master themes, "force-fed", "starved" and "digesting", containing qualitatively similar superordinate themes.

The use of food-related language was employed as it reflected the therapists' mirrored responses to their clients. The themes were embedded in a psychodynamic frame of reference as adopted by the therapists. "Force-fed" and "starved" captured the therapists' descriptions of transference-countertransference responses and projective identification. "Force-fed" reflected the way in which therapists interpreted their emotions as though they were part of a maternal transference, a two-way abusive transference or as if they were experiencing their client's feelings. The theme "starved" represented the therapists' interpretation of their experiences as though they were being starved of feelings or sensations by their client's restriction in therapy. "Digesting" highlighted a process in which the therapists were making sense of their experience through reflecting, which consequently reduced the intensity of their emotional experience.

Interpretation of the therapists' use of psychodynamic concepts, taking into account the double hermeneutic, suggested that therapists experienced issues relating to power dynamics and professional identity. It is also suggested that the interpretation which therapists engaged in, was drawn on to relieve the therapist of uncomfortable feelings towards their clients. These findings shed light on an important therapeutic dynamic and it is suggested that therapists use their own emotional experience as a compass to guide therapy with anorexic clients whilst also considering the issue of power within their therapeutic work.

Introduction

The literature and research on professionals' work with individuals being treated for anorexia, portrays challenging and difficult experiences (e.g., DeLucia-Waack, 1999; Frankenburg, 1984; Franko & Rolfe, 1996). It seems to be a common theme that therapists find this specialist area particularly onerous. What is missing from the literature and research on this subject is a detailed phenomenological account from therapists, which would add value to the understanding of the process of therapy as both an interpretive and phenomenological experience. This research aims to gain insight into this by learning about therapists' emotional experiences and how they make sense of this in treatment of their clients.

The history of anorexia will be explored in order to position the research within the current literature. As anorexia touches on psychological, psychiatric, sociological and feminist issues, these perspectives will be briefly discussed to explore how the concept of anorexia is constructed and theorised from multiple perspectives and to highlight how it is a complex phenomenon. This chapter aims to critically explore and review literature that is relevant to the emotional experiences of therapists when engaged in therapy with anorexic clients. As there are few studies about these experiences this literature review will take a broader perspective by including research that discusses other aspects related to working with this client group.

The current research in this area will be summarised briefly; then the literature review will move on to more specifically evaluate the research and literature on therapists' emotional reactions and 'countertransference' responses. The bias towards psychodynamic concepts will be explored. The chapter will end by outlining the aims and research questions of this current investigation.

The terms "counselling", "psychotherapy" and "therapy" are synonymous and will be used interchangeably. The term "therapist" will be used to refer to any professional delivering psychotherapy to a client with anorexia; this may be a psychologist, psychotherapist or a counsellor. Any other professional involved in the treatment of clients with anorexia, such as social workers, nurses and dieticians will be referred to as a "clinician" or "practitioner". The anorexic in treatment will be referred to as the "client" or as an "anorexic client". The singular pronoun of choice will be "she" rather than "he" because anorexia tends to be more related to females (Strober, 2004). These definitions are congruent with language used in existing research.

It is important to define the meaning of the term "countertransference" in this context as there is not a unanimous consensus on the definition of the term across

psychotherapy. Since Freud (1959) introduced the term, the definition of countertransference has been modified and expanded and different schools of psychotherapy have assigned different meanings to the word. Although the term originated from the psychodynamic model, it is now being considered in different models of psychotherapy such as cognitive behavioural therapy (CBT; e.g., Prasko et al., 2010). For example, some people have broadened the definition to include all of the therapist's reactions to a client (e.g., Little, 1951; 1960). This chapter covers a range of definitions, which is reflective of how the existing research refers to this concept. When the term is referred to in regard to specific research, the researchers' definitions of this concept will be outlined if it has been provided.

History of Anorexia

The phenomenon of self-starvation through choice existed prior to the medical diagnosis "anorexia": the concept of self-starvation was first documented in a paper by Richard Morton in 1694. Anorexia was first given its name by Sir William Gull in 1873 (cited in Lawrence, 1987).

In medieval Italy self-starvation became a way of being "holy" amongst females at a time when an increasing number of women were becoming female saints. Self-starvation was part of a wider culture of asceticism. This was a way for women to strive towards spiritual perfection through discipline and denial of the most basic of physical needs. Bell (1985) proposed that "holy anorexia" was a representation of the conflict women felt in their aspiration for autonomy in a patriarchal culture.

Within Christianity it is believed that there is a dualistic nature between body and soul (Griffin & Berry, 2003). Griffin and Berry (2003) proposed that this dichotomy has fostered the belief within Christianity that the body has to be renounced to get closer to the soul. Some people believed that self-starvation was a form of self-renunciation that came about, in medieval periods, from the dualistic nature of religion. Self-starvation became a popular form of self-denial, mostly for women (Griffin & Berry, 2003). Whilst religious beliefs may be continuing to impact on women in the present day, society and culture have evolved since medieval times. Culture is now heavily influenced by the media and there continues to be a feminist movement towards women being treated as equal to men. Therefore, the context in which people are developing anorexia has changed.

The concept "holy anorexia" is a social-constructionist perspective of anorexia, which highlights the influence of context on the development of anorexia in individuals. Whilst

this is clearly an important factor in the explanation and meaning of anorexia for this specific group, it discounts individualised or psychological explanations. These perspectives raise the question that there might be something in common amongst the small proportion of individuals who developed "holy anorexia", e.g., similar pre-disposing personality traits or life experiences amongst these individuals. It is possible that there was a difference between those women who became saints through their self-starvation and those who did not. There must have been something over and above the impact of culture and rebellion against a patriarchal society. Therefore this social-constructionist perspective does not account for the differences amongst certain individuals within a culture, and therefore does not explore the underlying issues of individuals that contributed to their motivation to starve themselves for God.

Diagnosing Anorexia

At present there are two classification systems that are used in the diagnosis of anorexia. There is the 10th edition of the International Statistical Classification of Diseases (ICD-10; World Health Organisation, 1992) and the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-R, American Psychiatric Association, 2000). Using the DSM-IV-R (APA, 2000, pp. 544-545) the following four criteria must be met.

- Refusal to maintain body weight at or above a minimally normal weight for age and height.
- Intense fear of gaining weight or becoming fat, even though underweight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
- In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles.

Anorexia is mainly a female disorder: only an estimated 5% to 15% of people with anorexia or bulimia are male (National Institute of Mental Health: Eating disorders, 2011). Anorexia is less prevalent in non-Westernised countries. Griffin and Berry (2003 p. 44) stated that it is considered the "culture-bound syndrome" of the West. Cooper (1987) argued that there is a clear pattern in the socio-economic status of young girls who develop anorexia, suggesting that they tend to be white, middle class and from high-achieving families, and there may be something about this demographic that creates conflict in the development of these individuals into adulthood. The DSM-IV-R criteria could be criticised for not representing pre-pubescent individuals or males who develop anorexia.

Williams (2009) highlighted that the diagnostic criteria is heavily focused on the physical aspects of anorexia. The psychiatric diagnosis is rooted in a positivist epistemology, believing that illness is a disease that impairs the "normal" functioning of a human, and that illnesses are entirely objective. From a subjective perspective, qualitative research that has asked sufferers about their experience of anorexia has found that the underlying psychological factors are considered to be more important than the physical aspects (Williams, 2009). This suggests that the experience of being anorexic may deviate from the diagnostic criteria. The DSM-IV has also been criticised for being too specific and therefore not necessarily adequate in identifying all cases of anorexia (Anderson, 1990; Garfinkle, et al., 1996). Also, it does not account for any fluidity in the eating disorder which may occur within an individual across time (e.g. many people develop bulimia after a period of being anorexic). Fairburn, Cooper, & Shafran (2003) have proposed a transdiagnostic approach to eating disorders which uses an umbrella diagnosis for all eating disorders because they are viewed as being indistinct from each other.

It has been argued that psychiatric diagnoses such as anorexia nervosa developed as a way to control, exert power and "governmentality" (Foucault, 1978). Kleinman (1995) argued that all illnesses are socially constructed realities and therefore need to be understood in this context. This perspective adopts a critical stance of the process of diagnosis stating that, both "disease" and "illness" are purely human constructions that emerge from the authoritative and powerful medical establishment. Such "illnesses" reinforce the power and privilege of medical science (Hacking, 1999; Murphy, 2001).

A feminist approach would question the pathology of eating disorders. MacSween (1993) would argue that "scientific" psychiatric explanations for mental health contain hypotheses about what is normal based on nothing more than assumptions, because they have not been analysed or answered sufficiently. She would argue that, because psychiatry is rooted in a bourgeois patriarchal culture, being "normal" or "stable" means functioning and adapting appropriately within this culture. Therefore, it could be argued that the medical model assumes that anorexia is a fact within the culture rather than a socially constructed concept. MacSween (1993) criticised the aim of treatment because it assumes that the patient needs institutionalising to become "normal".

The phenomenological viewpoint proposes a body/social dichotomy, arguing that disease is a physiological state while illness is a social state, presumably caused by a disease (Conrad & Schneider, 1980, p.30). The latter perspective provides insight into the different interpretations of certain physiological presentations among different cultures.

There is an argument that the diagnostic criteria might be useful to both individuals and therapists as it can help appropriate support to be sought for the individual, as well as giving some individuals a sense of relief by being able to label their difficulties. For some it can help them gain access to psychological services, but it can also limit the approach to treatment and distance the professional from the individual (Fletcher, 2012).

This present research acknowledges that the diagnostic criteria for anorexia are embedded in a medical model and a traditional empirical positivist model. Bury and Strauss (2006) suggested that, within counselling psychology, several alternatives to the traditional empirical, positivist model have been proposed in order to better understand the science and practice behind the profession. A critical realist approach accounts for and acknowledges multiple social, cultural and language-based constructions, as well as empirical positivist approaches. Regardless of the label, the construct of anorexia is argued to exist independently of social context.

Psychological Perspective

Psychological theories of anorexia posit a need for control in the person's life, and this need is both a contributing and maintaining factor (e.g., Fairburn et al., 2003). Bruch (1974; 1978; 1982) was very influential in thinking about anorexia nervosa from a psychological perspective and proposed that some individuals develop anorexia in their adolescence because they struggle with the meaning of this developmental milestone. The literature suggests that adolescence brings out difficulties from early experiences of the mother-daughter relationship.

Bruch (1974) proposed that these earlier difficulties would become problematic in adolescence, because of the developmental move towards independence and the experience of bodily changes that feel out of control. Bruch proposed that individuals attempt to control these changes by starving themselves. She suggested that the task of therapy should help the anorexic develop a stronger sense of self and identity in which she is able to regulate her own needs and desires and feels as though she is the agent of her own body.

This perspective can be criticised for placing a lot of responsibility on the mother in the development of an individual's anorexia. Most psychodynamic theories of anorexia focus on the individual's early relationship with their mother and have been criticised for "mother-blaming" (Hepworth, 1999). It is thought that these perspectives do not take into account the wider meanings of food and weight in the culture that influences both mother and daughter. MacSween (1993) criticised Bruch's perspective because it

"ignore[s] the possible role and meanings of food and the body in anorexia" (p.41). The perspective could also be argued to be gender-biased as it focuses on mother-daughter relationships.

Bruch's (1974; 1978; 1982) theory touches on attachment theory, which is a perspective that has contributed to the understanding of anorexia in its own right. Pearlman (2005) sees people with eating disorders as experiencing difficulty in forming their first attachments, in which they experienced misattunement and disconnection and used dissociation as a way of coping with this. Bruch suggested that food becomes something concrete for the baby to focus on, and that this can cause problems later in life. Pearlman (2005) stated:

> The felt sense of difference and therefore of emotional separation from parents, or the immediate or larger cultural peer group, can also trigger conscious or unconscious memories of unbearably frustrated desire for connection. Family and the culture at large offer "legitimized" ways to channel such frustration and anxiety by excessive emphasis on weight, appearance, nutrition, or conversely on comfort through food (p.230).

Therefore, whilst Pearlman (2005) was primarily theorising about anorexia from an attachment perspective, she also acknowledged the impact of culture on assigning meaning to food and weight. She also drew from psychoanalytic notions such as the "unconscious" and talked about the therapeutic relationship as a "psychological arena", approaching anorexia from a psychological perspective.

Psychiatric Explanations

Psychiatric explanations of anorexia tend to focus on the biological and psychological symptoms, and seek a cause-and-effect relationship between factors that contribute to the development of anorexia and how these can be treated. One example of a psychiatric explanation can be provided by Crisp (1980).

Crisp (1980) proposed that anorexia served a function related to biological regression. He suggested that some individuals are overwhelmed by the physical experiences of adolescence. The physical changes are seen as the trigger for self-starvation, which becomes an adaptive state in order to remain in "psychobiological childhood". This is supported by the tendency for anorexia to develop mostly in young women who are at the adolescent stage.

Crisp (1980) suggested that treatment should include weight gain to overcome the fear of pubertal weight, alongside therapy to help the individual develop a sense of self that integrates sexuality, independence and the establishment of one's own needs and desires. The psychiatric approach focuses on curing the symptoms rather than trying

to understand the dilemmas and the difficulties that underlie the symptoms (MacSween, 1993).

Feminist Perspective

Generally, feminist theory takes a social constructionist approach to anorexia as it proposes that it is the consequence of a misogynistic society. However, as will be discussed later some feminist accounts propose a combination of a psychological and social constructionist view. Edwards (1987) argued that anorexia is culturally specific and is an indicator of the immense pressure that society puts on females. This argument proposes that during adolescence there is an intense conflict experienced in females about their roles within a patriarchal society (Griffin & Berry, 2003). It is thought that women have to be both womanly and manly in order to be treated as equal in a patriarchal society. This has been coined the "superwoman syndrome" (Rose, 1951). The expectation is that women achieve in all areas, and that they can be the feminine, nurturing, family type, assertive with their own needs, as well as ambitious and career driven. It is thought that this pressure creates stress and a fear of failure.

Lawrence (1979) proposed that this experience may make them feel powerless and controlled and as a response to this may change their body. Therefore, the anorexic exerts control over her physical and psychological needs, which can make her feel, empowered and give her a sense of autonomy; anorexia has been posed as a statement of power over others (Cooper, 1987). Cooper (1987, p. 186) stated that this power is evident in the "extremely violent emotional responses" the anorexic can evoke in those who are acquainted with her because of her refusal of anything that they have to offer

Orbach (1986) and Lawrence (2008) are two other female therapists who have written and proposed psychological-feminist approaches to anorexia. Orbach (1986) argued that popular media heavily influences women's relationships to their bodies and that this can be a contributor to the development of an eating disorder. She also asserted that a big factor in the development of an eating disorder is how one has come to relate to their body from early on in life. She proposed that anorexia can become a way of rebelling against femininity and the responsibility of managing to resolve the conflict one experiences.

Orbach (1986) included the mother-daughter relationship into her feminist understanding of anorexia. She said that:

> A tragic repercussion of women's inferior social position is that in the transmitting of culture from one generation to the next, the mother has the dreadful job of preparing her own daughter to accept a life built on second-class citizenship (p.171).

She suggested that it is through women's experience of their mothers that they learn about what it is to be a woman in this world and how to find their place in society. Later on, Orbach (1986) suggested that anorexia is a way in which a daughter can express her ambivalent relationship to her own physical and emotional needs that have been learnt through her mother.

Lawrence (1987) proposed that an anorexic woman feels that she has to deny that she has any appetite for anything, denying herself of having any needs because she feels that her needs will be too overwhelming for others. She theorised that anorexia is a manifestation of a conflict between independence and autonomy (Lawrence, 1979), which stems from a social world full of conflicts about what a woman should be.

Orbach (1986) and Lawrence (1987) both believe in a two-level approach to the solution to anorexia. The first is to address the problems on an individualistic level through personal therapy, and the second is to address them on a sociological level in which there would be social change to the patriarchal nature of society. These approaches address what meaning food, weight, and body have for women and anorexics and why they feel the need to control these aspects rather than just seeing this through gender-neutral ideologies.

What is clear from the different views on anorexia is that anorexia is seen as a "solution" (Bruch, 1978; Orbach, 1986) by the individual to help them when they feel powerless and out of control, whether that be theorised psychologically, medically or sociologically. The difficulty is that therapists would have a different view and see it as problem (Vitousek, Watson, & Wilson, 1998).

Treatment for Anorexia

Treatment for anorexia in adults outlined by National Institute of Mental Health Guidelines (National Institute for Clinical Exellence (NICE), 2004), proposed that most people with anorexia nervosa should be managed on an outpatient basis with psychological treatment. Individuals requiring inpatient treatment should be admitted to a setting that can provide the skilled implementation of re-feeding with careful physical monitoring in combination with psychosocial interventions. Treatment is funded by the government, which looks for improvements within diagnostic criteria. NICE guidelines outline that psychological treatment should aim to "reduce risk, to encourage weight

gain and healthy eating, to reduce other symptoms related to an eating disorder, and to facilitate psychological and physical recovery" (2004, p.10).

Psychology in the NHS is underpinned by the medically orientated diagnostic system. Milton (2006) recognises that counselling psychologists need to work within this system but can go beyond it in their work with the client.

The Clinical Challenge of Treatment for Anorexia

Approximately 11 in 100,000 people develop anorexia each year (B-eat Facts and Figures, 2011). Mortality rates for anorexia are the highest of all the psychiatric illnesses at a shocking 10% to 15% (Birmingham, Su, Hlynsky, Goldner, & Gao, 2005; Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Crisp, 2006). There is serious concern and anxiety for people involved in treating these patients, as anorexics are a population that dangerously flirts with death. An 11-year longitudinal study investigating mortality rates of the eating-disordered population found that women with anorexia were nine times more likely to die with a 58 times greater suicide rate than healthy females (Herzog et al., 2000).

Reviews of the quantitative research into recovery suggest that around 46% of anorexia nervosa patients fully recover, with a third improving and 20% remaining chronically ill (Steinhausen, 2002). It has been argued that the high percentage of people remaining chronically ill reflects the level of treatment refractory in this client group (Ratnasuriya, Esiler, Szmukler, & Russell, 1991; Strober, 2004). Strober (2004) suggested that it is possible that the likelihood of recovery declines with an increase in time spent ill with anorexia, highlighting a need for people to be treated earlier and effectively.

The length of time taken for a person to achieve a full-time recovery has been reported to average between seven and 10 years and has an unpredictable course that makes it very challenging to determine how best to support someone through their recovery process (Herzog et al., 1999). Furthermore, evidence suggests that recovery rates have not improved significantly despite on-going developments in therapies and research on treatment effectiveness (Eckert, Halmi, Marchi, Grove, & Crosby, 1995).

One reason why recovery is prolonged and difficult is because there is a high dropout rate in the treatment of anorexics. An estimated 20% to 50% of people with anorexia terminate treatment prematurely (Mahon, 2000). Both the nature of the illness and the ambivalent relationship anorexics have to recovery contributes to the likelihood of "dropout" (Cockell, Geller, & Linden, 2003).

People with anorexia have high rates of co-morbidity, including depression, anxiety disorders and substance misuse (Kaplan & Garfinkle, 1999). They are thought to have deficits in their sense of self, as discussed previously by a range of theories (e.g. Bruch, 1982; Crisp, 1980; Orbach, 1986) and as commonly seen in people with a personality disorder (Kaplan & Garfinkle, 1999). Piran, Lerner, Garfinkle, Kennedy and Brouillette (1988) found that people with anorexia meet the criteria for obsessive-compulsive, avoidant and dependent personality disorders. Kaplan and Garfinkle (1999) point out how these disturbances can lead to difficulties in the therapeutic relationship.

Counselling for clients with personality disorders is also considered to be an area that evokes difficult and challenging feelings (Arthur, 2000). Treating clients with such co-morbidity puts immense pressure on treatment providers to be able to manage this (Kaplan & Garfinkle, 1999). Zerbe (1992; 1995) stated that people with an eating disorder may have a history of physical, sexual or emotional abuse. She proposed that abused patients with an eating disorder may keep the therapist at a psychological and emotional distance as they "vomit back" the interventions that the therapist offers (Zerbe, 1992, p.170)

Aspects of the treatment and nature of eating disorders make them undesirable and challenging to treat. Treating eating disorders places high demand on mental health services to provide therapeutic help and input for this client group (Jarman, Smith, & Walsh, 1997). There are specialist eating disorder services that provide comprehensive treatment (Newton, Robinson, & Hartley, 1993), but they are under pressure from elevated demands of clients needing treatments that they do not have the resources to provide. This highlights implications for such specialist services as well as for other mental-health services that provide inpatient and outpatient care.

In rural settings there are minimal resources and the local services may be stretched to provide a service for someone with a complex eating disorder. Likewise, in urban areas there tend to be long waiting lists for treatment programmes, meaning that staff in generic services can be under pressure to provide treatment to these patients (Williams & Haverkamp, 2010). It has been noted by Williams and Haverkamp (2010) that the demand for treatment for eating disorders often exceeds the availability of appropriately trained mental-health practitioners within a given geographic region. This may tempt some therapists to practise in an area that is outside their competence, which, they propose, could be detrimental to the client. These claims made by Williams and Haverkamp (2010) need to be considered cautiously with regard to the

United Kingdom (UK) population as they are referring to services in the United States of America (USA).

The term "recovery" needs considering as there is not a unanimous consensus on the definition of this in the treatment of anorexia (see for example, Couturier & Lock, 2006), and the understanding of recovery will depend upon one's professional and personal stance. It is likely that there is a skew in the psychological literature towards a medical opinion on recovery, which draws on the clinical features and prognosis of anorexia (Malson, Finn, Treasure, Clarke, & Anderson, 2004).

Within the clinical picture of treating anorexia the challenges are recognised as a difficulty in "treating" the patient and making them better. It is possible that there is a fundamental difficulty with this because the challenge may stem from the expectation that anorexia can be treated and cured. Anorexia is notoriously difficult to "cure" and Gremillion (2003) suggested that this is usually attributed to the individual's "pathology". She shifted the concern to being about problems and difficulties in the therapeutic practices (Gremillion, 2003). The research from the clinical picture does not appear to consider the meaning that the individual assigns to their emotions or feelings about weight, food and their body and the function that the eating disorder serves for them. It is possible that recovery for this client group is a subjective phenomenon and follows a process that takes a different course or path for each individual.

Brief Overview of Recent Research on Eating Disorders

Fairburn (2005) identified that establishing evidence-based treatment for people with anorexia is nearly impossible because they are a difficult population to conduct randomised control trials on. Since then, psychological research has moved towards understanding the psychological facets of eating disorders and how these may present in therapy (Skarderud, 2007a; Skarderud, 2007b; Zerbe, 1993), as well as thinking about the role of emotions within an eating disorder presentation (Fox & Harrison, 2008; Fox, 2009;). Models of therapy are being proposed from this research such as emotion-focused therapy (Dolhanty & Greenberg, 2009) and mentalisation-based psychotherapy for anorexia (Skarderud, 2007b). These suggest ways of delivering therapy to these clients in order to promote recovery.

As already discussed, Bruch (1962; 1978) developed the hypothesis that anorexia nervosa is a condition that grows out of the inability to experience or express one's emotions. This psychological theory has gone on to develop and become a well-researched area with a general agreement that, for people suffering with an eating

disorder, their perception of emotional experience is aversive and overwhelming. It is proposed that the development of an eating disorder is a way of avoiding "feeling" (e.g., Dolhanty & Greenberg, 2009; Fox & Harrison, 2008; Geller, Cockell, Hewitt, Goldner, & Flett, 2000; Waller et al., 2003).

Fox and Harrison (2008) found that people with eating pathology have difficulties with emotional regulation and emotion perception. They discussed how weight loss may be a method to suppress emotions. Fox and Froom (2009) found that anger and sadness are strong contributors to eating dysfunction. Ioannou and Fox (2009) found that in eating disorders there was a perceived threat to feeling angry. There is a growing consensus in the research that threatening emotions (e.g., anger) are directed away from the self and onto the body, via body dissatisfaction (Fox & Harrison, 2008; Geller, et al., 2000; Hayaki, Friedman, & Brownell, 2002;).

Most of these studies use a broad classification of eating disorders (e.g., Fox & Froom, 2009; Fox & Harrison, 2008; Ioannou & Fox, 2009). Anorexia has been estimated to account for up to 10% of the population with an eating disorder (B-eat Facts and Figures, 2011). This is a small percentage and if this is reflected in the samples used in these studies, it is difficult to ascertain the exact implications on this population. Furthermore, it has been suggested that anorexia is a distinct disorder (Guinzbourg, 2011) and the anorexic specific data may have been obscured in a sample that consisted of a majority of the other sub-types.

Such quantitative studies in this area have yielded valuable findings and refined psychological theories on eating disorders. It is striking how difficult it is to generalise findings to the anorexic population and anorexia continues to remain an enigma in the quantitative world. The research within this area does not appear to consider the meaning that the individual assigns to their emotions or feelings. The researchers adopt a positivist position by assuming that the way in which one experience emotions can be fixed and made "normal". The assumption that there is a normal way of experiencing and expressing emotions draws on social norms and what is considered appropriate. With an experiential area such as "emotion", qualitative methods may provide ways of gaining insight into this aspect of anorexia.

Qualitative research would be more likely to capture the depth and richness of the individuals' worlds and their fear of such emotions which could complement the existing quantitative research: it would enable a better understanding of the embodied subjectivity of being anorexic (Ward, 2007). As suggested by Smith, Flowers, and Larkin (2009) a useful outcome of qualitative research could be information for clinicians to transfer into their practice.

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There is one qualitative research paper on emotional processing in anorexia, which looks at this from the perspective of the patients, their parents and clinicians (Kyriacou, Easter, & Tchanturia, 2009). Focus groups were used for each of the participant groups and inductive thematic analysis was used to analyse the data. The aim was to present descriptive accounts from the three different perspectives. True to the qualitative nature of the research it adopted thorough strategies to certify reliability and validity; in particular triangulation was used in developing the themes.

The following themes were found amongst all three participant groups: a lack of emotional awareness and understanding; inability to tolerate, contain and cope with emotions; emotional avoidance; difficulty in expressing emotions and negative beliefs; extreme emotional responses; problematic social interactions and interpersonal relationships and a lack of empathy. The level of correspondence across the participant groups suggests that there is a common agreement amongst clinicians and clients about the difficulties in the emotional processing of these clients. As the sample of clients was inpatient-based it is possible that clients have developed this perception through access to treatment and this level of insight may be lessened if they were newer to treatment.

There has been some research that has taken a phenomenological approach to the experience of anorexia. In particular, research is being published on individuals' experiences of their eating disorder and the recovery process through the use of qualitative methods in order to learn about their function, treatment and the process of recovery (Ross & Green, 2011; Spivak & Willig, 2010). There has also been research emerging from the therapist's perspective of working with people with an eating disorder and what professionals think is important in the treatment of this client group (e.g., Jarman et al., 1997). Recently there have been qualitative investigations into therapists working within this area who have recovered from an eating disorder themselves (Rance, Moller, & Douglas, 2010).

Practitioners' Negative Responses to Treating Anorexia

The clinical and medical picture of how working with this client group can be challenging has been outlined. There has been investigation into attitudes and experiences of professionals working with the anorexic population, which has highlighted personal feelings and responses. Orbach (1986) stated how personally demanding and anxiety-provoking these clients can be to clinicians. She proposed that clinicians would experience heightened responses if they were working within an area they had not received specific training for, or had not had experience of treating this

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client group. This suggests that training and experience are important mediators in the personal toll that this work takes.

Goldberg (1986) stated that the majority of psychotherapy and specifically eating disorders research has "ignored an extremely significant part of the process - the practitioner" (p.25). Jarman et al. (1997) point out how health-care professionals have multiple perspectives on anorexia and that this will guide the clinicians' understanding, interventions and what they bring to the therapeutic context. They emphasise that it is the "understandings and opinions of health-care professionals, working in localized treatment contexts that is of direct relevance to the clients' and clinicians' experiences of the treatment process" (p.139).

Jarman et al. (1997) focused their research on the individual professional's subjective understandings and experiences of treating young people with anorexia nervosa. They interviewed a range of professionals who worked in a multi-disciplinary team and used Interpretative Phenomenological Analysis (IPA) to analyse their data. They found that the issue of control was an important theme in the participants' experiences of their clients. The exploratory nature and idiographic emphasis voiced a rich insight into the participants' individual experiences which highlighted similarities and divergences across the team.

This exploration revealed how different professional interpretations of the concept of "control" resulted in different attitudes towards clients and impacted on the treatment that the client received. They also found that it influenced how the therapists personally experienced this process. They concluded that it is important to research therapists' subjective understandings and experiences and that a qualitative method is valuable in doing so for clinically relevant research. Further exploration or interpretation about the differences between the professional groups would have been insightful and useful. Future research could explore the professional groups individually to examine differences in their interpretations of their experiences when working with this client group. This would be insightful to multidisciplinary teams and may be useful in providing comprehensive treatments for clients with anorexia.

Hepworth (1999) conducted qualitative research on health-care professionals in which they found that behavioural practices caused the patients to become "resistant" to treatment and impeded on the therapeutic relationship. They found that this was related to a control and power struggle between staff and clients. This is thought to have affected the therapeutic relationship.

In a qualitative study by Reid, Williams and Hammersley (2010), where General Practitioners (GPs) were interviewed on their experiences of treating and managing anorexic clients, they found that it can be frustrating to treat someone who does not believe that they have a problem or does not want to change. This is depicted in this participant's response, "They're just so frustrating because they just don't, they don't see they have a problem. They see that we think they've got a problem but they don't see that they've got a problem." (Reid et al., 2010, p.5). The participants also found the clients to be "an awful lot of work", suggesting that treating these patients is both time-consuming and resource-consuming (Reid et al., 2010, p.5).

Williams and Leichner (2006) conducted a quantitative study investigating education and training in eating disorders for a sample of 225 Canadian psychiatry residents. They found that 28% of the sample reported that they had encountered negative attitudes towards patients with eating disorders from fellow students, nursing staff, physicians and other health professionals. This indicates that in treatment services, regardless of role, there can be a common feeling of negativity towards these clients. They found that 19.1% of these statements referred to eating disordered patients as being difficult, frustrating and/or exhausting to work with. The suggested implication for this study was to increase training opportunities in relation to this client group by strengthening the amount of eating-disorder content on the course and ensuring that residents are exposed to treatment research literature. This is in line with Orbach's (1986) earlier proposal about the impact of not having specific training.

In an investigation on treatment providers' experiences Warren, Crowley, Olivardia and Schoen (2009) used both qualitative and quantitative methods in a questionnaire. This elicited information about treatment providers' experiences of the frequency and management of commentary (direct or indirect) from patients about the treatment provider's appearance, personal change in affect, body image, and eating behaviours as well as asking them for their suggestions for others in the field.

The quantitative aspect of the research found that the large majority indicated that they received direct comments about their appearance, or felt that it was being monitored by their patients with eating disorders. This is enlightening with regard to how a professional could be exposed to such scrutiny, but it is the qualitative aspect that adds a deeper understanding to the impact that this had on the treatment provider.

The qualitative findings mirrored the earlier literature on this area (e.g., Kaplan & Garfinkle, 1999). They found that the most commonly referenced theme regarding the most difficult aspect of working with this client group was the resistance of severe and chronic symptom change. The second most common theme was the nature of the

illness and its prognosis which related to high risk aspects, relapse, and medical complications. This was followed by the nature of the illness and its prognosis, and then managing the personal negative effect this had. Alongside these difficulties, 20% of the respondents referred to relationship difficulties such as building a therapeutic relationship and managing countertransference reactions.

In constructing the questionnaire the authors have assumed which areas the treatment providers will find challenging. It could be argued that the authors have imposed a belief system onto the phenomenon. A questionnaire constructed from qualitative investigation may have been less presumptuous. This research does highlight some significant areas of importance for people working in this area, and how much of an impact this work can have on one's own self. The deductive nature does not allow the participants' experiences to be heard from their own perspectives. Furthermore, the sample size consisted of only 43 respondents, which is small considering its mixed-method approach. Its aim was to explore the overall personal experience and it could be argued that a phenomenological approach to this would be more suitable.

Such negative responses from practitioners are of interest and need exploration to increase awareness of this for professionals working in this area. Within this area, it seems that qualitative research methods are being adopted more frequently.

Impact of the Therapist on Treatment of Anorexia

There are a wide range of influences on "therapy" as part of treatment. Individual therapy itself is based within an individual or psychological perspective as it stresses that, through an individual getting to know themselves better, they can change (MacSween, 1993). However, the approach to therapy can differ depending on the individuals involved, their training, their beliefs about what influenced the development of anorexia for the client and their epistemological view.

Therapists are influenced by a range of theories in the treatment of anorexia, as discussed above, such as CBT (Fairburn, 2005; Fairburn et al., 2009), psychodynamic therapy ranging from self-psychology (Goodsitt, 1997) to an object-relation perspective (Winston, 2005), and feminist therapy (e.g., Katzman & Lee, 1997; MacSween, 1993; Wooley, 1995). Jarman et al. (1997) highlighted how much diversity and inconsistency there is amongst this literature on how to understand and treat people with eating disorders. In current literature there seems to be a common agreement across all schools within psychotherapy that people with anorexia struggle to manage their emotions and that a focus of the therapy is toward helping them to express emotions

and learn new ways to cope with these feelings (e.g., Bruch, 1982; Costorphine, 2006; Fairburn et al., 2009).

Thompson and Sherman (1989) acknowledged the importance of looking at the therapist in relation to the therapeutic relationship and therapy process, regardless of the psychotherapeutic model that they use. They argue that the therapy model could be considered less important than the deliverance of therapy to the client. In order to shed light on what hinders the recovery process for people being treated for anorexia, research in the 1980s turned the lens away from the anorexia and onto the therapy process and therapist (e.g., Frankenburg, 1984; Garner, 1985). Generally, research suggests that the therapist's emotional responses, or countertransference, influence the therapy process and treatment outcome across various forms of psychotherapy (Hayes, Riker, & Ingram, 1997). It is an important area to explore in therapy with these clients.

More recently, Williams and Haverkamp (2010) proposed that because of the difficulties of managing and treating this client group, only therapists who meet certain competency-based criteria should be working with this group. They conducted research using the Delphi technique on a mixed group of professionals who they deemed to be experts in this area. The method began with the authors bringing in the information from existing literature and documents, for example, the Practice Guideline for the Treatment of Patients with Eating Disorders (American Psychiatric Association, 2000) and similar documents, as well as an article entitled "Characteristics of an ideal psychotherapist for eating-disordered patients" (Anderson & Corson, 2001). They asked participants for their consensus and opinion on these documents in order to develop an understanding of the most common aspects that were considered important.

They developed a list of competencies that was comprised of experts' consensus on what would represent the minimum competency required for ethical practice in individual psychotherapy with this population. Amongst other findings, not relevant to this particular research, they found that developing and establishing a therapeutic relationship was a very important skill that was considered by the group of experts to be among the most critical required for minimally ethical practice with this client group.

The aspects of the therapeutic relationship that they found indicative of competency were building trust, safety and establishing facilitative conditions for this population. They specified managing client-therapist competition and comparison regarding body shape and weight as being specific to this population. Similarly to Thompson and

Sherman (1989), they argue that the therapy relationship is critical in recovery for this client group.

Williams and Haverkamp's (2010) strong consensus on the importance of competency in the therapeutic relationship suggests that the training of eating-disorder therapists must include significant attention to developing relevant relational knowledge and skills so that the benefits of the therapeutic relationship with anorexic clients are maximised and harm is minimised. They suggest that the implications of this research are: therapists should receive effective supervision by an expert in the area in which their countertransference responses are explored in order to manage the negative feelings that they experience towards their client; somatic and behavioural responses towards their client should be identified; any attempts to control the client's recovery should be addressed or any avoidance on the therapist's behalf to address the eating disorder symptoms acknowledged (Williams and Haverkamp, 2010).

This study has confirmed the importance of the therapist and their engagement in the therapeutic relationship, as well as the importance of their reflexivity on this aspect of therapy with anorexic clients. It enabled the participants to comment on pre-existing ideas, which are an objective and a top-down approach. This is interesting as the findings suggest that the therapeutic relationship is an important measure of competency, but it could be argued that it is difficult to understand and measure this subjective phenomenon. It is important to note that this research was conducted in the USA and may not be as applicable or representative of the UK. It is possible that the objective approach in this research represents a difference between the philosophies of counselling psychology in the USA and those in the UK (Moller, 2011).

Over 10 years ago, Kaplan and Garfinkle (1999) argued that research is needed to understand more fully the treatment difficulties that arise in these patients. Although this phenomenon has been well documented, few studies have actually examined it (Franko & Rolfe, 1996), and this has only improved slightly since. There is a need to re-visit this, as recovery figures and relapse rates are still bleak for anorexia (Keel, Dorer, Franko, Jackson, & Herzog, 2005). At present there are only two studies that have systematically researched how therapists feel towards their clients (Franko & Rolfe, 1996: Satir, Thompson-Brenner, Boisseau & Crisafulli, 2009). To my knowledge there is no research that looks at therapists' emotional experiences from a phenomenological perspective.

Systematic Research on Therapists' Emotional Experiences

Both of the empirical investigations in this area conceptualise the therapist's emotional response towards the client as countertransference. Franko and Rolfe (1996) provided the first research paper that examines therapists' emotional reactions to patients with anorexia and bulimia. They referred to emotional reactions as being countertransference. They used the term countertransference in its most general sense, which is "the feelings and emotional reactions evoked in the therapist during the therapeutic interaction with the patient" (Franko & Rolfe, 1996, p.108).

Countertransference reactions to anorexics, bulimics and depressed patients (control) were compared and it was predicted that the therapist would have more negative countertransference reactions to anorexic patients. The method required the therapist to reflect on the last therapy session that they had with the relevant patient and complete a questionnaire. The questionnaire focused on feelings, using adjectives, and a scale was provided to rate the intensity of the therapist's emotional response. The list of adjectives was created by the researcher and compiled from literature and from other experienced therapists in this area.

Their sample consisted of therapists who "specialise in the treatment of eating disorders" (Franko & Rolfe, 1996, p.110). However, there was no definition of what qualifies a therapist as being a "specialist" in this area. The authors later go on to explain that on average the participants' caseloads only consisted of one-third eating-disordered patients. This sample is not necessarily reflective of therapists who specialise in this area, who could be assumed to have a larger proportion of anorexic clients on their caseload.

The authors found that anorexic patients evoked more intense negative feelings in therapists than bulimic or depressed patients. The anorexic group had significantly lower scores than the other two groups for feeling "connected" and "successful". The highest rating was for feeling "frustrated" and "hopeless" after a session with an anorexic client. Anorexic clients generated significantly more feelings of hopelessness and helplessness than bulimic clients, but not significantly more than people with depression. Interestingly, therapists' reactions to anorexic clients were more similar to their reactions to those with depression than to those with bulimia, although it was found that people with anorexia were less engaged than people with depression. The authors linked this to the common risk of suicide and death in anorexia and depression. This also supports Guinzbourg's (2011) finding that anorexia is distinct from the other eating-disorder sub-types.

Overall, the authors proposed that the data are evidence for "patient-type" specific countertransference feelings with this client group. This study has provided evidence for and confirmed the commonly reported feelings in anecdotal accounts (e.g., Frankenburg, 1984; Garner, 1985). It also highlighted the negative nature of these emotions and proposed other aspects that were not "patient-type" specific as being influential on a therapist's countertransference. In regard to the number of eating-disordered patients on a caseload, the therapists reported feeling more frustrated and manipulated when they had a larger caseload of patients with anorexia. Length of experience working with eating disorders also had an impact on their responses; less experienced therapists felt more frustrated in response to their anorexic patients. They found that those with less overall experience reported more frustration, anger, fear and tension when working with their anorexic patients than did therapists with more experience.

These findings are concordant with Kaplan and Garfinkle (1999), who wrote a paper based on their experiences, alongside summarising the existing literature in the area. They proposed that the most obvious source for negative countertransference responses to this client group is the chronic nature and danger of their illness. They linked this to feelings such as anger, helplessness, and resentment.

The use of a questionnaire imposed a worldview and an agenda onto the participants (Hill, 2005). The research is not representative of the participants' actual experiences as it is difficult to get a sense of what it actually felt like to be in therapy with their client from a list of emotional adjectives. They suggested that it would be beneficial to include an interview in their data collection. However, they did not explore the rationale behind this or what this might add to the data that they elicited.

The other empirical study in this area is by Satir et al. (2009), which identified patterns of emotional responses and countertransference to adolescents with eating disorders from psychiatrists' and psychologists' perspectives. It took a quantitative approach to this phenomenon and a countertransference questionnaire was completed by the professionals alongside data collated regarding the adolescent (Clinical Data Form for Adolescents; Adolescent Eating Symptom Form; Shedler-Westen Assessment Procedure for Adolescents) and the therapy process (Psychotherapy Effectiveness Form). The countertransference questionnaire included thoughts, feelings and behaviours and was adapted from an adult countertransference questionnaire (Zittel & Westen, 2003). The use of questionnaires limits the information that can be gained about the experiences and it assumes a causality relationship.

It explored the nature of the countertransference responses with regard to these other measures, as well as patient and clinician descriptive statistics. The clinicians were required to reflect back on a session to complete the countertransference questionnaire. This research was not biased in the theoretical orientation of the clinicians, and countertransference was referred to in the same way as Franko and Rolfe (1996). This limits how the generalisation of these findings can be extended to areas that use a narrower definition of countertransference, such as psychoanalysis (e.g., Clarkson & Nuttall, 2000).

Whilst the authors defined the population as "adolescent" the average age of the anorexic clients being treated was 16.5 years old. In many services this age group could be treated in an adult service. Therefore, the findings from this research could still be relevant for young clients in adult services.

The research found that countertransference reactions reflected the following (listed in order of most experienced feelings first): bored/angry at parents; failure/incompetence; overinvested/ worried; angry/frustrated and aggressive/sexual. However, these feelings were not scored highly; interestingly, they found that the negative reactions scored lower than the positive ones.

This is in contrast to the popular belief and previous literature. It is possible that this may highlight a lack of positive feelings being reported in other studies. Alternatively, it may indicate that therapists feel more positively towards adolescents being treated for anorexia as opposed to adults. A limitation of this study is that it is subject to defence bias on behalf of the therapists; because of the introspective nature it could be argued that the therapists cannot be aware of all the process issues that arise between themselves and the client. Involving a third person may have cast light on process issues outside of the participants' awareness. It is also possible that the therapists found it challenging to disclose negative responses to their clients as part of a research process.

Unlike Franko and Rolfe (1999), Satir et al. (2009) did not find that number of years of clinical experience predicted lower levels of negative reactions. However, with regard to experience they only referred to number of years as a "professional", not as working within this specialist area, which could explain this discrepancy. Kaplan and Garfinkle (1999) stated that a therapist's inexperience in treating eating disorders can have a negative impact on the engagement of a client and on building a trusting relationship with someone with an eating disorder. They explain that this experience could impact on the client's faith in treatment and any future treatment.

Satir et al. (2009) proposed that the following aspects can also interact with process issues: the severity of the client's illness, whether the client is hospital-based and if they have a co-morbid diagnosis with personality disorders. Specifically, they found that a patient's personality was a considerable factor in explaining the clinician's reactions, as was level of functioning, length of time in treatment and client's improvement. These findings echo the suggestions from Kaplan and Garfinkle's (1999) literature review and anecdotal claims.

The sample used in this study needs critiquing. It consisted of psychologists and psychiatrists and these two different professional groups are quite distinct. Their profession could have elicited different reactions because of different training experiences. For example the psychiatrists could be more likely to understand their experiences based on the medical model. Satir et al. (2009) did acknowledge that it was likely that there was a difference in the feelings between these professions. In particular psychiatrists felt more anger, frustration, aggression and sexual drive than psychologists. It suggests that there was something different occurring between the two professions and perhaps it would have been clearer if the groups had been explored separately.

The combination of the information from the authors' different approaches to this phenomenon could be a good indication that working with anorexic clients will evoke negative reactions because of the nature of the illness. These findings are interesting and confirm the suggestions in the literature. Both the systematic studies on the area of a therapist's emotional experience rely upon retrospective methods, which may not capture the essence or the nature of the emotional reaction when it was at its most intense. Neither of the methods explores the experience using the participants' words; it could be argued that the research lacks a true understanding of their individual experiences. The quantitative research in this area fails to acknowledge the "subjectivity" of the participant, which is the way that the individual makes meaning of their experience.

Influences on Emotional Reactions in Therapists Working with Anorexia

The preceding section gave a thorough overview of the aspects of anorexia that evoke strong emotional responses in therapists. However, within the personal and intimate therapeutic relationship, there are thought to be other aspects that contribute to the therapist's emotional responses, such as personal aspects of the therapist and of the

client. The following will be explored in relation to countertransference, therapist variables, therapy relationship and process.

Therapist variables

In their review Kaplan and Garfinkle (1999) acknowledged that a potential contributor to the difficulty in therapy with this client group was aspects within the therapist. This emphasises the therapist as an active ingredient in the treatment and assumes a level of responsibility to ensure that the therapist is mindful of himself or herself, and how this may contribute to the success or failure of therapy.

Within all areas of psychotherapy, self awareness is a critical component of clinical practice (La Torre, 2005). The "counsellor's self" has been described as encompassing their inner processing of thoughts, feelings, beliefs and their personality, all of which will influence their experience of their client and the sense that they make from this (Reupert, 2004). The positive contribution of self in therapy has been found to be due to self-awareness and reflectivity (Reupert, 2004). In most therapy training courses a therapist is made aware of how their personal experience can influence how they relate to and understand their client.

The gender of the therapist has been proposed as having an influence on the emotional reactions of the therapist when with this client group (Burket & Schramm, 1995; Franko & Rolfe, 1996; Kaplan & Garfinkle, 1999; Satir et al., 2009; Thompson & Sherman, 1989; Waller & Katzman, 1998; Zimmer, 1995). Kaplan and Garfinkle (1999) stated that gender issues can arise when working with these clients with regard to female therapists. Possible reasons for this have been explored in the discussion on feminist and sociological perspectives on anorexia.

Frankenburg (1984) found that there were issues around competitiveness for female therapist-client relationships. They referred to female therapists as being subject to scrutiny of their bodies from the client. This may create competitiveness within the relationship, which can have a negative influence on the therapeutic alliance. Shisslak, Gray, and Crago (1989) found that a large proportion of their sample of professionals felt greatly affected by their work with their client. They reported a heightened awareness of food and their physical conditions which led to changes in body image, appearance and eating habits. Rance et al. (2010) explored "recovered" eating-disordered therapists' experiences of working with clients with an eating disorder and found that they experienced their eating disorder history to be a "double-edged history" (Rance et al., 2010, p.382). It either hindered or helped the therapist in their work with their clients.

Attention from the client to the therapist's body has been reported as a contributor to the therapist's experience of their client. Warren et al. (2009) documented that therapists can experience a client with anorexia as being aware of their body. They agree that this may be experienced as challenging for a female therapist working with female clients and that such scrutiny of the therapist's appearance can influence their awareness of their own eating patterns, food and appearance. This highlights a feminist perspective on therapists' experiences, as these too refer to the pressures of society on women that may be highlighted when faced with a potential analytical eye.

Koenig (2008) highlighted that being an overweight therapist treating an underweight client can be difficult for both parties. A restrictive client may not believe that an overweight therapist can help them, or the therapist may feel some level of difficulty about their own weight in relation to an underweight client (Koenig, 2008).

Lowell and Meader (2005) provided an autobiographical account of how being a "thin therapist" can induce transference-countertransference responses. The authors reinforced how the therapists' bodies should be used as a tool to explore the client's feelings. They also proposed that under these influences a therapist can struggle consciously and unconsciously with wanting to be curvier to ease the discomfort of the feelings that are targeted at their body. Neither of these perspectives on being underweight or overweight explores gender issues that may arise from different gender-mixed therapeutic relationships.

Presumably there are more than just the weight and body issues that may contribute to feelings of envy in a client towards a female therapist. Frankenburg (1984) explored how clients may have fantasies about and feelings toward their therapist, as the "working woman". They may view this as something out of the ordinary based on traditional societal beliefs. Or they may view the therapist as someone who is functioning at a high level and has managed aspects of life that they have not. The way in which the client responds to the therapist may evoke countertransference responses.

A female therapist with children may be faced by other doubts due to the many demands on her time. She may experience guilt for feeling as though she has neglected her maternal role and duties, as well as feeling resentful towards her children for no longer being able to fully focus on her professional commitments (Person, 1982). This may influence the way in which she feels towards working with clients. It has been suggested that the therapist's over-identification with a client can create countertransference issues (DeLucia-Waack, 1999).

Baumann (1992) found that counsellors who worked in this area may experience feelings of ineffectiveness and inadequacy. As proposed by Hamburg and Herzog (1990) this may be a therapist's countertransference response because of an aspect within them. They stated that it is a sign of countertransference if the therapist interprets this experience as being because of a personal shortcoming in their ability as a therapist and not because of the complexity of the client. This suggests that the therapists understanding of countertransference extends beyond the broad classification of all feelings towards the client, to an interpretation of their experience as either being about them or about their client.

In a personal account written by Derenne (2006) she offers her personal experience of the challenges she has faced when working with this client group. She reflected on how self-conscious she felt in response to experiencing eating disorder clients as berating when she was new to the area of eating disorders. This is interesting as professional competence in the treatment of eating disorders has been identified as an important issue (Gurney & Halmi, 2001). This suggests that therapists who are new to this area may be more likely to feel self-conscious and to experience self-doubt. However, Hamburg and Herzog (1990) stated that an expected aspect of working with eating-disordered clients is feeling a sense of being wounded by the patient.

Exploration of aspects of the therapist's self has illuminated that there are tendencies within therapists that may evoke negative responses towards their clients.

The therapeutic relationship and the therapy process

Cohler (1977) stated that the negative feelings experienced when working with eating disordered clients are, "perhaps the most intense encountered in a therapeutic relationship" (p.353). In their theoretical paper, Thompson and Sherman (1989) uncover what they think are mistakes that affect the therapy outcomes with anorexic clients. They believe that the therapeutic relationship can be both helpful and harmful. They propose that an inadequate relationship, lack of focus on emotional reactions and non-attendance to important aspects of the therapy process could be harmful and could maintain the anorexia.

They state that if the emotional reactions that are evoked in the therapist are not explored then the therapist could respond in a way that unhelpfully evokes an issue (Thompson & Sherman, 1989). Here they separate out unhelpful "iatrogenic" responses as being different from countertransference or transference responses. This adds another dimension to thinking about what is alive in the therapy process with this client group.

Hamburg and Herzog (1990) remarked that when in therapy with anorexic clients it can feel as though the client is in control of the therapy and therapist, and this can be paralysing for the therapist. It has been noted that anorexic patients often experience interpersonal difficulty trusting therapists and can struggle to share power and control with the therapist (Burket & Schramm, 1995; Kaplan & Garfinkle, 1999). This may evoke feelings within the therapist that could be experienced as negative in response to perhaps feeing challenged, shut out or disabled. They explore this from a psychodynamic perspective, arguing that it is partly because of the patient's projective identification. In their clinical experience they referred to a common response, when working with this client group, was feeling rage. They say that this can feel shameful and unfamiliar, particularly for young therapists.

The literature in this area strongly hints that there are common aspects of the therapeutic relationship and process that can feel challenging to a therapist. Whilst this seems to be a common notion, there is a lack of research that examines this area so it is hard to generalise or interpret these claims in relation to personal experience. Furthermore, these experiences are often framed within a psychodynamic interpretation.

Psychodynamic Perspective on Countertransference and Anorexia

Most of the literature on the topic of therapists' experiences of working with people being treated for anorexia is based either within a medical model, or talked about using psychodynamic concepts. A majority of the papers within this area are anecdotal accounts from psychoanalytic perspectives as opposed to research.

Unlike Freud (1959) who saw countertransference as something that contaminated therapy, Clarkson and Nuttall (2000) stated that countertransference can be an important indicator of transference and can offer rich information about the client's psychological world. The attitude that it can facilitate therapeutic growth is more common now within the broad psychodynamic point of view.

It is particularly relevant here because framing something as countertransference requires the therapist to be reflexive and to think about their experience in relation to their client. From the psychodynamic perspective a therapist's emotional experience in response to a client may be a countertransference response depending on the origin of the response.

In Erlichman's (1998) paper he explained that he has found his countertransference response to be a powerful tool to use with this client group.

> Eating disorders can induce strange and curious countertransference responses, and for that reason many therapists, veterans, and energetic newcomers alike, choose not to work with this population. The countertransference reactions and memories induced in treatment are frequently too difficult to tolerate. The profound pain that patients unravel is sometimes like balls of yarn that may have been tied so tightly that fingers hurt loosening the knots and tangles that have laced together over the years. (Erlichman, 1998, p.289)

He noted that therapists can leave sessions feeling confused, angry and frustrated; which can be the feelings that reflect the patient's own difficulties through an unconscious and conscious identification on the therapist's behalf. He commented that it is impossible for a therapist not to fail at times or to be tripped up by their countertransference responses. He asserted that these responses are a natural resource to be used in therapy.

Zerbe (1992; 1993; 1995) has written extensively about the challenges faced when working with the eating disordered population. In a review on eating disorders she outlined the importance of the therapist considering their countertransference responses and the process of projective identification with this client group (Zerbe, 1992). She said that countertransference dilemmas can be evoked by recognising three core relationship struggles. The first one is that the client's masochistic tendency will unconsciously attempt to control the therapist and coerce them into being the "bad object". Secondly, she used Freud's (1936) term "identification with the aggressor" to describe the eating-disordered client's tendency to be hostile. Finally she recognised that the therapist's excessive need to change the client and their eating behaviour can be a countertransference response. Zerbe (1992) asserted that the therapist, and the structure of therapy, may feel attacked through a process of projective identification as well as made to feel worthless or useless. She stated that the therapist "becomes the vehicle for the patient's own projections of inner badness" (p.179). She concluded by urging therapists to be more emotionally available to their clients.

Hughes (1997) wrote a paper on countertransference in the treatment of anorexia from her clinical experience and from a psychoanalytic perspective. The essence of this paper is that countertransference reactions in therapy with this client group are essential for the therapist to be aware of and to use therapeutically. She suggested that the therapist working with this client group is "likely to find himself in the painful grip of countertransference feelings" (p.262). In the paper she presented four anecdotal scenarios which focused on difficulties that may occur in the therapeutic

relationship, and concludes that the therapist's reactions can give insight into the patient's conflicts.

The four scenarios that are presented are as follows: 1) denial of the reality of sexual maturity; 2) withholding and the implicit refusal to take from the therapist or the therapy; 3) eliciting "special" help only to sabotage it; and lastly, 4) evoking acute anxiety in the therapist while remaining free from anxiety.

Hughes (1997) talked about how countertransference responses may be a reaction to the anorexic's self-destruction and how this is acted out in the therapy, and in the therapeutic relationship, which is similar to Zerbe's (1992) reference to the client's masochistic trends. This is in agreement with Hamburg and Herzog (1990), who stated that intense countertransference reactions were the result of the anorexic client's "tortured relationship to nurture, both nutritional and emotional" (p.370).

Within these scenarios several emotional reactions, such as frustration, feeling inadequate, disappointment, helplessness, inflated responsibility, hatred and fear are referenced (Hughes, 1997). She suggested that countertransference reactions could be similar to those that the anorexic's parents feel and that the family dynamics will be played out in the therapeutic relationship. It has been proposed that there is a parallel between the role of the mother and the role of the therapist in therapy with anorexic clients (e.g., Frankenburg, 1984; Hughes, 1997). Within the literature on anorexia, attention has been paid to anorexics' relationships to their mothers (Jessner & Abse, 1960; Lorand, 1943; Meyer & Weinroth, 1957).

Frankenburg (1984) acknowledged that often in the early stages of therapy, both the therapist and the client's mother want them to gain weight. He wrote about this as if this relationship could mobilize unconscious conflicts over trust and control. It is proposed that therapy and the therapeutic relationship is the place to work through these and the therapist needs to be aware of such transference issues in therapy.

Hughes (1997) stated that the patient's confusion between the reality of her family relationships and her internal world will get played out in the therapeutic relationship. She spoke about how the therapist will experience the feelings that the client and parent have felt in this situation. This implies that the therapist may simultaneously experience feelings that are familiar to those of the mother of the client, as well as experiencing how the anorexic child feels.

Hughes' (1997) paper explored therapists' emotional reactions from a psychoanalytic perspective. It provides in-depth interpretations on experiences, which can be

insightful for therapists grappling with these issues. This could be useful for all therapists' clinical work, regardless of their preferred model.

It is important to note that it is difficult to generalise all of these accounts of countertransference because they are based on the authors' experiences. Although, it is often the case that important understandings about a phenomenon are exposed by analysing an individual's experience and explanations, this highlights an area that could benefit from being researched. In order to maintain the richness from the personal accounts, qualitative research could provide a robust methodological framework to explore such issues, which would enable the findings to be interpreted by the reader within the context that the research was conducted.

Importantly Zerbe (2003) stated that in professional meetings, such as review conferences, there are often discussions regarding therapists' management of their feelings. She concludes that this is a signal for:

> the treater's need to feel heard and understood in working with such challenging patients. The desire to be recognized for one's unique struggles and inner turmoil at a most dangerous treatment impasse is thus a central problem for both patient and therapist (p.162)

This suggests that the therapist needs to be encouraged to voice their experience and to feel heard.

It can be concluded that the research on countertransference reactions has been explained as being a response to the client's destructiveness. Once acknowledged and understood, the literature recommends using countertransference responses as a powerful tool in therapy (e.g. Hughes 1997). This is in stark contrast to Freud's (1959) earlier opinions on countertransference. With these suggestions in mind the current research hopes to encourage participants to explore and document their own emotional reactions. This disclosure appears to be backed up in the literature as helpful to therapeutic practice.

Criticism of the psychoanalytic approach

The dominant psychoanalytic perspective discussed is focused solely on the individual intra-psychic experience. More specifically, the majority of the literature uses concepts that come from a Kleinian perspective e.g., projective identification. Frosh and Baraitser (2008) have proposed that the psychoanalytic perspective adopts a "top-down, expert-knowledge epistemological perspective" (Frosh & Baraitser, 2008, p.347). They highlight that the psychoanalytic perspective tends to the belief that there are certain "truths" about psychic life and that through interpretation an individual can

discover this "truth". Thus this perspective concedes that the "interpreter" (therapist) knows better than the subject (in this case, the anorexic client). It could be argued that psychoanalysts have moulded their experiences around a theoretical perspective. This is in conflict with a phenomenological approach, which maintains that the individual is the expert on their experience.

Wetherell (2003) criticised psychoanalysis for separating social relations from the deep psychological aspects that psychoanalysis is concerned with. She argued that they are static and confined to thinking only about an individual's early development whilst ignoring the fluidity of human development, and how people relate to other and develop through social interactions. Furthermore, the psychodynamic perspective does not account for wider contextual issues that might be influencing therapists' emotional responses, such as those of culture and society. It is possible that an individual is both social and psychosocial; anorexia could be viewed as being formed through social formations, as well as the individual having agency over her and an internal world.

Summary of literature and research justification

It is striking that clients with anorexia have been found to evoke powerful negative feelings in therapists (Frankenburg, 1984) considering that the expression of negative feelings has been proposed to be almost "absent" in therapy with this client group (Winston, 2009). This raises an important question for the field of psychotherapy about how therapists experience therapy with anorexia clients and how they go onto make sense of their experience.

Although there has been a development in research to consider the influence of the therapist in the treatment of eating disorders, there is still little systematic research that has explored how therapists experience this client group, the emotional challenges that they face and how they personally and clinically manage this. Finding out more about the phenomenological aspects of emotional experiences may enable therapists to be better prepared for their therapeutic interactions. This is especially important considering the finding that negative feelings in therapists can be found to be predictors of poor outcomes in treatment (Free, Green, Grace, Chernus, & Whitman, 1985; Parloff, Waskow, & Wolfe, 1978). As Warren et al. (2009) stated, this type of research is important to "create a forum to explore, process and discuss common personal reactions, and provide data that normalises potentially difficult experiences when working with patients with eating disorders" (p.29).

This current research requires the therapist to reflect on their feelings, thus raising the issue of reflexivity. Reflexivity is not discussed in the other research on this area,

perhaps because the research is rooted in a positivist epistemology where there is an objective truth, and the truth can be studied from a position of neutrality. Frosh and Baraitser (2008) argued that the psychodynamic perspective upholds that an objective truth does exist. This research is introducing a new aspect to this field by moving towards a reflexive view of this area in which an experience cannot be studied objectively. It challenges the idea that there is a truth and looks at the process of how someone's reality is constructed. This requires the researcher to provide an honest account of what they bring to the research to transparently show how they made sense of the subject's meaning-making process.

Non-model specific understanding and exploration of emotional reactions with this client group would be insightful to all therapists of all backgrounds. This is needed at a time when a broader range of people will be offering therapy to this client group as a result of current changes to the National Health Service (NHS) and the introduction of Improving Access to Psychological Therapies (IAPT) workers. With these changes there is a drive to practise evidenced based therapy and there is a current movement towards a transdiagnostic model for treatment of anorexia (Fairburn et al., 2009). It is important that all therapists, regardless of model are aware of the emotional responses they may engender.

Research Aim

The aim of this research is to explore explicitly the emotional reactions therapists have to clients being treated for anorexia, during and after therapy, and the psychological process they embark on to make sense of this.

This study will contribute to the development of an understanding of the nature and the experience of the emotional reactions therapists feel when with anorexic clients. This aims to help therapists in their everyday treatment of anorexia, with the focus on the phenomenological experience of emotions in the process of therapy.

Objectives

This research is intended to look at "emotional reactions" in the broadest sense. It has been recognised that for many people this could be referred to as countertransference. However, in order not to define and impose a definition, model, or concept onto participants the research will remain neutral regarding terminology and not refer to countertransference unless the participants do. The objectives are as follows:

- To increase awareness of the common emotional reactions and the psychological processes behind this.
- To normalise and share the experience of emotional reactions in therapy with this client group.

  - To provide an extensive and detailed account of this phenomenon.
  - To highlight the importance of paying attention to emotional reactions and the therapeutic process with this client group.
  - To contribute to the understanding of the therapeutic process and increase knowledge about the nature of individual therapy with this client group.

There are no hypotheses for this research to allow it to remain an open exploration (Heppner, Kivlighan, & Wampold, 1999). A common feature of qualitative research is that it is not constrained by hypothesis; general research questions are asked to allow the researcher to be open to new and unpredicted ideas (Heppner, et al., 1999).

Research Questions

- How does this group of therapists experience their emotional reactions and feelings when in therapy with clients being treated for anorexia?
- How does this group of therapists make sense of their emotional reactions and feelings towards their client after the session?
- How does this group of therapists experience reflecting on their emotional reactions and feelings towards their client after the session?

Personal Reflexivity

Willig (2012a) stated that the researcher's personal experience, or lack of personal experience of the phenomenon under investigation, needs to be thought about as it will inevitably frame the researcher's approach to the topic. I will declare my relationship to the area of therapy and anorexia and how this has shaped the research.

I have worked in a specialist eating disorder unit for over five years as an Occupational Therapy (OT) technician alongside my training as a counselling psychologist. The majority of my work has been with patients on the severe end of the spectrum of anorexia, who have been treated in an inpatient setting. The professional team encourages acknowledgement and exploration of my own emotional reactions towards clients, which I have found helpful. I have found this to be both a professional and personal release as well as an insightful process.

My OT job was my first experience of working in a "therapeutic role" and this has shaped the way that I approach therapy and counselling psychology. The service was multi-disciplinary but managed and delivered treatment from a medical and psychodynamic model. Before I came into my training as a counselling psychologist I did not question these approaches but accepted them. I believed that we, as a service, knew what was best for the "patients". My training has opened my eyes to a much wider view of "treatment" and how this can be biased by social, linguistic and political forces, which all shape an individual's experience. During my training I have been introduced to different therapy models, met a wide range of people and broadened my knowledge of therapy.

I would now describe myself as "integrative" in my approach as a counselling psychologist. My natural inclination is to use psychoanalytic concepts to make sense of my experience. However, I try to be transparent and open with my clients, as I believe that this can facilitate change and interpersonal closeness in the therapeutic relationship.

As I have come to the end of my training, I am aware that I need to find my place within counselling psychology and I am continuing to develop a more critical approach to the medical model and the psychoanalytic approach to help me challenge my tendency to search for a "truth". Throughout the research process I have attempted to acknowledge my beliefs to show how they have shaped the focus of the research and my biggest challenge has been to take a more critical slant as an IPA researcher.

When it came to deciding what to investigate as part of the counselling psychology doctorate I knew that I wanted to focus on therapy and anorexia. I found that there was a wealth of information on this area and more qualitative research surfacing into understanding people's journey of recovery from anorexia (e.g., Espindola & Blay, 2009). My experience of working with two anorexic clients as a counselling psychologist pointed me in the direction of the emotional response of therapists.

My first experience of offering therapy to anorexic clients was quite intense, anxiety-provoking and bewildering. This surprised me as I had classed myself as experienced in this area and had read a breadth of literature on theory on anorexia. However, nothing could have prepared me for the intensity of my own emotional responses to two clients. With one client I experienced strong nurturing and protective feelings, but an intense neediness, which felt frightening at times. She was a healthy weight, timid and in need of nurturing. With another client I felt hostile, irritated, defensive and rarely experienced any feelings of warmth. She was spiky, emaciated and critical of

me and of therapy. This confirmed my belief that emotional experiences towards clients should be encouraged to be expressed in services.

Consequently, I was not surprised to read in the literature that this client group is a particularly challenging group to work with and can induce negative responses from clinicians (e.g., Frankenburg, 1984; Garner, 1985). As a neophyte therapist considering specialising in this area I wondered how experienced therapists understood, formulated, and made meaning from their experience and if they too felt as bewildered and overwhelmed as I had. I was hoping to find some answers to some of my perplexing experiences. On reflection I may have approached this research looking for a tangible reason, truth or secret to help me in my journey to becoming a therapist who specialises in this area. The question I wanted to answer was whether the therapists are feeling the very emotions that these clients disowned. By holding this question in my mind I was aware that this was my main motivation for exploring this area and I was drawn into looking for this in the data. However, I have reflected on this throughout the research process and attempted to stay as close to the individual's experience as possible.

I soon discovered that there are a multitude of truths to explain people's experiences and what was actually more interesting was how people made sense of their experience.

Through working with people suffering from an eating disorder I have become much more aware of my own struggles with my body image. When I started working in this area I was very unhappy about my weight, not comfortable with my femininity, and I was struggling to navigate my way into independence after completing my undergraduate degree. The "adult" world seemed a competitive and frightening place and I now believe that I unconsciously opted out by settling into a "comfortable" job with little career prospects (OT) and moving home to live with my parents. On reflection, I think I felt powerless to change this situation until I decided to embark on some further professional training.

As I embarked on my professional training I felt the pressure to be as good as I can be at everything. This, alongside my day-to-day contact with people having similar struggles and using eating as a way of managing this, meant that I too lost weight and I began to feel more in control and better about my life. This was short-lived and I managed to work through this in personal therapy and in my relationships with friends and family. I have found a middle ground in which at times I do get drawn into fixating on my body, but I am more aware that it is a sign of me feeling out of control and powerless in my day-to-day life. I am now more comfortable with myself and, instead

of using food so unhealthily to make me feel more in control, I am able to express myself verbally. Now that I have navigated the transition into the "adult" world I feel like many women in society today: enormous pressure to balance a career, to be good enough in my relationships, to maintain a home, as well as trying to keep up to date with fashion and to look as good as possible.

Methodology

This chapter discusses theory relating to the methodology by looking at the epistemological view point the study adopts and the theoretical perspectives that underpin the study. Crotty (1998) claimed that "the philosophical stance inform[s] the methodology and thus provide[s] a context for the process and grounding its logic and criteria" (p.3). This chapter will also address how the method was borne out of these perspectives and outline the research procedures that were carried out in conducting the research.

Research Design

The study employed a qualitative research design using a combination of a diary method and semi-structured interviews to enquire about the meanings the participants assign to their experience (Reid, Flowers, & Larkin, 2005). This was gathered from a small homogenous sample and the data collected was analysed using Interpretative Phenomenological Analysis (IPA), and presented across multiple cases to form a collective account.

Rationale for Adopting a Qualitative Methodology

In the existing research, quantitative methods have yielded valuable findings in confirming and expanding upon the belief that people with anorexia evoke negative feelings in therapists. However, the richness of this experience has not been the focus of, has been captured in, these studies as suggested by Gelso, Hill, Mohr, Rochlen, and Zack (1999). The focus has been on trying to understand the cause and effect relationship between working with these clients and the resulting emotions. Similarly the anecdotal accounts of this phenomenon are insightful, detailed and capture a sense of the complexity surrounding this area but they only explore the author's perspective and reality and there is not a sense of a collective experience.

This research is committed to exploring, describing, interpreting, and putting into context how each participant makes sense of their emotional reactions in response to their anorexic clients. It was imperative that the participants provided this information in their own words to capture their experience, their sense making and their relationship to their experience (Taylor & Bogdan, 1998).

As Solomon (2006) argued "it is as living human beings, not just as scientists, that we want to understand and appreciate our emotional lives", (p.1). This belief captures the underlying premise of the current study in its quest to understand more fully therapists'

emotional experiences. A qualitative method was adopted as it provided the means to explore the research questions and to enable a richer description of the experience and capture the complexity of the phenomenon. Qualitative methods would also enable the presentation of a collective account which has gone through a set of analytic stages to ensure that the research is rigorous.

There are wider aspects of the intentions of this research that would be best addressed by qualitative methods. The research aimed to produce findings which are particularly applicable to clinical settings, and qualitative methods are considered to be ideally suited to this (Gilgun, 1992). Jarman et al. (1997) emphasised that qualitative methodological approaches for clinically oriented research are valuable, especially in the field of eating disorders. Furthermore, research that investigates the concept of countertransference in psychotherapy and its implications has moved into a qualitative paradigm (e.g., Hill, 2005).

Rationale for a phenomenological approach

The nature of therapy is a phenomenological encounter in which one tries to understand the essence and quality of another's lived experience. For this research a phenomenological perspective was required to focus on the embodied experience of therapists, whilst accounting for and acknowledging the complex reflexive process required throughout this process with regard to researcher and participant.

Rationale for Interpretative Phenomenological Analysis

IPA was considered the most compatible qualitative methodology because of its in-depth analysis of an individual's lived experience (Eatough & Smith, 2008). As Smith et al. (2009) claimed "emotional experience is probably one of the strongest prevailing themes in the IPA literature" (p.200). Its ability to describe experience through inclusion of areas such as discourse, affect and cognitions made it the most compatible method for this research (Smith, et al., 2009). It enabled an investigation of the individual cognitions and experiences involved in the emotional reactions towards this client group (Eatough & Smith, 2008) alongside the scope to make tentative inferences about these aspects of their experience based on the participant's collective experience.

Language is another important feature of the study alongside the other aspects previously discussed. It is important to explain that Foucauldian Discourse analysis (FDA) was considered but was not thought to be as suitable in addressing the aims of this research. However, the particular approach to IPA that has been adopted does

share some common ground with FDA in examining how an individual's world is discursively constructed and how these shape their experience. This type of IPA acknowledges multiple influences, such as cultural, historical and social influence. It does this alongside recognition of discourses but its core focus is on the participant's overall experience (Eatough & Smith, 2008). The focus of this research is to throw light on the internal subjective experiences of the individuals, as well as reveal something about the outward social activity and the implications of this, if it arises. Discursive analysis could have overlooked the emphasis on internal activity, whereas IPA provides the opportunity to review the wider socio-cultural factors impacting on the researcher and participants' experiences, as well as the internal experience.

Eatough and Smith (2008) stated that "what is missing from such {discursive} accounts are the private, psychologically forceful, rich and often indefinable aspects of emotional life" (p.184). In this research, language has been approached as something that can uncover a deeper emotional experience. Emotions have been illustrated by Eatough and Smith (2008) to not just be discursive acts; they say that discursive accounts of emotions are not just illustrations of cultural labels that have been attached to something experiential, but may be purposeful in the communication, whether consciously or unconsciously. This suggests that language is affected by emotions, and that regardless of language, these experiences would still occur.

Grounded theory was contemplated as a methodological approach to this research area, but was considered less suitable than IPA because of the research's aim to provide a detailed and nuanced analysis of the emotional experience of the participants. If a grounded theory method was applied to this research, a theoretical account of the phenomenon of emotional experience would be produced (Smith et al., 2009). It was not the focus of this research to produce such a conceptual explanation or understanding of the phenomenon. It was considered that this approach might jeopardise the aim to provide the individual divergences and convergences amongst a small sample.

In relation to other qualitative methods, IPA is developing a reputation for being epistemologically flexible which can be desirable in psychological research (Larkin, Watts, & Clifton, 2006). IPA's flexibility with regard to methodological approach enabled a novel and adaptive method to suit the research and its aims. It allowed for the use of different data collection methods as well as an interpretative analysis of the raw data.

Compatibility of IPA and Counselling Psychology

It has been argued that the philosophical stance of counselling psychology is similar to that of qualitative research and IPA appears to be a compatible methodology to investigate a topic of interest to counselling psychologists, such as therapy (Ponterotto, Kuriakose, & Granovskaya, 2008). Humanistic and psychodynamic approaches to psychotherapy were originally anchored in qualitative research (Ponterotto et al., 2008). Such methods have served as a host to the development of many theories within psychology and psychotherapy (Ponterotto et al., 2008). For example, Roger's (1951) person-centred approach was borne out of analysis of case studies.

There has been increased attention recently in developing qualitative research methods in the field of counselling psychology (Ponterotto et al., 2008). Ponterotto, et al. (2008; p.461) acknowledged that "Counsellors and psychotherapists are naturally drawn to qualitative inquiry because this broad class of methods often emphasize the emotive and cognitive aspects of participant's experiences from their socially constructed worldview".

It has been acknowledged that qualitative methods emulate that of clinical practice for therapists and have more clinical relevance to their work. Findings from these methods can be considered more meaningful because they can be generalised to the therapy context, and the ideas generated can be applied to clinical work (Hill, 2005). As qualitative research encourages the active involvement of participants, it is a collaborative process that produces a rich account of specific contexts and subjective experience (Silverstein, Auerbach, & Levant, 2006). This imitates the basis of therapy, where the focus is on understanding the subjective experience of the participant, therefore they both imply a bottom-up approach. It seems that qualitative methods are a suitable match to research into issues related to therapy and is a suitable approach for this research.

Overview of IPA Methodology and Philosophical Underpinnings

Henwood and Pidgeon (1994) reflected on the ongoing debate in the 1950s and 1960s between nomothetic and idiographic approaches, and it was Allport (1962) that argued that uniqueness of personality and subjective experience could not be understood merely by results from statistics. This gave rise to the concern of subjective experience and idiographic emphasis in psychology. The need for qualitative methods based in psychology led to IPA being developed as it provided a commitment to idiographic experience which enabled exploration and consideration of "...subjective and

interpersonal involvedness of human emotion, thought and action, and the messy and chaotic aspects of human life in the hope of getting a better understanding of the phenomena under investigation." (Eatough & Smith, 2008; p.183).

IPA is both phenomenological, in that it is interested in the experiential aspect of a phenomenon, and interpretative which gives emphasis to the role of the researcher in making sense of the phenomenon (Eatough & Smith, 2008). Therefore, the theoretical underpinnings of IPA are both phenomenological and hermeneutic (Eatough & Smith, 2008). Hermeneutics is the theory of interpretation and a way of being in the world (Eatough & Smith, 2008).

Phenomenology is concerned with the individual's lived experience of phenomena. Its premise is that reality for people is experiential and it attempts to understand how one engages with the world in a meaningful way (Eatough & Smith, 2008). Ashworth (2003, p.145) refers to the term "lifeworld" as the main focus of phenomenological psychology, in which the aim is to reveal the phenomenon through thorough interrogation. In IPA, the individual's lifeworld is considered within a context and the individual's social world, history and the context are taken into account (Eatough & Smith, 2008).

To study an individual's life is to do so through a lens of cultural and socio-historical meanings. Studying "lived experience" takes into consideration the embodied experience in its socio-cultural and historical context, which an individual lives in meaningfully through their interpretation of the world (Willig, 2012b). IPA is able to attend to all of these aspects of lived experience.

IPA is influenced by phenomenological philosophers such as Husserl (1927) and Heidegger (1927; 1962). Husserl's (1927) phenomenology involves the examination of human experience to identify essential qualities of that experience, in other words, the "essence" of the experience. This approach influences the descriptive aim of IPA, in which it attempts to reflect as closely as possibly the participant's life world (Eatough & Smith, 2008).

Heidegger (1927; 1962) emphasised that reality was based within the human individual who interpreted and made meaning from the world. He disputed the Cartesian idea of a divide between mind/body, subject/object and the person/world (Eatough & Smith, 2008). Heidegger characterised "human-being" in terms of Dasein (individuals being in the world). Larkin et al. (2006) proposed that this is central to IPA's phenomenology as it implies that by "being there" we are always involved and within some kind of

meaningful context and level of interpretation. As Eatough and Smith (2008), articulated, "{the} human being is self-interpreting" (p.181).

Furthermore, Heidegger (1927; 1962) approached phenomenology from a hermeneutic philosophy, which is central to IPA. Eatough and Smith (2008) explained that our relationship to the world operates in a "hermeneutic circle" (p.181), in which we are involved in a process of making sense in order to understand our experience. Heidegger (1927; 1962) asserted that it was impossible to be free of any preconceptions when looking at someone else's lifeworld. One's interpretation of something is inevitably shaped by their experience. In research, the "hermeneutic circle" requires the researcher to acknowledge their preconceptions and assumptions when they attempt to understand the other's experience (Smith, 2007). This enables an open and empathic response to a participant's experience which is important in IPA.

The hermeneutic circle requires the researcher to use "fore-knowledge" that they have in order to think about how they approach the phenomenon (Packer & Addison, 1989). Therefore it is imperative that the researcher discloses their relationship to the topic, and their socio-cultural position, as this is implicated in their process of interpretation and meaning making. The researcher is also required to take a sensitive and responsive position by acknowledging the impact of themselves on the research (Larkin et al., 2006).

Furthermore, IPA recognises that access to the experience of others is dependent on what others choose to communicate, and it is the researcher that will interpret this account to make sense of it (Smith, et al., 2009). During the process Smith and Osborn, (2008, p.51) explain that, "a 'double-hermeneutic' is involved. The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world".

As Smith et al. (2009) proposed, there are no set guidelines to how an IPA approach should be conducted, as it is influenced by a broad range of philosophical influences and can adapt to the uniqueness of research titles (Larkin et al., 2006). Therefore, it takes a non-prescriptive stance with respect to sample size, sample strategy, data collection methods, analysis and how the research is written up (Eatough & Smith, 2008).

Epistemological Standpoint

IPA is not rooted in a distinct epistemological position due to its broad philosophical influence. Willig (2012a) emphasised the importance of the researcher's awareness of,

clarity about, and preparation to, acknowledge and "own" their epistemological position. This research is constrained to only access the participant's relationship between reality and their discourse, and it realised that this knowledge is provisional, and dependent on the context and conditions (Madill, Jordan, & Shirley, 2000). This section will endeavour to declare its position on the understanding of reality, contextual influences and discourse.

This research is best described as adopting a critical realist position as it assumes that there is a "real world out there" and each individual constructs their reality through a process of perception and communication (Eatough & Smith, 2008). This position sees participants as owning their own experience as their reality, which is constructed in relation to their experience of the "real world out there", and will be affected by the context in which it is experienced (Willig, 2012a). For this research, context and data collection have been considered carefully with regard to the participant's phenomenological experience (see section on *data collection*). It attempts to understand the inner experience of participants' emotional reactions within a particular context, which includes wider influences such as their socio-cultural and historical context (Willig, 2012a).

The positioning on understanding 'emotions' and 'emotional experience' for this research can best be described as being influenced by a phenomenological approach. This position is analogous with Solomon's (2006) philosophical approach to emotions which ascertains that emotional experience drives feelings, thoughts and behaviours. It is also a main contributor to how people make meaning from the world and how they construct their reality. Smith et al. (2009, p.199) claim that "Emotions are absolutely central to our phenomenologist's understanding of intersubjective acts", is key as it places emotions at the core of phenomenology.

Furthermore, phenomenology views emotions and cognitions as closely related in the way in which we view the world. This is in agreement with Eatough and Smith's, (2008) belief that cognitions play a central role in "meaning making" but are not distinguished as separate functions from experience. They acknowledged that cognitions work as part of a bigger embodied experience of the world and they emphasise the complex process of emotional experience. They assert that IPA disputes emotional theories for over-simplification of the "messy and turbulent process of making sense of emotional experience" (Eatough & Smith, 2008, p.183). By focusing on emotional experience the research was intended to capture the "messy" process.

As indicated by Solomon (2006) an important aspect of emotional experience is feelings, which is a key focus in the research. Some definitions of feelings include unconscious aspects of emotional responses (Winkielman, Berridge, & Wilbarger, 2005) which are congruent with the standpoint of the current research. Emotions are viewed as an overall experience which involves a multifaceted response to an occurrence (Dolan, 2002). Experiences such as non-verbal signals, autonomic patterns, core affect, the quality of the affect, the appraisal of the experience, and the feelings all constitute emotional experience (Russell, 2003). Therefore the participant's manner in which they discuss their experience, the tone of voice, chosen language, their appraisal of a situation, and their non-verbal communications (in the interview) have been considered as indicators of their emotional experience.

The research was conducted based on the assumption that individual accounts encompass the real and the constructed. As Willig (2012a, p.22) described it;

> critical realist approach does not assume that our data directly reflects reality (like a mirror image); rather, the data needs to be interpreted in order to provide access to the underlying structures which generate the manifestations which constitute our data.

Attention has been paid to the conscious material of the participants whilst trying to make deeper sense of their experience. This will require consideration of their motivations and observations for hidden meanings within their accounts. This aspect of the research relates to the hermeneutic underpinning of IPA. It has been described as a process of identifying and empathising (Smith & Osborn, 2008), as this deep reflection requires the researcher to draw on their own response to the data.

Alongside this close inspection of the data it is imperative that the researcher is aware of how they shape this process. Therefore, reflection on pre-conceptions, expectations, prior experiences and assumptions are important (Smith et al., 2009), and this will be reflected on throughout this research in order to be transparent to the reader. This research is influenced by interpretative phenomenology (Willig, 2012a), this is the same as the Madill et al. (2000) contextualist approach.

The importance of discourse has been considered when thinking about how knowledge of the world is constructed and how this is shared with others. As discussed previously in *Rationale for Interpretative Phenomenological Analysis*, Eatough's standpoint on IPA is that language is integral to how one experiences the social world (in Eatough & Smith, 2008), but that it is only an aspect of one's experience. The research could also be said to adopt a position in connection with the social constructionist perspective with regards to its belief on how society and the cultural environment are woven into one's understanding of one's experience. This is considered in terms of the therapy

relationship but also in thinking about the therapist's sense of self as being drawn from their social and personal world. A "symbolic interactionism" perspective was adopted within social constructionism, as it holds that the sense of self emerges from the process of communication between individuals (Eatough & Smith, 2008). Individuals are creatively involved in the development of a sense of self through the interpretative action of interpersonal contact (Eatough & Smith, 2008). Reflexivity from this perspective is crucial in constructing a sense of self and of reality (Eatough & Smith, 2008). Therapists use their self as the main tool in their work (Wosket, 1999). Therefore, their own social, cultural, political, relational and psychological context will be integral to how they construct their experience and make sense of it.

The research is influenced moderately by social constructionism because it did not assume that reality is completely constructed through language and social interaction. This is in accordance with Eatough's view of IPA (Eatough & Smith, 2008). These aspects were considered important in the individual's way of composing themselves as a therapist (Frosh & Saville-Young, 2008), rather than to focus on how social constructions can be drawn from their personal accounts. The moderate social constructionist recognises construction as being influenced by references outside of discourse and has an affinity with critical realism (Willig, 2012a).

Reflexivity

IPA as a methodology has implications on the findings in research as the participants' experiences are seen through the interpretative eyes of the researcher (Larkin et al., 2006). Willig (2012a) argued that researcher reflexivity is an integral part of any qualitative study. In an earlier publication she distinguished between two types of reflexivity; personal reflexivity and epistemological reflexivity (Willig, 2001). These will be addressed in this section.

Epistemological reflexivity

Epistemological reflexivity has been important to this research because it explores and discloses how the research has been shaped and influenced by wider influences. This enables the reader to interpret the research with as much understanding of the philosophical influences as possible. This process has required reflection on the researcher's personal assumptions about knowledge and what can be known (epistemology) as well as personal assumptions about the world (ontology) and how these might have influenced the research and the findings.

There have been epistemological tensions throughout the research process, which have been reflected on. The over-arching tension was that between the study's commitment to both critical realism and constructionism, identified as a common dilemma by Henwood and Pidgeon (1994). One of the aims of the research was to reflect the participants' inductive reality of their experiences whilst advocating the researcher as an active ingredient in constructing the meaning from their account. There has been commitment to representing an account as close to the participant's experience as possible whilst being mindful of the researcher's context and how this may have influenced the process. It has been necessary to be explicit about the researcher's presence in shaping the research and making decisions that impact on the participants' offerings to the research. Reflections on such epistemological tensions can be found all the way through, as well as in *methodological and procedural reflexivity* sections which will feature throughout.

Personal reflexivity

It has been recognised that personal and professional experiences of the researcher have impacted upon the methodological process. It has been essential that this effect has been acknowledged and reflected upon. During the process the researcher has attempted to expose personal pre-conceptions and value systems, as suggested by Larkin et al. (2006). Throughout this report there will be sections at the end of chapters that are dedicated to *personal reflexivity*.

Assessing Quality of Research

There is an ongoing discussion about how to best assess the quality of qualitative research (Willig, 2012a). However, Willig (2012a) argued that the criteria used to evaluate a qualitative study must be informed by the epistemological position adopted. Several authors have compiled lists of generic criteria for evaluating qualitative research; the ones that were considered for this research's epistemological position was Elliott, Fischer, and Rennie (1999) because of the phenomenological-hermeneutic focus, alongside Willig's (2008) more general guidelines, and Yardley's (2000) guidelines.

Willig (2008) proposed that phenomenological methods can be evaluated by assessing the extent to which they have grounded their observations within the contexts that have generated them. Reflexivity is crucial from this standpoint, the researcher needs to acknowledge and demonstrate how their perspectives and

positioning shaped the research. This corresponds to Elliott et al. (1999) guideline "owning one's perspective".

This research was aimed to abide by Elliot et al. (1999) guideline "grounding in examples" and this has been attended to by incorporating examples of the data to demonstrate the analytic procedures and the understanding made from this. Verbatim extracts of the participants' data have been included (see *analysis* section), with the purpose of showing the descriptive account and the interpretation. Interpretations made from the research are offered tentatively and no claim is made that they are correct. The research endeavours to show how the participant interpreted their experience initially before making an interpretation.

Throughout the analysis stage, colleagues and the research supervisor were asked to check the interpretations made from the research, the grouping of the themes that came out of the data, as well as the labels that were assigned to sub-ordinate/master themes. This is in line with Elliot et al. (1999) "credibility checks"; these were essential when assessing discrepancies between interpretations made from the research which differed from the participant's conscious understanding of their experience. This process was similar to what Madill et al. (2000) refers to as triangulation in a contextualist epistemology (see *analysis* section for a more detailed explanation).

It was important for this study to "situate the sample" (Elliott et al., 1999) which required necessary information about the participants to be provided. This was important so that the reader could gauge the applicability and relevance of the findings to their practice but this needed to be balanced alongside protecting anonymity of the participant. Only the information that emerged from the qualitative enquiry will be presented (*see demographic section*).

This research should resonate with the reader and be "accomplished in addressing a general understanding" (Elliott et al., 1999) of therapists' emotional experiences when with anorexic clients. It will present an in-depth analysis of collective accounts that is aimed to provide depth and breadth which was appropriate for this particular research. It does this by presenting the findings in a way that will be relevant and resonate with the reader in the hope that it provides a detailed and comprehensive account of the research process. As well as linking it cautiously to existing theory and literature on this research area, to provide theoretical context as well as personal accounts.

The research aimed to demonstrate "coherence" (Yardley, 2000) within the themes that have been provided for the reader. This has been addressed by giving voice to the individual participants in the research as well as providing a collective account; this

required a balance between idiosyncrasies and common themes. With reference to Yardley's (2000) guideline of "sensitivity to context" the research method has been designed to be sensitive to the demands of the participants in their workplace, and provide the most effective way for them to gather their data. The research aims to be sensitive to their preference regarding data collection in order to facilitate the process of obtaining rich detailed information.

Methodological Procedures

The sample group

The research required therapists that worked with clients being treated for anorexia nervosa in specialist eating disorder services in the United Kingdom. Therapists were approached from all training backgrounds. This was assumed to be reflective of the professionals delivering therapy to this client group nationwide. It was also in order to maximise the recruitment potential by not putting a further restriction on the sample.

Inclusion criteria

Participants: Purposive homogenous sampling was implemented as consistent with IPA (Smith et al., 2009). The inclusion criterion was that participants were therapists that were offering individual therapy/counselling to clients at a specialist eating disorder unit. It was required that therapists were working towards accreditation or were accredited by a registered professional counselling/psychology body (e.g. BABCP, BPS).

Trainees were included if in their final year of training, and people working towards accreditation needed to have completed their counselling qualification. Final year trainees were specified purely for reasons that they were nearer to qualifying and closer to being autonomous practitioners.

Cross and Watts (2002) highlighted trainee counselling psychologists are required to spend significant time to read, write, observe and reflect on their practice. This seemed like an opportunistic situation especially as the research required participant reflexivity.

Clients: Inclusion criteria also applied to the clients. Clients needed to be female, over 16 years old and diagnosed with anorexia nervosa according to Diagnostic and Statistical Manual of Mental Disorders (4th ed. [DSM–IV]; American Psychiatric Association, 2000) or ICD-10 (World Health Organisation, 1992). As well as engaged in individual therapy as part of their treatment. Female clients were specified because

anorexia occurs more in females than males (Strober, 2004), and were chosen to represent a homogenous group in order to enable the findings to be more applicable to a larger part of the anorexia population. The clients needed to be treated for anorexia nervosa primarily even when there were co-morbid diagnoses, which was expected as eating disorders often occur alongside other psychiatric disorders and disturbances (Kaye, Bulik, Thornton, Barbarich, & Masters, 2004).

Exclusion criteria

The exclusion criteria was that participants could not be working with the client in a supportive role, it needed to be psychotherapy. Nor could the client be experiencing a psychotic episode as it was thought that this may complicate and interfere with the therapist's emotional experience.

Sample size

The focus for this study was idiographic and based on the individual's experience which the sample size reflected. Eight participants were recruited and took part in the research. Smith et al. (2009) recommend that for a professional doctorate between 4 and 10 interviews was apt. It was considered that eight participants would provide enough data to conduct a thorough analysis, because of the two different data collection methods.

Situating the sample

Participants consisted of one trainee clinical psychologist, two clinical psychologists, two psychodynamic trained nurse therapists, one CBT trained nurse therapist, one counselling psychologist, and one psychodynamic psychotherapist (retired psychiatrist). Brief details of each participant's demographic details, which are considered directly relevant to the research, can be found in a table in the appendix (see Appendix A: Demographic Information).

Only one participant was a CBT therapist, three psychologists were psychodynamic/integrative, one trainee was integrative, and the other three were psychodynamic in their theoretical orientation. The average years of experience working in the specialism of eating disorders was 6.6 years ($SD = 5.87$). The implications of this have been reflected on in *methodological and procedural reflexivity*.

Gender was not specified in the inclusion criteria but only females offered to take part. This resulted in a more homogenous sample and prior research indicates that gender may be a factor in eliciting emotional reactions in therapists (Burket & Schramm, 1995;

Franko & Rolfe, 1996; Kaplan & Garfinkle, 1997; Satir et al., 2009; Waller & Katzman, 1998; Zimmer, 1995).

For some of the participants, their parental status was elicited during the data collection process. This has been included in the demographic table because it was relevant to contextualising their emotional experience. One participant (Chloe) was in her trimester of pregnancy with her second child. It was considered that this may potentially produce qualitatively different data to the other participants. She was included in the research because of IPA's idiographic emphasis and it would have felt unethical to not include her.

The study has acknowledged the potential variability between the participants and attempted to maintain an idiographic approach. It has attempted to contain the variability in the participants' experiences within the analysis, which is important in IPA (Smith et al., 2009). It was unknown how much the participants would be influenced by their therapeutic model when making sense of their experience and how much variability there would be across the participants. Since the decision was made to include trainees, only one took part, which may have been a challenge to the homogeneity of the sample as she was alongside therapists that had specialised in this area.

There was a dilemma between the need to recruit participants and maintaining a level of homogeneity in the sample. There was a low take up rate of participants despite the variety of recruitment strategies, and it was decided that to be more specific in the participant criteria may have constrained the amount recruited.

Pre-Study Questionnaire

Participants were asked to complete a pre-study questionnaire (*see* Appendix B: Pre-Study Questionnaire). This served three functions: firstly it acted as a way to screen eligibility for the study, secondly this information was important for the analysis of accounts in order to contextualise the experience and situate the sample, and finally it attempted to contain variability between participants within the analyses. These questions were based on factors that had been shown in literature to impact on therapists' emotional reactions (e.g. Franko & Rolf, 1996; Satir et al., 2009). They were asked whether they had had an eating disorder as it has been proposed that roughly one in three therapists who specialise in this area have had an eating disorder (Warren et al., 2009) and it is thought this can influence the therapist's emotional responses (McEneaney, 2007). None of the participants in this research stated that they had a history of an eating disorder.

For the same reasons participants were required to complete demographic information for the client/s that they chose to reflect on (*see* Appendix A: Demographic Information). They were asked to give details of each client's diagnosis, age, amount of time seen in therapy, treatment history and any additional information. They were encouraged to keep information anonymous.

Recruitment process

The majority of participants were recruited by asking colleagues to pass on research flyers (*see* Appendix D: Research Advertisement.) to anyone they thought would be interested. This method recruited six participants from two different establishments, NHS based and from the private sector.

Email addresses for therapists working with people suffering from anorexia were found on Counselling/Psychology professional body websites. An initial email (Appendix C: Research recruitment email & Appendix D: Research Advertisement.) was sent to therapists advertising the research and telephone contact was made if interest was shown. One participant was recruited by contacting a psychotherapy group where the research flyers were disseminated (*see* Appendix D: Research Advertisement.).

Recruitment emails (*see* Appendix E: Recruitment emails to university course administrators) were sent to administrators of universities who offered the Doctorate in Counselling Psychology/Clinical Psychology, Counsellor and Psychotherapy courses asking if they would be willing to forward my recruitment e-mail to students on the programme. City University was not included in order to eliminate the risk of knowing a participant. One out of the 14 universities I emailed responded to say that they were able to send out an email. Attached to the e-mail was an information sheet that outlined the research project (see Appendix D: Research Advertisement. & Appendix F: Information Sheet). One participant was recruited through this method.

An advertisement was placed (*see* Appendix G: Advertisement in the Division of Counselling Psychology*)* in the Division of Counselling Psychology's weekly newsletter and an advertisement was posted on UKCP website but there were no responses from these.

Briefing meeting

A briefing meeting was offered to each participant before the data collection started. This was to discuss the research, the requirements and to provide them with their research pack (pre-study questionnaire, an information sheet, informed consent form,

a diary, and a prompt sheet [*see* Appendices]).   Not all participants accepted this so as an alternative it was discussed over the phone and information was sent via email.

It was important to brief the participant on the meaning of emotional reactions and its complex nature in a manner that took into account their advanced understanding as therapists.   The rapport between researcher and participant began as soon as a participant responded showing interest in the study.   In some cases participants were happy to organise things via telephone or email and to continue to embark on collecting their data without a meeting.   This was respected this because it is possible that the anonymity helped with their reflections.

Data collection

Data collection was divided into two sections, diary keeping and semi-structured interviews.   Diary methods were used to capture the participant's emotional experiences; they were invited to reflect on their experience of keeping their diary and reflecting on their emotional reactions in an interview.

Participants were required to reflect immediately on their experience after a session with a client in order to capture the "meaning making" process as soon after the experience as possible and to invite them to offer an in-depth first person account of their experience.   Willig (2012a) states that ideally qualitative data should be collected "in situ" (p.7), where and when the experiences actually take place, which is why a diary was considered the best option.   This method has been referred to as being able to capture the immediacy of the participant's experience and to prevent retrospective reporting/interpretation which may affect the information after time has lapsed (Willig, 2001).

The interview was a movement from a messier sense making to a more concrete understanding and an opportunity to expand on contextual issues or influences.   Smith et al. (2009) identified that IPA data collection tends to move between sequences in which participants are more descriptive and story-telling, to a more analytic and evaluative stage.   This was reflected in the choice of data collection.   Furthermore, according to Smith et al. (2009, p.53) this multi-perspective approach to a phenomenon can be referred to as "triangulation".   It was considered helpful in developing a more detailed and sophisticated account of emotional reactions to this client group.

Pilot study-diary method

The pilot study aimed to test out the method of using a diary for data collection for two reasons; to see whether it was a method that participants felt comfortable with and could commit to using, and to look at whether the data was rich enough for analysis using IPA. An initial interview schedule was devised as part of the pilot study and this was trialled on colleagues. This process led to a revision in the initial aims of the research. The aim of the interview had been to reflect on their experience of keeping the reflective diary, as though the diary keeping was the experience. However, this changed by moving the focus away from the diary to using the interview as being a further forum to continue reflecting on their whole experience.

Two colleagues (one counsellor and one clinical psychologist) completed an unstructured diary. They were asked to reflect on their emotional reactions and feelings towards one client during and after the session, after a couple of sessions. The feedback was varied, one participant reported that she found keeping the diary to be a containing experience as it was, "somewhere in which she could offload her feelings but revisit the experience when I need to". She acknowledged that it required "forcing" herself after a session to stay with the experience/feelings.

The other participant reported finding it useful to look at her experience on a piece of paper, rather than it being in her head. However, she found it hard to find the motivation to complete the diary even though she had found it useful.

The data that this produced seemed rich, both participants' accounts were unique, and the diary appeared to capture this diversity. Both accounts seemed to have captured the complexity of the thinking process and it became apparent that the feelings and emotional responses seemed to be embedded in therapy process issues. It was evident that the participants might find it difficult to remain motivated to complete the diary.

Initially an extensive interview schedule was devised to address issues regarding the experience of keeping the diary. Getting feedback from the therapists in the pilot highlighted how the interview process could be a way of further capturing the participant's sense making of their emotional experience. It was decided that the aim of the research and therefore the purpose of the interview was to further reflect on the individual's experience of being with their client as well as reflecting on their experience and keeping the diary. It was felt that the interview needed to adopt a more open approach in order to facilitate a deeper psychological exploration (Smith et al., 2009).

Diary keeping/reflective sheets

From seeing the amount of data gathered in the pilot, six sessions per client for each participant were considered to produce enough data. All participants were instructed to write down their immediate responses straight after a session in a spontaneous account. They were encouraged to explore their experience as much as they felt able to (the passage below is taken from the diary). In the unstructured diary the same open-ended questions as the reflective sheets were incorporated as prompts, as part of the front sheet.

I am really interested in capturing your immediate response after a session with a client and a spontaneous account. It does not matter that this may be an emotional account as this will add to the richness of your experience. I would encourage you to use the diary in a way that is most useful for you.

Below are some prompts you may wish to consider if you are finding it difficult to respond spontaneously.

- *What were your emotional reactions during the session?*
- *What are your emotional reactions after the session?*
- *How do you make sense of that*
- *What impact did that have on the session*
- *What will you do with this information*

Participants were instructed to refer to these prompts if they were struggling to write a spontaneous response (*see* Appendix N: Extract from participant's diary transcript). These written instructions mirrored a brief interview schedule as appropriate for an IPA interview (Smith et al., 2009).

During the recruitment process it became apparent that the word 'diary' was off putting to potential participants; the feedback was that people did not have time to complete a diary. Consequently the approach was adapted and 'reflective sheets' were created and were structured around the same open ended questions/prompts given in the unstructured diary, but instead were formatted in a booklet with sections to write in (*see* Appendix H: Reflective Sheets). It was recognised that some people may have a preference for one style over the other so participants were offered a choice.

Only one participant chose the reflective sheets (Caroline). All participants were asked to complete the diary/reflective sheets for two clients. However, only three participants did this because of client drop out and not having an appropriate client on their caseload. It was decided that even if the client 'drops out' before this criteria is met the data will still be used for analysis

A computerised version was sent to the participant who opted for 'reflective sheets' which meant that she could adjust the space that they had to reflect. Some participants preferred keeping their notes on the computer. Contact was made with the participants on a regular and agreed basis in order to maintain contact with the participants, answer any questions and to encourage motivation to keep the diary as suggested by Willig (2001).

Semi structured interviews.

Interview

The interview was to incorporate and provide an opportunity for the participant to voice their experience of reflection, keeping the diary, as well as to further reflect on their emotional experiences during this process.

Interview schedule

Open-ended questions were constructed to aid the participant to formulate their experiences, without guiding them too much (see below for interview schedule). The schedule consisted of eight questions. In some of the interviews fewer questions were asked when the participant had already covered the area in their spontaneous account. There were also prompts within the schedule to help facilitate deeper reflections from the participants, as shown below;

- *Can you tell me about your experience of the diary?*
- *How did you use the diary*
- *How you have found the experience of reflecting on your emotional reactions?*
- *Can you expand on the feelings that you felt when you were with the clients?*
- *Can you describe if and how this process has impacted on your work with the client?*
- *Did you notice anything interesting for yourself during this process?*
- *Can you tell me about occasions in which you did not complete the diary after a session when you had planned to?*
- *If you were to be writing up this experience in the Eating Disorders Review for other professionals to read, what would be your key points?*
- *How do you feel about parting with your diary?*

In hindsight the multiple aims to the interview process may have meant that it was directive and extensive, rather than being more open and phenomenological. Perhaps using fewer and more open questions may have enabled the areas to have emerged

from the participants' rather than attempting to address them through the questions, e.g., *"Can you tell me about how you have found the experience of focusing on your emotional responses with your clients?"* Smith et al. (2009) states "verbal input from the interviewer can be minimal" (p.59).

Question seven was included to encourage the participant to think on a deeper level about their experience. This question was useful to gather concrete information about the participant's experience, and how they made sense of this on a professional level. However, this may have imposed some personal desire for concrete findings and answers, and a professional opinion. This was a reflection of my clinical perspective at this time, an initial interest in the "professional's opinion" on how they conceptualised and understood anorexia, as well as an uncertainty to facilitate psychological exploration with professionals.

The participants found question seven challenging and often needed to think for a while before answering. Their answers tended to be a snapshot of a core understanding of their experience. This helped to give a succinct explanation of how they made sense of their experience but was drawing on a professional opinion. If this research was repeated, interviews would involve less rehearsed questions and draw more from the actual interview to allow more flexibility.

The interview

The interview was held at a convenient location for the participant, which was at the participant's workplace. Safety precautions were taken when visiting locations, by alerting people of where the interviews were going to take place, and contacting them before and after the meeting.

The semi structured interview allowed for a dialogue between the researcher and participant to be led by the responses of the participant. The interview loosely followed the interview schedule which was aimed at facilitating discussion as suggested by Smith et al. (2009).

The interview aimed to hear what the participants were communicating and to gently probe to learn more about their inner understandings of these areas. It was attempted to validate the participant's engagement by building a rapport with them, as Lewis (2008) stated is important in gathering rich data. Due to previous contact with the participant a rapport had developed prior to the interview which facilitated a more relaxed environment.

At the beginning participants were informed that they were free to withdraw at any point during the interview and they were asked if they had any time restrictions. In order to engage the participant the first question asked them to sum up their experience of keeping the diary, this gave an indication into each individual's own style and how freely they explored their experience. It also accessed the surface level experience in order to allow for a deeper exploration later.

The parallel between being a counselling psychologist in training and a researcher in an IPA study were particularly pertinent at the interview stage. The counselling skills that complimented the interviews were establishing a rapport, active listening and allowing enough space for the participants to respond to questions, encouraging story-telling and probing (Melles, 2005).

The interview attempted to be both open in a way that the participant could explore the phenomenon for themselves, alongside being encouraging and prompting. This was difficult to balance especially in the initial interviews. However, with practise it became apparent that following the participant and being more relaxed about the questions enabled a more natural and fluid interview.

Transcriptions

The interviews were transcribed verbatim; this included any vocal utterances, pauses or broken words (*see* Appendix P: Example extract from Chloe's Interview). This was in order to create a text which was representative of the verbal account. The diary transcripts did not need transcribing (*see* Appendix N: Extract from participant's diary transcript). In order to become familiar with the text they were read several times.

All identifying features of participants were changed at the time of transcription in order to maintain anonymity. This included names and other identifying details as far as possible in order to protect privacy. Pseudonyms were employed for the participants and their clients; a key was devised noting which participant corresponded to which pseudonym. These alongside the transcripts have been kept securely and separately from any other research data. These will be destroyed when the research and assessment have been fully completed.

Ethical Considerations

Adhering to ethical principles for this study was essential. It relied on the participants revealing something personal hence a certain level of trust and confidence was placed in the researcher (King, 1996). These were carefully considered at the initial stage of

the research proposal, and ethical guidelines proposed by the British Psychological Society code of conduct (2009) as well as those proposed by City University were adhered to. The proposal for this study was granted full ethical approval at the Department of Psychology of City University (see Appendix J: Consent Form)

Five issues were particularly important to consider which were as follows: protection of participants, anonymity, safe-keeping of data, confidentiality and debrief.

Protection of participants

Informed consent was obtained from participants once they had agreed to take part in the research. They were informed of the explicit aims and purposes of the study and required to sign a consent form (*see* Appendix J: Consent Form).

Participants were informed that their participation was voluntary, and were informed of their rights to withdraw from the study. It was made explicit in the information sheet that after August 2011 it would not be feasible to retract their data. Participants were given ample opportunity to ask questions and consider their interest in participation.

Anonymity and confidentiality

Participants were asked to fill out their diaries using pseudonyms or codes for the clients, in order to protect their anonymity. All identifying data collected during the process was deleted. The identity of the participants will be protected by not publishing demographic data that would easily identify them. Participants were informed that parts of their diary or interview would be published and an opportunity for them to review their diary and interview transcript to ensure anonymity was provided.

Safe-keeping of data

All data gathered from participants was locked in a cabinet and personal details were stored in a separate place to their diaries, audio-files and transcripts, as according to the Data Protection Act (2010). Consent was obtained as to either destroy or keep their data once the research was complete (*see* Appendix K: Consent for the Release of Diary and Transcript Data). All computer files were saved on a password protected computer.

Debrief

The interview after the diary collection was a way of managing any emotional issues that may have been aroused during the research process. Additionally, after the interview participants were asked how they felt, and how they thought the interview

had gone. They were encouraged to speak to their supervisor if they had any concerns, and a list of sources for emotional and psychological support was provided (*see* Appendix M: List of contacts).

Methodological and Procedural Reflexivity

Reflexivity on recruitment

The first epistemological tension that I encountered during this process was the specification of clients with a diagnosis of anorexia nervosa. Reflection on this revealed that this requirement drew from criteria based within a medical model, which conflicted with a critical realist outlook. A diagnosis could be viewed as a truth being imposed on an individual, as is often the case with people diagnosed with anorexia, who often believe that they do not have a problem.

Strawbridge and Wolfe (2010) argued that counselling psychology derived from understanding the subjective world of the self, and that this philosophical position was in objection of diagnostic criteria and pathologising. However, the reality of working with anorexia in professional settings does require working within or alongside the medical model (Larsson, Brooks, & Loewenthal, 2012). Therefore, this research reflects this reality in which therapists have to work with the clients and their subjective experience within a medical structure. This is in line with a critical realist perspective because it suggests that reality possesses "enduring structures and generative mechanisms" which can be engaged with critically (Bhaskar, 1989, p. 2). Therefore the diagnostic categories are comprised of scientific and psychological perspectives which are only concepts and need critiquing.

Willig (2012b) discussed how being diagnosed with an illness plunges an individual into an interpretive event because their experiential world is interpreted as an array of signs and symptoms of an illness which have been medically and socially constructed. Once a diagnosis of anorexia has been given the individual becomes part of the discursive field associated with the illness (Willig, 2012b). This means that the "diagnosed" become subject to cultural interpretations of their illness as well as to individuals interpreting their anorexia based on their understanding of it. It also positions them as the 'patient' and 'sufferer'. Therefore, using the diagnostic criteria as part of this research will have captured some of this context in which the therapist and patient are influenced by social and cultural understandings of anorexia.

Heidegger (1927/1962) emphasised the importance of language in giving us meaning, he saw language as the means to interpret our socio-economic and social-cultural practices. The label "anorexia", will have informed how the therapist constructed their experience of the "anorexic", and it will influence the relationship the patient has towards the experiential aspects of their illness, as well as towards treatment of this

"illness". Therefore, it could be argued that this label constructs aspects of the relationship between the individual and their therapist (Willig, 2012b).

The decision to incorporate the diagnosis of anorexia in the inclusion criteria was made in order to eliminate other confounding aspects that may have compromised the findings as being unique to the experience of working with anorexic clients. I have recognised that this is a conflict within this research as it is more aligned to a quantitative methodology. The distinction was made early on in the formulation of the research, which reflects my novice position within qualitative research and my lack of awareness of the philosophical underpinnings of qualitative research. However, IPA as a methodology enables consideration of how anorexia is constructed within the participants experience and how wider socio-cultural factors may impact on their experience.

My professional identity as a trainee counselling psychologist and how I presented myself to the therapists should be recognised as interacting with the recruitment process. I was conscious of how therapists may feel about revealing their personal emotional experiences related to their professional world to a trainee. It is possible that this prohibited some people from taking part as it was difficult to recruit for this research.

It was important in the initial contact with the therapist to engage them and afterwards to develop a trusting relationship. I aimed to be as transparent as possible in the hope that this would set precedence in our interactions. In practical terms this meant that I offered information about myself in the recruitment flyer and answered any questions throughout the process honestly.

The first participant that was recruited was Chloe and she was pregnant. Time was spent deliberating how her individual experience would not be lost within the data. I considered writing her up as a case study alongside everyone else's experience. However, once data collection and analysis commenced it became clear that her data were qualitatively similar to the others, just more amplified. It was decided that her data were best situated with the other accounts rather than as a singular case study.

Reflexivity on sample

It is important to reflect on the sample in the research as this is fundamental in providing contextual information to the analysis in order to help interpret how the participant's reality is constructed. The two important factors in the sample were that they were all female and that they were predominately psychodynamic in their orientation.

There was initial interest from male therapists but the few that showed interest did not take part because they expressed not feeling comfortable, or not having enough time to complete a diary. Possibly females felt more comfortable sharing their emotional experiences and more comfortable with writing their feelings in a diary. Another reason could be that there are fewer male therapists in the area but the reasons for this are outside the scope of the current research.

It is important to notice that the topic "emotional responses" tends to evoke thoughts about "countertransference", as shown in the existing literature. It is possible that the topic of this research also attracted psychodynamic therapists who conceptualise their emotional responses as part of the bread and butter of therapy. Inevitably this has been influenced by my interest in countertransference and the therapist's emotional experience. Furthermore, in the recruitment emails I spoke about my interests and this was rooted in a psychodynamic framework. This may have influenced the responses to the research advertisements.

The implication of this is that the research can only shed light on how female psychodynamic orientated therapists make sense of their experience, and how they use this theory to understand their experience. This is more specific than originally intended. However, the double-hermeneutic aspect of IPA enables exploration on how the therapists use theory to understand their experience, and to consider the social and cultural influences on women.

Reflexivity on data collection

The phenomenon of "emotional experience" emerged through the data collection process in which there was an interaction between the participant, their diary, the interview and myself. It is important to reflect on how these aspects could have influenced the phenomenon.

There was an epistemological tension that arouse during data collection with regard to the format of the diary. This method had been chosen in order to be true to IPA and to offer an unstructured space for spontaneous reflections, as well as to impose as little as possible regarding the researcher's agenda. However, this was revised during the research process and a format that appeared more structured was implemented (as discussed in *data collection* section), this was only used for one participant. It is possible that this compromised the participant's inductive reality, as it imposed a structure on their reflections and may have constrained their responses. There was a conflict between attending to this whilst also ensuring that enough participants were

recruited and that they felt their needs were met. At this stage I recognised my commitment to the phenomenological aspect of the research.

The information that I would have given the therapists in the briefing meeting may have influenced their approach to the diary. I did not want to be bound to a script because I wanted the focus of the interaction to be on building a rapport with the therapist. I was careful in how I presented the diary and encouraged the participants to use the diary in a way that was helpful to them, as I was interested in their experience.

I provided a brief description of emotional responses to help guide the therapists. In hindsight, I recognise that I was assuming my understanding of this as being the same as the participants. If I were to do this again I would ask them what their understanding of emotional experiences was, in order that they set the parameters of the phenomenon for themselves.

The interview process drew my attention to how difficult the therapists found reflecting on their emotional experiences after a session. I came to realise that this research actually required the therapists to do something that was emotionally taxing; it highlighted that it is difficult to stay with the feelings after a session and some of the participants found it challenging to complete a diary after their sessions. The reasons for this will be explored in the *analysis section*, but I became aware that this method was perhaps not adhering to Yardley's (2000) criteria "sensitivity to context". It was necessary to consider their needs and how this research was impacting on them and I considered adapting my approach when recruiting subsequent participants.

I contemplated interviewing participants after a session and offered this to the new recruits. I also offered for them to speak into a digital audio recorder after a session so that I could transcribe their responses. This felt like a conflict as I was not necessarily as sensitive to how busy and stressful their working day may have been, but I felt it was important to capture the immediacy of a response. I managed this by offering the alternatives discussed and by fully explaining the requirements of the research before they committed themselves.

There was a marked difference between participants in the way that they used the diary and the interview. There appeared to be a split, some participants used the diary to capture a sense of their emotional experience alongside their interpretation of this; others had used it to note their feelings as a list alongside a brief theoretical description. In the interview I noticed that some participants were more removed from their emotional experience than in their diaries. It felt as though they had made sense

of their emotional experience as a therapeutic opportunity and moved away from the immediacy of the feeling by rationalising it. The exceptions to this were May and Sophia, who offered more in-depth exploration in their interview.

This led me to wonder how each therapist felt about documenting negative emotional experiences and whether, at times, these feelings were being muted by interpretation or theorising. It may have been difficult for the therapists to admit these feelings and see them written down in black and white. It is possible that interpretation and theorising were an ingrained process within these therapists and that is was almost impossible for them not to do it.

To some degree, I considered myself as a "cultural insider", I had many similarities with the participants with regard to being a therapist myself who had worked within specialist eating disorder services and engaged in therapeutic training. Smith et al. (2009) stated that IPA researchers need a level of cultural competence in order to understand the culture that is being explored. They stated that "...the empathy provided by a shared humanity and common cultural understanding can be an important bridge between researcher and participant and a valuable analytic resource" (Smith et al., 2009, p.10).

There were both advantages and disadvantages to this in the methodological process. It enabled me to relate to the participants and the topic from a personal perspective and as an insider. At times it was difficult to separate myself from their experiences. This required deep reflection and a constant process of self questioning.

I found it was more difficult to think empathically when I related strongly with the participant's experience in an interview. During the interview process, I attempted to bracket this off as an attempt to stay with and hear the participant. I noticed that it became easier to quieten my own thoughts as I became more experienced at the interview process, and more aware of the similarities between interviewer and my role as a counselling psychologist. I was tempted at times to disclose my experiences when I related strongly to what was being said. I refrained from doing so because I was aware of contaminating an individual's account.

Within the interviews there tended to be more of a sense of the participants sharing their views on working with this population, as specialists in the area. This provided an interesting insight into their views, more generally on how they conceptualise anorexia, how they interpret their emotional experience, and how they have adapted to manage this. A possible disadvantage to this was that there was potentially limited raw

emotion in the accounts. Despite this I was surprised by how honest and open each therapist had been in providing some very difficult and uncomfortable feelings.

At times, it felt as though the participants were the experts on the subject, because they are the expert of both their experience and of working within the field of eating disorders. This drew my attention to a potential dynamic of expert and novice. Sometimes it seemed hard for them to stay with their particular emotional experience of clients, and not talk too generally about their professional experience. This was more apparent for the participants who were experienced therapists and tended to be older in age. It was not present for Alicia who was a trainee psychologist.

I look younger than I am and I wondered whether my own age alongside my trainee status may have influenced this. I was also in a place in my own training in which I was developing an identity as a therapist. This may have influenced how I interacted with the therapists and I may have given off cues about wanting to learn from therapists that I perceived as "experts". Being in training has been recognised as a time of creating an identity as a counsellor/psychotherapist (Grafanki, 2010). Furthermore, my interest in psychodynamic therapy and theory was the main driving force behind looking at the therapist's 'emotional experience' and I was intrigued by their understanding.

The level of experience seemed to be an active dynamic during the data collection process. This was also reflected in a couple of the participants' accounts as being an influential factor in their emotional experiences. I wondered how this would have influenced the findings if I had been from a different profession. It is hard to predict whether the participants would have presented as differently or the same.

Reflexivity on ethics

I have reflected on issues surrounding ethics and how I have been involved in managing these. A couple of the participants were recruited from the same place and through each other. It is since writing up the analysis section that I have reflected on the issue of anonymity and how to best manage this. There have been particular details that I have included in the analysis section that are personal, such as being a mother and years of experience, which could be deemed identifiable information. I have made every effort to change names and identifying details but these details were part of the participants' narratives and were important in contextualising their accounts and I decided to include the information. I got the sense from the way in which they spoke about it that it was not information that they would be uncomfortable others knowing.

Such details were only included when it served to thicken the data and these details have only been included in the analysis section. I wondered if the participants that this involved had made the connection that their colleagues could read their accounts in the final report, and whether this had influenced what they felt comfortable documenting or talking about, although none of the participants made reference to other participants taking part.

I have reflected on the ethical issue of "situating the sample" (Elliott et al., 1999) in relation to my epistemological position. In the beginning of the research I felt that asking for the participants' demographic information was important in contextualising the findings from this research. The demographic data gathered was based on previous literature and my own experience and was being imposed onto the participants

On reflection I believe that this was rooted in a positivist approach, in which I was tempted to look for causal rules to human behaviour. This was reflective of my position at the beginning of this process. I have learnt that to be phenomenological is to not impose an interpretation onto the individual's account unless it is rooted in their experience. It no longer felt necessary to provide such information, unless it came up spontaneously from the participants in their account as being a significant factor. I would argue that inclusion of such details would only provide information for others to interpret the data further and to impose their beliefs onto the data.

Another ethical dilemma that emerged was regarding my level of interpretation over the participants' accounts. This is relevant to Elliot et al. (1999) guideline, "grounding the analysis", which required analysis to be presented using examples of verbatim data from the participants' accounts. These were included alongside my interpretation. If participants chose to read this report they will be able to see aspects of their data alongside my interpretation.

Whilst I have attempted to be as grounded in the data possible, I have no doubt interpreted aspects of the participants' experiences that may be out of their consciousness and beyond just their emotional experience. The participants knew that this would be part of the process as it was explained to them at the debrief session. However, I have been mindful to be as respectful to them and their professional practice as possible. At times there has been a tension about how comfortable they would feel reading my interpretation. I have wondered what it would feel like for them as the "experts" to have their experience interpreted by a trainee. I have attempted to present my interpretations tentatively, and respectfully, in order that they do not feel undermined. I have been explicit that it is my understanding of their

experience. I have decided that if requested, I will give the participants access to the full report. I think that it would be less transparent and honest to provide them with a censored account.

Analysis

Analytic strategy

The process of analysis moved from the specific to the general, each therapist's data set was analysed before moving across the eight therapists to organise the data into higher order themes. This required immersion within the accounts of the therapists and a progression from the descriptive accounts to a more interpretative understanding. There was a shift in the focus from their emotional experience, within the therapy context, to a reflection on their experience more generally (Smith et al., 2009). The analytic process could be described as dynamic.

Although the analytic process was fluid and dynamic it will be outlined in a linear approach to explain the strategy that was employed. Madill et al. (2000) stated that it is important that the researcher explains how they approached analysis within a contextual constructionist position, as the approach has an influence on the analysis. The method of analysis followed a step-by-step procedure which was guided by Smith's et al. (2009) outline for analysis.

Analytic procedure

The data were analysed in the order that therapists were recruited and they were assigned numbers related to this order. There were five steps of the analysis. Until step five each therapist's data was analysed individually before moving onto the next therapist's data set. The therapist's data set included both the reflective diary and their interview transcript. In order to follow the sequence of data collection the individual analysis started with the diary before it moved onto the interview. The five steps of analysis will be outlined below.

The first step of analysis was to be immersed in the data which involved reading and listening to interviews a number of times in order to become familiar with the data and to note down any initial responses. This included noting my emotional response to the data, as Lewis (2008) highlighted, is an important part of qualitative analysis.

It was harder to separate out my feeling towards the therapists account when I felt "bogged down" in the data because it felt heavy and I could feel overwhelmed by its complexity.   I logged these thoughts down and questioned my feelings in relation to

the text in order to clear the pathway for me to tune into the data and return to this at a later date. Smith et al. (2009) recommend using a notebook to capture initial thoughts as a way of temporarily bracketing them off and I found that this was essential.

The second step was a line by line examination and exploration of the data. Notes on the right hand margin of the data were made. For some diaries a table was produced to write comments due to a lack of physical space. This stage focused on description, language and conception (*see* Appendix O: Example of Initial Notes and Coding from Chloe's diary*).* The investigation started with looking at what was important to the therapist but moved to a more interpretative level to make sense of why and how this could be the case. Aspects of the individual participant's context were considered in relation to their data if they had highlighted it as being of importance.

Descriptive comments: Indications of emotional responses were looked for and recorded as well as key words, phrases and explanations. Particular focus was paid to the phenomenology of the account and what aspects of the participant's lifeworld were important in understanding their experience.

At this level I felt overwhelmed by thoughts on the data. Most apparent was my inclination to theorise, which I had to acknowledge. I dealt with this by parking my thoughts in my research diary in order to try and stay with the description of the accounts. It was clear that there were differences in the therapists' level of interpretation of their experiences. Some accounts seemed far more interpretative whilst others remained descriptive. This influenced my ability to interpret the participant's experience; when the participant had interpreted their experience it felt harder to get a sense of the phenomenological aspect of the accounts.

This stage required a slow and thorough pace in order to assimilate the description, which at times felt arduous and insurmountable, because of the depth of detail required. When I felt saturated by a particular transcript it was useful to share with my research supervisor. Someone else's view inspired engagement with the text again and a novel way of looking at something that had begun to feel one dimensional.

Linguistic comments: This step focused on how meaning was constructed. Close attention was paid to the language, how something was communicated (non-verbal aspects of communication) and the meaning behind this. In particular, attention was paid to the use of symbolisation and metaphor to describe experiences and language that was related to "eating" was noted.

Conceptual comments: This required a more interpretative approach to the data and the idea of "hermeneutic of suspicion" came into play (Ricoeur, 1970). Thoughts about

psychological concepts were often sparked by the participant's references to theory or concepts within the data. The data were looked at with regard to the concept that was being discussed through an analytic eye. Ideas about how the participant seemed to be making sense of their experience, what theory they were drawing on, as well as sociological and cultural aspects were noted. At this stage I drew on my own experiences and understanding in an attempt to make further sense of the data. This process of deep reflection was necessary to discover dormant meaning as Schwandt (2000) recommended. This required several re-visits to the transcript as well as time away to process.

I discussed my thoughts with the research supervisor in order to refine my ideas because of the level of subjectivity at this stage. This could be described as a process of triangulation, as it enabled a wider lens on the data and a finer tuned analysis as proposed by Madill et al. (2000). An example of this analytic strategy is shown in *Table 1*.

Line Number	Emergent Themes	Exploratory Comments		
		Descriptive	Linguistic	Conceptual
4-8	Unspoken communication	T(therapist) links C (client)'s lack of predicted progress to her announcement of pregnancy.	C has "'delayed' reaching target" suggests that the client has taken control of weight gain	T is hearing a non-verbal communication in the lack of weight gain. Using psychoanalytic theory to make sense of her experience

Table 1: An example of step 1 of the analysis taken from participant one.

Step two was returned to at several points of the analysis. I managed this by a process of re-reading and note taking. This enabled space to look at the subtleties and nuances within the data.

Step three focused on developing emergent themes for the participant based on the initial comments made in step two. It required a shift from the raw data to the exploratory notes to produce some over-arching themes. Within the exploratory notes

higher order themes were looked for in order to capture what the participants were describing. These were written in the left hand column of the transcript (*see* Appendix P: Example extract from Chloe's Interview, Appendix Q: Example coding from Chloe's Interview). Finding the best suited words to label the emergent themes was difficult. I tried as much as possible to use the language of the participant. When the theme was more conceptual I felt uneasy about importing words from outside the transcript. Sometimes this was necessary and I attempted to root it in what the participant was describing and to use their frame of reference which was often psychodynamic. In order to share their interpretative framework such psychodynamic terms were used and elaborated upon.

It was difficult to condense the complex nature of the data into themes and to account for the interrelations and connections between the themes. At this stage the hermeneutic cycle that Eatough and Smith, (2008) referred to was at play, and I returned to look at the raw data in light of the emerging themes. I moved backwards and forwards from the descriptive accounts and my emerging interpretations. I was struck with how immersed I had become in the accounts, which made interpreting from a position within the data more comfortable and less imposing.

I found this stage particularly challenging for one transcript that was very descriptive and was focused more on the client's than the therapist's experience. I sent an extract of the transcript to a colleague for them to do the initial coding so I could check it against my attempt. Reassuringly, they yielded similar themes.

Step four shifted the focus to a collective formation of the emergent themes within an individual's account. Smith et al. (2009) suggestions for this were followed and a list of all the emergent themes within a therapist's data set was created, in a chronological order (*see* example in Appendix R: Example of emergent themes from Chloe's diary on client 1). There was repetition at this step and so the frequency was noted for the emergent themes. Then connections across emergent themes were searched for; making maps helped with this process. Themes that seemed similar were put in clusters and then their relationships to each other began to emerge (*see* Appendix R: Example of emergent themes from Chloe's diary on client 1). This required movement back to the raw data in order to check out the meaning of the emergent themes, and to ensure that they were being clustered in a way that was rooted in the therapist's experience. I have logged this process in my reflective diary to record the decisions that I made.

Once the themes were in groups they were labelled. The process of condensing and summarising resulted in moving emergent themes into different categories, if they

fitted another group better. Once this was complete, a table of superordinate themes was created (*see* Appendix U: Superordinate themes - Chloe), which included the superordinate themes, alongside a list of emergent themes and quotes from the data to support the theme. This ensured documentation regarding the source of the theme (Smith et al., 2009), so that they could be readily traced back through the analytic process and ensure validity.

Before the process moved onto the next participant's data, I contacted and met up with Chloe to show her the superordinate themes that had been elicited from her data. She had shown interest in the research process and agreed at the debriefing stage to be involved in refining her themes. This was to ensure the analytic strategy was doing justice to her data and was ensuring validity. Her feedback was invaluable and helped establish the themes for her data.

I repeated step four for each participants' data set to attempt to look at each participant's account from a different viewpoint. This was harder to do when there were obvious common themes occurring across the therapists. I found that by writing down what I had noticed in my diary it had been parked somewhere safe, so that I could return to the individual's understanding of their experience and re-visit the commonalities later.

By step five, there were eight tables of superordinate themes. In order to start the process of looking for patterns across cases, as suggested by Smith et al. (2009), a frequency table of the superordinate themes was made, (*see* Appendix V: Frequency of themes across participants). All the themes were placed in chronological order and their frequency of occurrence was documented. This helped to get a sense of commonality amongst themes, as well as highlighting the patterns that emerged.

It became clear that the therapists used a type of language to articulate their experience. Some therapists used psychodynamic terms, and others used descriptive metaphors. What emerged was that the therapists were using powerful words to describe their experience. Within this there appeared to be three higher order experiences occurring, which were formed out of clusters of similar emotional experiences, as documented below (*see* Table 2). An example of the process by which the themes were categorised can be seen in this table. However, it is not a comprehensive list of all the superordinate themes; there is a more extensive diagram of this that documents the classification for each superordinate theme across participants and explains the rationale for this [*see* Appendix X: Example of Super-ordinate themes and master themes across participants and justification (Sophia)].

Cluster 1- Forceful change in feelings Powerful and difficult feelings	Increase in feelings, feels the client feelings, strong feelings directed at other, relapse increased feelings in therapist, frightened, attacked, angry, painful, burdened, annoyed, guilt, abused, abuser, tortured, resentment, confused, punished, responsibility, powerful maternal transference, becoming the bad object (therapist), reacting to the unspoken, frustration, encroached on, sadness, useless, disabled, full of feeling, anxiety.
Cluster 2- Nothingness/Emptiness/disconnection Extreme experience	Cut off, hopeless, drained, exhausted, client drained therapist, switched off, and emotionally drained, hungry, desperate. Deathliness, Tsunami effect, Lifeless and full of life, primitive process, therapist holding hope and feeling hopeless, surviving something intense.
Cluster 3- More positive, 'therapeutic' Process of therapist making sense	Sadness, interpretation, relief, reflection, positive feelings when connected to client, emotional reactions used as a therapeutic opportunity, relief when client expressed feelings, therapeutic use of emotional reactions: self-supervision, therapeutic relationship.

Table 2: A collection of superordinate themes.

At this stage each transcript were re-visited and re-read. Segments from each transcript that appeared rich in emotion and meaning, with regard to the therapist's emotional experience and their experience of keeping the reflective diary, were documented for each therapist. In relation to the clusters, segments from each participant's data were extracted and summary notes were written alongside the

segment in order to attempt to capture the meaning of the experience. This was in order to check that the clusters I had formed did actually fit the participant's experience (*see* Appendix W: Example for quotes for cluster one from Beth). This process of mapping the themes with actual quotes was vital to once again check validity and to ensure that the interpretation was true to each therapist's data. The superordinate themes were revisited and re-labelled at this point, based on the development of a higher order structure.

The themes were clustered together to derive three master themes and tables were made in relation to this for each theme (*see* Appendix Y: Example of table of theme for 'starved'). These appeared to capture and organise the majority of the data from the transcripts in relation to the participants' emotional experiences, their general experience of being with the client, and the sense that they made of this. As well as considering how the participants might be responding to pressures that are rooted in the cultural and social context of being a professional working woman and having to prove one's competency in this context and in the research situation.

From this point, the analysis process continued to be iterative and to move between a close case-by-case focus and interpretation of the individual accounts, to a more global and amalgamated account of the group as a whole. This continued onto step six which required development of a master table of themes for all the participants based on the above three clusters. Each cluster was given a quote from each participant, when possible, to illustrate its meaning and to illustrate its representation from the individual's unique experience (*see* Appendix Z: Example of master table with quotes). In order to fine tune and capture the essence of the themes as an essential part of the IPA process, this was done again to check validity and also to allow easy reference once the writing up process had begun. There was tension around choosing the quotes that best represented the theme as there were often more than a couple of rich quotes for each participant. The quotes chosen helped to highlight divergences and commonalities within the master themes.

This step continued to require flexibility, as some themes were reworked at this stage, and the data were yet again reorganised. In particular, because there is a strong relationship between the themes, the boundaries were blurred between the categories, and there was often overlap. Further clarification of the themes required an ongoing cyclical and iterative process. The process further enhanced the identification of similarities and differences in participants' accounts of their experience. Superordinate themes have been included that only related to a couple of participants, in order to

account for such converges and divergences, and also to give voice to these important aspects of the individual's experience.

After the analysis section a model of the themes was produced (*see* Appendix AA: A diagram to illustrate the themes). This is just a tentative illustration of the themes and has been based upon my interpretation of the themes in relation to each other from the participants' collective experiences.

Results: An Account Summarising the Phenomenology and Interpretation of the Therapists' Emotional Experiences.

The master themes which have emerged from the therapists'[1] transcripts, from their diaries and interviews, will be outlined in this chapter. Analysis of these transcripts yielded data which covered specific and general aspects of the therapists' embodied experiences of working with anorexic clients. In the analysis it was necessary to prioritise the development of an account that sought to explain the therapists' emotional experiences. This has been taken from their reflections in their diaries and in their interviews, both of which offer in depth insight into this experience in relation to their clients. This has highlighted that the process of keeping a reflective diary became part of their emotional experience.

This section aims to present the therapists' emotional experiences first under three broad master themes which have aimed to capture the totality of this experience. Firstly the interpretative process of naming the themes will be described and explained to show transparency on how these were formed.

Naming the Themes: A Mirror Process

The themes were labelled using the language of eating which came about from the therapists seeming to experience a mirrored process to their client. In this context a mirrored process refers to a feeling or behaviour on behalf of the therapist which mirrored their experience of their client. Also the therapists used food related metaphors to describe their emotional experience. These two reasons will be explored in further detail.

It is important to note that psychodynamic concepts and language have been used throughout the analysis as discussed in the *methodology section*. In particular the majority of the therapists have drawn upon a traditional Kleinian object-relation theory to make sense of their emotional experience (this will be discussed further in the *discussion*). Concepts rooted in this approach will continue to be drawn upon throughout the analysis, whilst taking into account the double hermeneutic. The interpretation of the data has been influenced from these concepts because of the therapists' frames of reference, my relationship to the therapists and to their data, as

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[1] In this and subsequent sections, the participant's will be referred to as therapists as it is more personal, and it refers to their role that the research is exploring.

well as my own theoretical stance. This will be reflected on further in the reflexivity section.

The "mirrored process" was a common undercurrent amongst the therapists' accounts of their experiences in relation to their clients. However, it was subtle in its occurrence. At times the therapists did recognise this process and interpreted as being a countertransference response. If the therapists' predominate psychodynamic viewpoint were applied to this process, it may be interpreted that the mirrored process was an unconscious process that they were not always aware of. I have tried to make deeper sense of their experience by considering hidden meaning through interrogating their texts.

To illustrate this process I will present two examples from Sophia. These will demonstrate how she showed awareness of this mirrored process, and where I have used her awareness to reveal further meaning in a later extract.

In the passage below, Sophia compared her process of forgetting what had occurred in the sessions with her client, and likened it to her client's difficulty to retain anything from the sessions.

> I don't remember anything and I wonder whether she is kind of the same
>
> Int[2] 11: 274 [3]

Below is another example taken from Sophia where she described difficulty in staying with the feelings that are generated from being with her client. In context of other reflections Sophia has made in her diary, which referred to feeling as though her client is avoiding facing difficult issues in therapy, it could be argued that Sophia is experiencing a similar process to the client. I have interpreted this as a mirrored process.

> I wonder whether they were really unbearable {feelings} and I couldn't make sense of it all so I had to just, I had to lose it because I couldn't actually stay with it.
>
> Int 2: 48

As the superordinate theme, "mirror process" was founded in my interpretation of the therapists' experiences it has been presented in the master themes in this way. The therapists often referred to what I thought indicated a mirrored process by using food

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[2] "Int" is an abbreviation for interview.

[3] Therapist quotes are referenced as: therapist name, source (whether Interview, diary or diary 2) page number and line number.

related metaphors. The master themes were labelled using words commonly used in eating discourse, in order to embed the mirrored process.

This implied that the therapist had experienced something similar to being anorexic, alongside experiencing a process of eating (digesting). This could have been a higher class theme, that encapsulated the overall experience and all the superordinate themes. However, I decided to present three master themes to demonstrate the difference in the degree to which the therapist experienced feeling one category of clusters over another. Furthermore, there was often difference in the feelings over the course of keeping the diary which illustrated the ups and downs and to's and fro's of the experience, and which I felt would be lost unless explored as distinct from one another.

I am aware that none of the therapists used the words that have been used to label the themes exactly to describe their experience. They did use words related to eating such as "feeling full" and "needing a custard doughnut". In the analysis the act of eating provides a metaphor for the experience of feelings when working with anorexic clients.

Theme	Master Theme	Superordinate Theme	Emergent Themes
1	Force fed feelings	a. Feelings associated with being maternal b. Feelings associated with being abused or abusive c. Feeling the clients feelings	
2	Starved	a. A near death experience	
3	Digesting	a. Reflection on self as influencing emotions b. A therapeutic feed c. The diary as part of the therapist's digestive process	I. level of experience II. being a mother III. tiredness

Table 3: The themes.

The Master Themes

It is important to note that within this overall classification the master themes are not mutually exclusive. Instead they appear to be related to each other and permeable. The aim of the section is to convey the therapists' experiences as a whole group whilst also portraying the idiosyncrasies and nuances of the individual's experience. In order to stay true to the therapists' phenomenology and the interpretative analysis this section will not introduce relevant theory or literature as this will be presented in the *Discussion.*

There was a prominent Kleinian perspective amongst the therapists' accounts. It is possible that the therapists experienced such overwhelming and difficult feelings that they used psychodynamic interpretations to "rationalise" their negative feelings toward the client and the therapy. These interpretations do not always seem to be made on a conscious level, and they can appear as though the interpretations are absolute fact and not a tentative hypothesis. It is possible that these interpretations serve an important function for the therapist.

Force Fed Feelings

   a. Feelings associated with being maternal
   b. Feelings associated with being abused or abusive
   c. Feeling the client's feelings

All therapists have described experiencing feelings as being "dumped" on them by their clients or pushed onto them. There was a forceful nature to their descriptions and often in their reflections they acknowledged these feelings as being about the client and not them. The concept of being force fed is a metaphor for experiencing unwelcomed feelings that the therapist interpreted as being maternal, abusive or a mirror of the client's feelings. The therapists showed elements of being overwhelmed by their feelings and after the sessions they appeared to be "full of feeling" as described by Chloe.

> I have felt much more full up of feelings after the session.
>
> Chloe: diary 1, 16: 282

This was present across the three different superordinate themes.

Feelings associated with being maternal

A majority of the therapists spoke about having strong maternal feelings towards their client. Five out of eight of the therapists interpreted these feelings as being related to a maternal transference, which is a psychodynamic explanation for their experience. They understood this as experiencing feelings that were evoked in them because the client was projecting something onto them that tapped into their own maternal feelings. They understood their experience as being a reflection on the client's need to entice a maternal response. The overarching emotions related to the maternal response were guilt and responsibility. The other three therapists spoke about an overwhelming feeling of responsibility for their client, which was related to the role of being a therapist. I have interpreted this experience as the therapists feeling as though they were being force fed feelings which they identified with and interpreted as feeling maternal towards their client. This was based on the metaphor of being force fed as representative of receiving projections from the client. It is possible that their feelings of responsibility as a therapist were intense and using psychodynamic theory to help understand their experience may have relieved them from the intensity of the responsibility that they felt.

Chloe stated that the biggest feature she noticed when working with her clients was feeling a lot of guilt which she associated as being linked to a level of responsibility that a mother would feel (Int 11: 200). Both Anna and Chloe alluded to feeling as though they felt they were the only person that could help their client, which in reality was not the case. They assigned this phantasy experience to being part of the maternal transference. Sophia also described this experience but had a different interpretation of this experience. She understands her experience of feeling like the only person who can help her client as being controlled by them. She is one of the three therapists that did not talk about maternal feelings or a maternal transference. In Sophia's account it is almost as though there is some benefit to the client by making her feel useful.

> I suppose it is nice, it is a nice feeling if you do feel useful but then I suppose that the other side to it is you have to wonder why someone is making you feel like you are useful, because I suppose it's making you feel like you are the only one that can help and feeling like the only one that they can tell things to. And actually is that a way of maybe controlling you in some way, I don't know. (laughs)
>
> Int, 5: 188

The therapists that referred to a maternal transference described it as feeling although it was absolute and concrete. Chloe referred to the experience as though there was a distinct lack of an "as if" quality, this is another example of her drawing on theory to understand her experience. For example, it did not feel *as if* she was her client's

mother but she felt feelings associated with *actually being* the client's mother. She often spoke about feeling absolutely and literally responsible for her client and as if she could damage them. However, this seemed to shift over the course of the six weeks that she kept the diary.

> I have much more of a sense of being a therapist, who is helping a client work through an earlier loss, than an actual mother abandoning their child.

Chloe: diary 1, 27: 465

Chloe spoke about how something "confirmed it was a maternal transference". This suggests that she believes this to be absolute and the truth. In a way it puts her in the "expert position", perhaps similarly to a mother who feels that they know best about their child's needs. She seemed to be struggling with fears of letting her clients down because she was going on maternity leave which may have enhanced her particular feelings of responsibility and guilt. She later spoke about being vulnerable to a maternal transference because of her own pregnancy. It is possible that interpreting this as being part of a maternal transference helped relieve her of some painful feelings.

> this whole sort of feeling of ending early with a client, whether there is a strong maternal transference or whether, whether that actually is, I was doing more harm, not more harm than good, but whether I was doing something umm that was that was not helping them at the time. Umm and I know, not helping them, that is not how it was, it was kind of, if I wasn't going could they do more sort of feeling. It was cutting their time short and not giving them as much as they need.

Int 24: 520

Anna illustrated how powerful the feelings can be when she described feeling a concrete maternal transference. Like Chloe, there was a difference in Anna's experience of this in her diary compared to her interview. From the perspective Chloe adopted, I wondered whether there was less of an "as if" quality to the described transference in her diary. This seemed to shift in the interview when she seemed more able to hold onto and reflect on the "as if" quality. The quote below is extracted from Anna's diary and illustrated her feeling absolutely responsible for her client.

> Something awful happened today. I was meant to inform her {client} at the beginning of the session that I was taking a break for one week in two weeks time, so we would have one more session and then one weeks break. However, I had forgotten and informed her towards the end instead! It was awful, her face fell and she said "What am I going to do without you? I am not getting out of bed all week!" I realise now how dependent she is upon me and how I need to be very careful now with what I say and do to manage her separation and loss from me. I need to be careful that I continue to repair the ruptures. She needs a corrective experience and I have a lot of responsibility, I feel now, to manage this break with her. I am nervous when I tell most of my patients but this was more heavily weighted!

Later in the interview when she was reflecting on the work with her client, when she said:

> We had a real relationship and I used to talk about, well I still do talk about the transference and the real relationship and I am able to explain to her terms about in theory and she is able to take that on board and she thinks about it in her other relationships in that way now. Before it would just used to be, "you are it" you are my internal figure and that is a lot of pressure on me, and I felt a lot of responsibility. Like "I don't have kids, I don't know what this maternal instinct is meant to feel like", but yet, I found myself feeling something quite maternal towards her and again that was the transference and the countertransference. That I was getting pulled into something with her, and she was, well she was powerful in creating that between us.

> Int 3: 81

In the first extract there is a total sense of responsibility. Anna interpreted the client's response to her having a break as it being her responsibility to make this better so as not to damage her client. It seems plausible that actually Anna is feeling guilty, and, if one was to adopt her interpretation of her feelings being part of a maternal transference. It is possible that her drawing on these concepts helps her make sense of her experience and relieve her from guilt and responsibility,

The two extracts illustrated a shift in her response to the client after a significant time had elapsed and she had reflected on her process in the interview. She was able to interpret her experience as being less about her and more about what the client was communicating and about the phantasy aspects of the relationship (this supports May's theory presented in *digesting*).

It is possible that Anna felt in the session as though she was powerful enough to actually damage her client, she seemed overwhelmingly aware of the impact that her actions could have on her client. This seemed to be relieved in the second extract, and it is possible that her drawing on theory and interpreting her experience helped her to re-distribute the power in the relationship, and acknowledge that her client had been "powerful" in creating the dynamic. The object-relation perspective that Anna appears to be using to help understand her client views an individual as being powerless to intra-psychic conflicts. She may understand her experience of emotions in therapy as being part of the client's "intra-psychic conflicts", which is a way of attributing her emotions to being part of the client and not necessarily a reflection on her. It is possible that this interpretation helps give Anna distance from her emotional experience.

In addition, Anna spoke about feeling as though the client had a lack of boundaries; this resulted in her feeling as though the client encroached on her and stayed with

her. She linked this to having maternal feelings towards her client and feeling as though these were related to having a young child. Anna is not alluding to a physical encroachment but feeling as though the client had psychologically forced herself on her. From Anna's perspective, this can be explained metaphorically as the client's feelings being forcefully pushed into her. From a theoretical perspective, I wondered whether Anna's link to this being an aspect of her maternal feelings was because she had interpreted this process as the client trying to be kept in her mind.

> After Cara's[4] sessions it takes me a long time to unwind and let go of her. I feel like she has encroached upon my being. We have a very strong therapeutic bond and I feel very maternal in my transference towards her. Sometimes I feel that I want to protect her just like a child.
>
> Diary 1: 9

Anna's response to feeling force fed was that she felt sick of her client, which I understood as her feeling sick after being force fed. This can be demonstrated in the below extract from her interview, after she had some time to process her feelings and recognise how intense her experience with the client had been.

> Maybe I am a bit sick of her (laughs) that is what it is. I do feel a bit sick of her sometimes.
>
> Int 15: 346

May offered a different perspective to feeling as though she is on the receiving end of a maternal transference. She expressed how frightening it can feel for her to be put in the position of an idealised mother. May interpreted this as a reaction to the client's hunger for a perfect mother as she talked about the client's insatiability. This suggested that May thought about her client's relationships with others as being similar to their relationship to their need for food. The extract below illustrated her exploration of this.

> She is certainly feeling that she is not getting enough. She is not getting enough of this ideal woman that she is making me out to be, the ideal mother. That is giving her the kind of feel that she didn't get it. So, I think it's quite frightening that the idealisation is probably about her insatiability.
>
> Int 3: 56

Furthermore, May drew a parallel between the client-therapist relationship and the client-mother relationship. In May's reflections on two clients she reported experiencing being both like an idealised mother and a bad mother. I wondered

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[4] All names have been replaced by a pseudonym in order to protect the confidentiality of all individuals concerned.

whether this is about the client or the stage of therapy that they are in, or whether this can be a simultaneous experience with a client. Below is an example of her feeling like a bad therapist/mother. These terms she used interchangeably reinforcing her interpretation of a maternal transference.

> It feels like I am being a bad mother…I wonder whether she is trying to make me feel like a bad therapist that's what I was wondering. Like she tries to make her mother feel…
>
> May: int 6: 142

May's thinking was rooted in a traditional Kleinian object-relational view, which helped her to make sense of her experience throughout the diary and the interview. She appeared to use her emotional experience to try and understand what was happening in the intra-psychic world of her client. She attributed this to being part of a maternal transference operating between her and the client.

In May's account she refers to feeling controlled by her client and as though her client is powerful in her ability to project out her phantasy (her words).

This can be seen in the quotes from her diary entries below. It is as though when the feeling is intense and she feels out of control she looks for a reason for the feeling to help her understand and perhaps gain some control back of herself and the therapy. Perhaps this, alongside the psychodynamic lens in which she views her experience, is why she attributes it to a maternal transference.

> Wrote a note! Determined she wouldn't feel she stopped me! I'm trying to resist her control.
>
> Diary 1: 20
>
> Wanting to be fair. She's so powerful she catches me in her fantasy that she can manage life.
>
> Diary 2: 46
>
> I felt more in control and as if I was being more useful.
>
> Diary 1: 56

On a couple of occasions Chloe spoke about "feeding her client". I interpreted this as being twofold; firstly this is another occasion in which food is used as a metaphor to describe the therapy process, secondly, within Chloe's account, she seems to be responding as a mother to her baby. For example;

> Had to work hard to keep feeding her enough.
>
> Diary 2, 35: 597

> I certainly feel satisfied that she has had a good feed today and that I have done all I can for now.
>
> Diary 2, 40: 695

I have understood this as Chloe feeling as though she is experiencing maternal responses to a very young infant. It is possible that this may be relevant to the client that Chloe experienced this with or it could be because Chloe is actually a mother to a young infant, or finally it could be because she draws on Kleininan theory which links most of the understanding of the psyche to early experiences between caregiver and the infant. This will be discussed further in the section, *Digesting: Being a mother,* as it appears that her experience is influenced by being a mother.

Alongside this, the therapists experienced feelings that were not being verbally expressed by the client. They spoke about picking up on the client's feelings in the room and they seemed to be tuned into their client's unspoken emotional experience. Lou described feeling as though something was occurring in the room with her client that was pre-verbal. This reminded me of a young infant not equipped with language to communicate their internal states which may be a result of Lou using object relation theory to interpret her experience:

> Some of what happens in the room seems very pre-verbal, there isn't a language to describe it
>
> Lou: diary 3: 38

She was also someone who described a maternal transference with her client. Specifically she said, "I become the mum in the transference, who can be attacked and rendered powerless" (Diary, 8: 77). More explicitly it may be that the maternal transference she was experiencing was as though she was mothering a young infant. Her description of this is also absolute, as though it is the case that she is the mother. It is as though Lou did not have a language to describe her experience with her client. Perhaps as a response to this she chose the language of psychoanalytic theory to help her make sense of her experience.

May spoke about how she responded emotionally when she picked up on her client's unspoken feelings. She highlighted that she was angry when she felt her client's unspoken anger. In the extract below, May linked this experience to being a possible indicator to how the client's mother feels towards her client. The image that she conjured up in her description is that of a demanding baby, further suggesting that she feels like she is having the experience of being a mother to a demanding client and that she has linked the maternal transference to a young infant who needs feeding.

> You know it feels quite difficult just to maintain the silences and just to wait. She is often so sulky about it that I can feel her anger and therefore sometimes I can get angry about it. So it makes me feel angry, and I do quite frequently feel angry, and I wonder how her mother feels about her because she is very very demanding of her mother, and she wants her mother to sit with her whilst she is eating and Lizzie feels that she can't feed herself.

> May: int 5:130

An additional example of this can be evident in Anna's account in which she interpreted her experience as being a process of projective identification. She has made sense of her anger as being identification with her client's anger which she has understood from an object-relational perspective. The concept of being force fed acts as a metaphor for Anna being fed her clients feelings.

> I felt angry at first when I heard that she was considering missing the therapy to go elsewhere. I started to wonder why it felt like an attack to me…. I felt annoyed with her because she was rejecting me. She was rejecting me before I rejected her. She wants to punish me before she experiences the punishment maybe? My feelings of frustration come from the same place as my maternal instincts towards her. I am thinking now that the anger that I feel could be projective identification. Could it possibly be the anger that she experiences towards me that she is not allowing herself to feel towards me and therefore avoids facing me to talk about it?

> Anna: diary 2: 72

This segment also embodied a process of Anna making sense of her experience in relation to her client. She acknowledged that she felt both maternal and punished/punishing towards her client, which seemed to be a confusing experience for her. She linked the frustration as being rooted in the same place as a maternal transference, which could be linked to feeling a level of responsibility. Anna's account reinforced that there is a relationship between the superordinate themes categorised in *force fed* and that there is overlap between them.

Overall, the therapists seemed to feel an overwhelming sense of responsibility. Some therapists used an object-relational theory to help them to understand this experience. It is possible that clients with anorexia evoke an intense feeling of responsibility in therapists, which feels over and above the role of being a therapist. This may have helped them to relieve some of the intensity of this feeling and enabled them to feel more able to cope with their experience. Sophia, Beth, Alicia and Caroline all referred to feeling a responsibility to be helpful to their client and to do their job properly but they did not use psychological theory to understand this. Even the therapists who interpreted their experience of responsibility as being part of a maternal transference did, at times, also talk about feeling responsible as therapists. For example, Lou expressed awareness of her responsibility not only as a mother but also as a therapist:

Need to find a way of connecting to her through the choice of language used

Diary 3: 38

Is she going to drop down dead?

Int 6: 126

She also felt it was her responsibility to find a language to connect with her client. In her search for this she further adopted the language of the life and death drive. Perhaps using this was a way of trying to understand her experience and put a language to it. It is possible that this was a reaction to feeling responsible to provide life for the client and to adopt a language to understand their client, and to help the client understand themselves.

There is a real 'deathliness' a sort of life/death instant, and the death instinct is really powerful and so trying to engage even a chink of life was quite difficult

Int 2: 56

Chloe also reflected on a felt responsibility as a therapist alongside her interpretation of feeling responsible as being linked to a maternal transference:

I have some responsibility, she was communicating things to me quite clearly when I looked at it, umm, and I have the responsibility as a therapist to bring that back or keep it in the room…I took more responsibility for her for getting her to keep the feelings in the room

Int 17: 371

Alicia described feeling responsibility to be a "helpful" therapist and it appeared that she faced some resistance in the client in allowing her to be useful. Therefore, she seemed to feel responsible and frustrated at the same time.

She described feeling as though the client was controlling the session and how difficult it was not be "drawn" in by this. Interestingly, as a response to this Alicia feels responsible to manage this which appears to be linked to the responsibility of her role as a therapist but could be linked to maternal feelings.

Session is very full, little chance to stop and feel, feels very cognitive, lots of talking, client seems keen to fill every second of the session. I feel drawn in by this….feel confused about how to keep her engaged, not disappoint her whilst also working in a helpful therapeutic way

Diary 12: 171

She also seemed anxious and aware of her position of responsibility and her position of power in relation to the client. This was apparent when thinking about having to intervene over a child protection issue, which placed her in a position that she experienced as powerful. Below shows this struggle:

96

> Aware of other issues I will need to ask her about next week- don't want to as I am afraid of what she might tell me and how I will manage that information/emotions. Fear of making things worse?
>
> Diary 5: 56

She also seemed to feel the responsibility to not fail her client or let them down:

> Frustration- C saying she wants to make changes, but can't see role of therapy helping her with this in the long term…Feel that I really want to help her, that overcoming her eating disorder would be so beneficial to her….Wonder if I have failed to convey my feelings that therapy could help her despite her age
>
> Diary 15: 218

The common theme throughout the therapists' accounts was that they felt a level of responsibility and some guilt. Some therapists related this to being responsible as a therapist and some interpreted this level of feeling as being related to a maternal transference.

Feelings associated with being abused or abusive

On several occasions the therapists talked about feeling as though they were subjected to being abused, or feeling as though they were abusing their client. Within this category they also referred to feeling like the punisher/punished and feeling attacked/attacking. They reflected on this experience as being a countertransference response to the client's unconscious communications. The therapists seemed to interpret these feelings as being unconsciously forced upon them by their client, and have related this to feeling abused or abusive. This implied that they have understood this dynamic as being created by the client, who they viewed as being at the mercy of intra-psychic conflicts which were played out in the therapeutic relationship. It is interesting how the therapists interpreted from this theory which could act to dilute the responsibility of this uncomfortable dynamic. The object-relational theory, that was drawn from to understand their experiences, identifies such dynamics as being something that the client could not help happening, but that reside in the client.

On occasion the therapists acknowledged and reflected on this process in the diary. However, the majority of diary entries that were interpreted as feeling abused or abusive tended not to explicitly acknowledge this dynamic, but were more descriptive and emotive. In the interview the therapists appeared more able to interpret feeling this dynamic in the relationship than in the diaries. In terms of my interpretation, the information from the interviews helped elicit meaning from the diary reflections to further interpret the therapists' experiences as feeling abused or abusive. This theme required more interpretation on my behalf to understand how the therapist was responding to their client when captured in the thick of their emotional experience.

It could be the case that the therapists felt more cautious of acknowledging this dynamic in the diary as they may have felt uncomfortable evidencing this. It may also be possible that they felt more wary of this when in the midst of their emotion.

The passage below from Beth gives a sense of how emotive the diary extracts could be when related to feeling abused or abusive. In this case, whilst being full of feeling she has still managed to make sense of her experience as feeling tortured. The language that Beth used to express herself is powerful and evocative, suggesting that her experience is just as powerful and full of feelings. Beth tended to use metaphors to describe her experience instead of using theoretical language, even though there were indicators that she was drawing from a psychodynamic perspective. I argue that the extract below is evidence of how full of feeling Beth was after the session with her client. This seems to be a response to the lack of expressed feeling by the client and by the therapists understanding of her client as her withholding in therapy. Beth referred to withholding on several occasions which I interpreted and understood as a psychodynamic concept. From this, my interpretation is that Beth could be experiencing all the feeling that the client is not explicitly bringing to the therapy, which is an example of Beth being force fed these feelings by the client. She referred to herself as a "therapist/abuser" suggesting that for her there is literally such a fine line between these two experiences when with her client.

> Bloody hell- that was totally and utterly fucking torturous!! Instead we had another session of her holding her head in her hands, silently sobbing, body turned away from me like I am one malevolent, bulldozing therapist/abuser. I am so tired of this. What made things worse today is that I feel quite unwell today also so I don't feel on the ball. I told her that she needs to either communicate or not for the time being but that we have to step outside this (awful) withholding dynamic. She said that she "felt so alone" (I felt **FURIOUS** with her for saying this! What am I? Chopped liver???!) after we had spent yet another entire session with me waiting and hopefully being supportive. I'm so tired.
>
> Beth: diary 2: 17

The use of the metaphor "chopped liver" in the context of feeling disconnected from the client could signify a complete feeling of severance to the client and to digesting anything in therapy. It is this block to digestion that seemed to leave Beth feeling full of feeling. It also implied that for Beth feeling unwell impacted on her emotional experience of her client in a way that amplified her feelings and perhaps lessened her ability to be "on the ball" and make therapeutic use of her experience.

Anna described a similar emotional experience which she too referred to as her client withholding in the session. From her experience it sounded as though the client's non-engagement in therapy felt as though the client was controlling the session. In

response to this Anna worked harder to try and engage her. I wondered whether she felt as though she had been manipulated or controlled. Like Beth she also expressed feeling exhausted by this described withholding dynamic. There seemed to be something about allowing herself to feel abused as she urged the client to connect to her. This also resonated with Beth's account, perhaps the more that they tried the more abused they would feel. Below Anna explains feeling as though she was on the receiving end of anger which she felt was being used by the client as a tool.

> I was sitting on the edge of my seat today, urging her to talk and come forward. I felt like I was doing all the work again just like a few weeks ago. I was tired by the end of the session, exhausted with her withholding. It's such a powerful tool, quite manipulative and possessed with anger.
>
> Diary 3: 100

At times the therapists described feeling as though the client was sabotaging and refusing therapy as a way of communicating feelings. The therapists also described feeling punished as they are a significant aspect of 'therapy'. This can be seen in Sophia's account below where she described feeling like the therapy is being squashed, stamped on, poisoned and dumped on. She has used very evocative words to describe this experience and one can get the sense of how difficult and violent this feels. It's as though Sophia feels like these things are being done to her that are out of her control, and in her reflecting on this she alludes to feeling both abused and disabled as a therapist.

> It just feels very squashing of therapy. It feels like it is just completely stamping on the work and just a lock down really…it feels quite, poisonous to have that into her in a way. It feels like she has been infected with this way of thinking…..I felt quite angry actually… But this is something that feels like it has just landed like a, well it's <u>dumped</u> on everything really and it's just flattened all. Oh like the tsunami thing, it's just totally laid it out and how can you? I can't see a way through that so. I am feeling depressed now thinking about that (laughs)
>
> Sophia: int 13: 323

It is interesting in this above account how Sophia experienced a flow of different feelings from anger to depression. Sophia described her experience of being with client as though she was on an emotional rollercoaster.

> I've been on an emotional rollercoaster
>
> Diary 5: 68

It seemed that she felt like a passenger on a rollercoaster that her client was in control of. She talked about feeling like her "clinical psychology head" knew what her client needed to talk about but that this was very hard to make happen as her client avoided

the issue and was therefore taking control of therapy by "high jacking" it with other issues.

> then with my clinical psychology head on I am like 'oh we need to be doing this or if we could work with this in a particular way I know would be really helpful but does she want to do that?"
>
> Int 4: 153

From these descriptions it is possible that Sophia felt out of control when with her client. It is possible that calling on her own professional opinion helped her to regain a position of feeling more in control. She seemed to realise that there was no way that she could be more in control if the client would not let her help her. This is explored from another perspective in the theme *starved*.

Sophia also used a powerful metaphor of the recent tsunami in Japan to describe what therapy with her client felt like. The likening of her experience to a tsunami denoted a horrendous disaster that she and her client were both out of control of and that she was powerless to do anything to help, or to prevent from happening. This shall be further reflected on in *a near death experience* but it is important here because it, alongside the idea of an emotional rollercoaster, implied an experience in which Sophia felt out of control.

> I suppose I have been thinking about it as like the tsunami that happened in Japan. And literally one minute your world is kind of how it is and, you, literally something awful happens
>
> Int 3: 70

In light of this it is possible that for Sophia the experience of feeling controlled or controlling when with her client, felt abusive in some way. In order to describe and communicate her experience Sophia often used descriptive words and metaphors as can be shown in the above extract as well as throughout her account. It is possible that she had a tendency to use metaphors over theoretical explanations in order to help her manage her feelings or feel more in control of the situation.

Beth described her experience of her client's restriction of help in therapy as something powerful being done to her, that she had previously referred to as feeling abused by her client.

> She would be sitting there like I and therapy was some horrible monster... She won't allow me to help her and that's probably one of the most powerful things you can do to your therapist, to not allow, to not be allowed to help somebody.
>
> Int 2: 33

Interestingly the diary accounts that consciously acknowledged the dynamic of feeling punished or punishing, in the case of Beth and Chloe, showed a revelation that whilst they had felt abusive towards the client that actually this could be more accurately described as feeling abused. There seemed to be a fine line between the two experiences and they seemed to have come hand in hand with each other. Beth described a realisation that she felt as though was being punished by the client, when she had felt like the abuser prior to this realisation:

> Started to feel like she was actually abusing me…I was aware that my feelings, my emotions towards her started changing because she was doing this and I always felt when I was with her like I was doing something terrible to her, and then I started to realise that actually she is doing something pretty terrible to me in our sessions.
>
> Int 2: 38

This can also be seen in Chloe's account in which acknowledgement of the dynamic is seen as progress, as she feels that she can now address this with her client. This revelation or her interpretation also resulted in a reduction of feeling guilty. It seems that guilt can also be linked to feeling like a bad therapist which can be a result of feeling punished. She proposed from a psychodynamic perspective, that the reason for this experience is because of aggression being acted out during therapy. It may be possible that there is such a fine line between these experiences because the therapist is unconsciously responding to being abused by being abusive in subtle ways. In Chloe's case she believed that she had been punishing by being drawn into being a 'bad therapist', which was a response to being under attack by the client.

> Feelings after the session: Writing the above makes me feel worried that the lack of feelings in Carrie pushes me into increasingly bad acts of being a 'bad therapist'. Changing session times, not listening, not challenging her, this is really poor practice for me. Yet she says nothing. We skirted around feelings today and so I got glimpses of her using the session, but they were quickly pushed out by the detailed storytelling that is such an attack on the space. NO Attack on me! I've never seen it like that before, no wonder I have been feeling guilty. I have been punishing her, as she launches ever more powerful attacks on what I offer. So much aggression that we are not acknowledging is getting acted out. Ok I don't feel so guilty now, I realise I can address this in the room.
>
> Diary, 2: 319

Furthermore, Beth talked about setting a discharge date for her client that they were working towards. These powerful feelings associated with feeling abused or abusive have been referred to by most therapists and to the point in which the therapist has considered discharging the client (this occurred for Lou, Beth and Sophia). At one point Anna questioned "is this really therapy anymore?!"

Lou questioned the effectiveness of therapy with her client and this theme continued throughout her reflections. This could be evidence of her feeling disabled by the client.

> {the client} Renders me again a useless object- reflecting her own internal state. In her mind she in un-helpable and worthless. We are getting to the point where a review {of therapy} is needed.
>
> Diary, 7: 89

It appeared across these instances that the therapist felt that the feelings they experienced, as a result of feeling abusive, made them feel as though they were an unhelpful therapist. This seems similar to Chloe's description of feeling like a "bad therapist". Sophia illustrated this and I wondered whether she was feeling abused by being made to feel as though she is cruel and abusive in the same way that Chloe did. This again illustrates how closely linked the two experiences are for these therapists.

> Moved patient onto a difficult topic of being sexually assaulted, as she had raised wanting to speak about this at the end of the last session. Even though I wasn't pushing her for details/information, I felt cruel for asking her to think about talking to me about the incident. She struggled to manage her feelings and it was difficult to end the session on time, as she was very distressed. This left me feeling incompetent and that I had gone about the session in an unhelpful way.
>
> Sophia: diary, 2: 30

A possible explanation rooted in a psychoanalytic frame could be that the feelings of being abused and made to feel abusive is unbearable. Therefore wanting to discharge the client could be seen as part of this dynamic being enacted. Another possible explanation is that it was a way of the therapist taking some control of therapy when it no longer felt to be helpful, because the client was taking control and blocking any help. It is possible that the experience of being abused or being abusive was a response to feeling controlling or powerful as a therapist versus feeling controlled by their client, and as though they were more powerful.

It seems that feeling abused or abusive are similar experiences that are accompanied with feelings of guilt and wanting to end therapy with the client.

Feeling the client's feelings

The expression "feeling the clients feeling"' refers to a process in which the therapist is left feeling overwhelming and powerful feelings after the session that they were not necessarily feeling before they saw their client, and that have not been interpreted as being related to maternal feelings or feeling abused or abusive. They are interpreted as reflecting the client's emotional state, like a mirror in the client's present or past life. This highlighted that this is about experiencing these feelings as a reaction to the client,

and perhaps feeling the same as the client. The therapists talked about feeling blocked and shut out by their clients which generated frustration. This is similar to the refusal of therapy discussed previously but, in this situation, therapists felt frustrated at the client's resistance to change. Below is an example from Alicia's diary, where she described feeling blocked by the client.

> During session I am aware of my frustration - feel we are going round in circles… Feel she is not making the same connections that I am making, but finding it difficult to convey this to her. Feel she is trying to block me from doing so.
>
> Diary 13: 186

The therapists often made sense of the negative emotions that they experienced when with their clients as belonging to their client. They explored this as either an empathic response or as experiencing something that the client was unable to verbalise. This seemed to require some level of digestion on behalf of the therapist. Alicia demonstrated this in her reflective diary.

> C {client} very anxious at the thought of trying this. Noticed in the session that I felt anxious too- worried that she might actually gain weight and fearful about how she would cope… After session feel confused- why was I so worried about what might happen if she gains weight- transference? After all, that is the aim of our work! Think I am experiencing her fear about weight gain.
>
> Diary 10: 139

May spoke about her client making her experience how she used to feel when she was a child. She has interpreted her emotional experience when with her client, as a countertransferential response.

> Oh god I don't know what she is going to come up with next', and that she is turning into her mother and she is demanding of me. Maybe I am starting to feel a bit like she used to feel as a child, and I am very demanded upon and wondering what is going to come next and that's quite frightening. So I am getting an idea of how she used to feel as a helpless little child which is quite frightening.
>
> May: int 3: 67

I wondered whether when May felt out of control and unsure of what to expect that she attempted to gain some insight, or control over her experience. She seemed to do this by understanding her client from a theoretical perspective, and from understanding her response as a reaction to phantasy aspects of the client being projected onto her to make her feel how she did when she was younger.

In summary, the therapists felt as though they were force fed feelings that were not related to them. These have tapped into something within them and they have felt

maternal or punished as well as having experienced what they suspect the client is feeling.

Starved

This theme encompasses the feelings and experiences associated with being a therapist to a client that starved themself of therapy. This interpretation was based within the therapists' accounts, as they often spoke about their experience as though the client was restricting therapy, and not taking in anything of value. This experience impacted on the therapists' emotional experiences.

Interestingly the therapists' language used to describe their experiences appeared to be synonymous to symptoms of starvation as well as representing a feeling of disconnection to their client. For example, May described feeling the client's "cut off-ness" (Diary 2, 1: 60) and nearly falling asleep as a response to her client being distant in the session (Diary 2, 1: 74).

It seemed that being with the client could actually evoke sensations related to hunger. Chloe summed it up after a session in which she acknowledged her need for something high calorie and comforting, and recognised that this was not about her need "I need a custard doughnut but I am not actually hungry" (*Diary 2, 37: 583).* It is possible that she felt empty and was left craving for something.

The therapists also described an experience of feeling starved of therapy or a connection with the client during the session. Often when the therapists experienced their clients as starving themselves of therapy, the therapist would express feeling exhausted, drained and hopeless.

In Lou's experience she described being left feeling hopeless and desperate. She thought about this from a theoretical perspective which perhaps made her feel empowered in what felt like a hopeless and desperate situation.

> In our session {the client is} restricting herself of nourishment in the way that she does outside. Does she take up the "thinking food" or does she starve herself?
>
> As in many of the sessions {there was} an overwhelming sense of hopelessness and desperation. Therapy is pointless and not moving forward.
>
> Diary 3: 56

Beth described her experience when with her client as feeling "cut off" from her. She reflected on how in response to her client's disconnection to her she would disconnect from the session and the client. She linked this to an angry response towards her

client's restrictiveness. I wondered if Beth was mirroring the client's response, in which both of them are being starved of therapy. The extract below illustrates this and I wondered whether it can be further evidenced in the last sentence where Beth loses track of what she is talking about. This indicates a further difficulty to remain thinking about how cut off she feels from her client.

> I suppose I often felt quite cut off from her so I would sometimes find my mind wondering to something quite outside, you know, thinking, and this sounds terrible, thinking about my internet shopping order later on (laughs) that I was going to make. And I sometimes, thinking about that now, I think that might have been a bit of an angry dissociation and that was the ultimate switch off in me to not even be thinking about her: to be physically with her but not thinking about her. Thinking about something mundane and so I felt quite cut off from her umm I felt. I am sorry can you repeat what you just said I have lost what I am talking about
>
> Int 3: 51

Anna offered a different perspective on feeling drained. She interpreted her experience of feeling exhausted after a session with the client as the client draining her out. This suggested that the client was taking from the therapist as opposed to pushing into the therapist as described in the theme *force fed.* This may be similar to Chloe's experience, which she interpreted as needing food to resolve. In Anna's reflections this seemed to be about her doing the work for the client.

> At the beginning of the session I asked her how she felt after last week and she said "ok", and I thought sure you're ok but I felt exhausted! However, that could also have been due to my other work stresses contributing to my well-being. Now I find myself making it ok for her to drain me out. I find that I excuse a lot of what I experience with her and possibly collude with it rather than use it in our work.
>
> Diary 1: 17

This has a different feel to the other aspects of feeling starved. There seemed to be two different experiences occurring within this theme, which has resulted in the therapist either feeling demanded upon (as in Anna's case) or deprived of something.

A near death experience

There was a sense from the therapists that, at times, they experienced something in the room with the client that felt reminiscent of surviving a near death experience. This seemed to be a sensation that was reminiscent of starving, because it was a deathly experience, but also seemed to relate to the residual effect of being *force fed.* Sophia referred to working with this client group as being detrimental to a therapist's health as though it is dangerous. This captured how difficult the experience of working with this client group can be.

> Working with eating disorders comes with a health warning I think, approach with caution.

> Sophia: int 16: 402

Lou spoke about a sense of "palpable deathliness" in the room when she was with the client. This was with a client that was severely underweight and very restrictive. She explained this as being a response to the little life left in her client and it was as though Lou viewed the restrictiveness as a deathly act. Lou expressed her experience from a physiological perspective as opposed to emotional. She interpreted that her experience was probably a countertransference reaction to her client which she later linked to the client being empty herself, and starving herself, of anything good in the therapy. I have interpreted from the passage below that the symptoms that Lou described could be a result of starvation.

> my sense of hopelessness being her sense of hopelessness, and switched off ness that sometimes we would get in the session where it just felt like neither of us could think. So you know a feeling of just completely, just feeling brain fogged really. Just being very out of it, spaced out and umm a bit mindless really, and that, that's certainly the way in which she is a lot of the time.

> Int, 2: 100

Sophia felt that in order to survive the work with her clients, she had to try and forget the feelings that she experienced during a session because it felt too overwhelming after the session to stay with them. Sophia reflected on feeling close to death, which she described as a contradiction. I wondered if Sophia felt that she was subject to a paradoxical experience, as she felt high levels of anxiety whilst also feeling a lack of life.

> I feel like I need to be resuscitated! I am sure my heart is beating faster than usual and my hands feel shaky. I've been on an emotional rollercoaster

> Sophia: diary, 5: 68

Sophia likened her emotional experience of being with her client to witnessing a real life disaster. She connected her experience to hearing about and watching footage about the devastation of the recent Tsunami in Japan. The images on the news that she had seen resonated with how she experienced her client with regard to her anorexia and to her pain. Sophia was not alone in her linking to a deathly experience, Chloe also hinted at her experience of connecting to, and engaging with her client as "surviving something intense". She felt it was unexplainable and difficult to understand. She described feeling a rush which was then followed by a sense of depletion.

> Nervous anxiety…realised I was full of 'adrenaline'. I am aware of working really hard to keep feelings in the room and this is extremely draining.

This is the passage from Sophia's interview:

> I remember feeling quite desolate after one session and she, I think she had just got to target weight and she had never, you know, she had never been a healthy weight for all of her adult life and she is in her 40's now. And there was a thing of, just a complete devastation like literally, I was thinking about it like, I suppose I have been thinking about it as like the tsunami that happened in Japan. And literally one minute your world is kind of how it is and, you, literally something awful happens. You open the door and you are left with nothing and it almost feels like she had been, she had this empty world where, where do you start to kind of build up from that? Because there literally was nothing there (welled up). I feel quite sad thinking about it. So yeah, it's just so not knowing kind of what to do with it, but then I think it was the next session she just suddenly was like 'oh its fine' (laughs). Maybe that was because it was so painful and she couldn't think about it.

Int 3: 70

On the surface level Sophia is describing how the client's reaching target weight felt like a tsunami that the anorexia had been fending off. As Sophia talked she connected to feeling sad about this. I wondered if she was connecting to her client through using a metaphor that helped her to understand her client's pain. However, Sophia quickly moved away from the sadness to remembering how the client retreated in the following session and as a consequence, Sophia felt blocked from working with her client on this. This is similar to what Sophia did as she spoke about this. She connected to her sadness and quickly moved to laughing off the experience. This is perhaps an indicator of a parallel process between Sophia and her client.

By synthesising Sophia's explanation into the other therapists overall experience left me with the following metaphor based on a tsunami. It links the overall description of a deathly experience to being a result of feeling force fed and starved simultaneously and deprived of a digestive experience. An area {the therapist} is being forcefully flooded by displaced volumes of water {force fed} and then sucked dry of its resources {starved}. It is only after the devastation of the experience that the survivors begin to contemplate and make sense of what has just happened, and the enormity of the situation {digestion}. I propose that this summarises the overall and general emotional experience of the therapists interviewed.

Digesting

a) Reflection on aspects of self as influencing emotions
    I.   level of experience;
    II.   being a mother;
    III.   tiredness

b) A therapeutic feed
c) The diary as part of the therapists digestive process

Digesting encapsulated a cognitive process in which the therapists experienced a working through of something. Therapists did this on their own to make sense of their experience of being with their client. It was a reflective process which they embarked on either, after the session, privately during their experience of their client in the session, or together with their client. The latter involved a dynamic two way process between client and therapist in which they both processed something together.

The process of the therapist digesting their experience after a session tended to relieve the therapist of the powerful negative feelings that they reported. Consequently they felt less full of feelings. Furthermore, the experience of digesting with the client tended to evoke more positive emotional reactions.

I have used digestion here as a metaphor to represent a process of taking in, breaking down and gaining insight from this experience in a way that mirrors the process of digesting food.

This theme has been divided up into three sections. The first section, *reflection on aspects of self as influencing emotions,* refers to the therapist noticing an aspect of them that influenced their emotional experience when with their client. This process of reflection tended to help the therapist make sense of their feelings.

The second section, *a therapeutic feed and digesting*, refers to a process when the client was engaged in therapy and the therapist felt that they were allowing themselves to get something from the session. On these occasions the therapists referred to a reduction in experiencing negative feelings, and at times feeling positive emotions in relation to the client.

The third section, *the diary as part of the therapist's digestive process,* refers to the diary as being a facilitator in the therapist's process of digestion. The diary acted as a catalyst for the process of digestion and it became part of their emotional experience.

Reflection on self as influencing emotions

There were three themes that emerged from the therapists' accounts that referred to aspects of themselves that they had identified as influencing their feelings and their emotional response to the client. These were level of experience of being a therapist and working within eating disorders, being a mother and feeling tired. These three aspects did not occur for all therapists but there seemed to be something important for

them about acknowledging the impact of their own self on their feelings. These will now be explored separately.

Level of experience

The theme level of experience emerged for Alicia and May as something that impacted on how they processed and digested their emotional experience. Although it wasn't a recurring theme that was embodied by all the therapists, it was of interest because it was a divergent experience for these two therapists. To help contextualise this superordinate theme, some brief personal details shall be mentioned about these therapists that were offered freely by them during the data collection process, in relation to their level of experience.

Alicia was a psychology trainee undertaking a short-term placement at an eating disorder clinic. This was her first experience of working with clients being treated for anorexia. She found both her trainee status and her limited experience contributed to her emotional experience.

> Familiar feelings about whether I won't be taken seriously as a "trainee". That the client will be disappointed not to be seeing a qualified member of the team and that I won't offer as good a service. Doubting my own ability to help, especially given my limited knowledge and experience of this specialist client group. During the session: I felt relieved that she doesn't seem bothered that I'm a trainee.
>
> Alicia: diary, 1: 5

Alicia's anxiety in this extract appeared to be more about her confidence in her ability as a therapist which she linked to her limited experience of eating disorders. She later goes onto explore whether her feelings of frustration were about her trainee status or about the client. It was noted that in Alicia's account she did have a tendency to attribute feelings after the session as being something about her and not necessarily a reflection on the client. The extract below highlights her struggle in separating whether the feelings she was experiencing were about her or her client.

> I think especially as a trainee, because I wanted things to happen quite quickly (umm) and often that wasn't going to happen, that was unrealistic. So, I suppose my frustrations about people not engaging or not doing things I wanted them to do, I found that quite difficult to separate out. Was that my own things? Or was that something that was reflecting, you know, what was going on for them? Or yeah, it was difficult to figure it out.
>
> Alicia: int, 3: 326

Whereas, May had worked as a therapist in an eating disorder service for many years. She spoke about how her length of experience enabled her to separate her feelings out from the client's much more and helped her interpret what was going on for the client.

Here she is reflecting on her experience of her client walking out of a session, which had occurred when she was less experienced.

> This time I think I felt less shocked, maybe as you become more experienced in therapy you see the patient as leaving as perhaps less of a reflection on you and more of a reflection on them and you can be more understanding about the intensity of the feeling they must have which causes them to walk out and walk out because they are angry. They must be pretty furious.
>
> May: int, 1: 13

It is interesting that the therapists, of whom this theme was relevant to, were at the extreme ends of the spectrum. One was very experienced and the other had little experience.

Being a mother

Another theme that emerged, as part of the therapists recognising aspects of themselves as influencing their emotional responses, was being a mother. This appeared to be related to the theme *Force fed - feelings associated with being maternal,* but different because here the maternal factors are based in the therapist's reality that being a mother is part of their lifeworld, as opposed to the client's phantasy. Those that were mothers recognised this aspect of themselves as impacting on some of their emotional responses to their client, which they used to help them further understand their client.

Chloe related feelings that she had towards her client to feelings that she had experienced as part of being a mother. This process helped her to make sense of the dynamics between her and her client. In particular, she related her emotional experience towards ending with her clients, because of her maternity leave, as feeling similar to when she left her baby to return to work after this leave. This appeared to be linked to feeling guilty for abandoning her clients before they were ready and she drew on her experience as a mother to understand her feelings.

> It had feelings that reminded me of going back to work after I had Evey {daughter}, and knowing I was leaving her when she was nine months well she was nearly 10 months old but having her in my mind that it would be better if I could be with her for a full year. It was a similar feeling and those are the same questions that I asked myself so it wasn't quite as powerful but I was aware, that I was in the same ball park of, umm, if only I could do a bit more then they would be all right. Which I get, you know, as I say related a feeling I knew well from being a mum, so it clearly fitted with a maternal transference.
>
> Chloe: int, 26: 536

Chloe used this information to confirm her belief that there was a strong maternal transference. At the time of the interview she was pregnant expecting her second child.

Although this was part of her experience at the time of keeping her diary she only referenced it on a couple of occasions, once in her diary, and once in the interview. It had a more subtle presence in her reflections, which appeared to have a stronger link to ending her work with clients to go on maternity leave. She acknowledged that being pregnant made her more vulnerable to experiencing maternal feelings towards her client.

> I would be vulnerable to that, and susceptible to it and the pregnancy, you know, bringing that out even more. Umm but I needed to be really careful not to be drawn into thinking that was absolute and that was the case, and that was the reality of the relationship rather than the 'as if' and the transference
>
> Chloe: int, 26: 547

Other therapists also referred to being vulnerable to these feelings because of their own maternal roles. Caroline referred to the fact that she had just returned to work after having maternity leave and that she felt this had impacted on her emotional experiences generally, as well as in her work with the client. There was a theme emerging about the impact of being a mother on one's general emotional experience, which seems an interesting idea.

> I had just come back off maternity leave. So I definitely think that having a baby changed my emotional reactions in some ways compared to what I was like before.
>
> Caroline: int 1: 3

Throughout Caroline's reflections she made reference to experiencing strong feelings about her client's children and feeling frustrated with her client that she was not taking responsibility for her children. She reflected on how this is probably more heightened now that she has become a mother. This seemed to get in the way of her connecting to the client as she seemed more caught up in her feelings towards the children.

> And I think particularly because the one client had got children. I think kind of looked, felt different about it than I did before because I thought more about the impact on the children more than I would have before I think.
>
> Caroline: int 1: 6

Similarly, Lou spoke about her tendency to have feelings about her client's children which she recognised as being something about her and not her client. It was on reflection that she identified this aspect of herself.

> I am tending to certainly with issues around the children umm responding more emotionally I think from my own perspective. I think rather than actually thinking about what has been projected from B {client}, and sort of countertransference issues. In that respect in terms of projection rather than my own concerns for the emotional welfare for the children and physical health of the children. So I

think it really highlighted for me that there is a tendency for me to be very enmeshed in that aspect of it.

Lou: int 1: 38

Lou was able to reflect on this and identify that is was interfering with her feelings towards her client.

Tiredness

May and Beth both noticed that when they felt tired in themselves prior to a session that this tended to heighten their emotions. May has noticed for herself that she can feel a more extreme emotional response if she is tired.

It is hard to put your tiredness aside and you may get some kind of blunting of how you feel and when you leave it to maybe the next day when you know that your normal energy has come back again you can reflect on your feelings in a more moderate way because sometimes when I am tired I am one extreme or the other...I can become more easily emotional if I am tired. If I am feeling more balanced then I am less emotional and I can get things more into perspective.

May: int 16: 369

A therapeutic feed

This theme captured the experience of the therapists when they felt connected to their client and as though they were both working through something together. The phrase "therapeutic feed" was used by Chloe (Diary 2, 35: 598), and described by Caroline, who referred to therapy as "nutritious" and as being "thinking food". This parallel between food and therapy has been maintained, and to describe this superordinate theme, the term "therapeutic feed" refers to the therapist feeling as though the client is taking in and engaging with therapy, as well as giving something back. In these instances there seemed to be a two-way process of digestion occurring in the room.

Aspects related to this theme were referred to positively and words such as sadness (an empathic response), warmth, positivity and relief were used. Most therapists referred to feeling relieved and less overwhelmed by negative feelings when their clients owned and expressed their own feelings for themselves. Chloe describes below how she felt relieved by the client giving back and feeding her something.

Zara {client} was then able to offer freely an admission that she was angry with me last week (the first time she has ever done so). This felt honest and real and a welcome relief from the sense that she is angry but isn't saying so. It was so much easier to have it there being talked about in the room, than to be in fear of its absence

Diary 1: 200

The therapists also described having more of a sense of a "real relationship" when the client was engaged during the therapy session. The real relationship was referred to in contrast to an overwhelming transference relationship. Chloe referred to feeling relief when she was more aware of the "as if" quality of the relationship with the client.

> My feelings were relieved slightly, I was more aware of the phantasy and the 'as if' quality to our relationship rather than feeling literally and absolutely responsible for her

> Chloe: diary 1, 4: 65

I have understood this as Chloe being more aware of a maternal transference, rather than it feeling so concrete and overwhelming. In the extract below, Chloe reported feeling less "consumed" by feelings when she feels that there is a "real relationship" and has felt more able to help her client.

> I think it is good that I don't feel 'solely responsible' for her though. As this is an aspect of the maternal transference and I can see I have moved from feeling this to now much more awareness of our real relationship. I feel so much less anxious and less guilty and calm and I have been much more able to help Zara than when I was consumed by feelings as I was (with her conversely not admitting to having any!).

> Chloe: diary 1: 539

Anna also reflected on how she felt able to help her client express feelings of anger, which felt a relief. The below passage highlighted a process in which Anna experienced anger towards her client and then proposed it back to the client, which she felt enabled the client to express her angry feelings towards her. Anna seemed to experience this as positive as though she felt enabled to do her job effectively.

> She said {client} I am "ok", "it was ok". I was sooooo frustrated by this response, how can you be ok with it? You were angry before and now here I am, I am angry with you. I posed this back to her. She was able to say again I am mad at you. She talked about the anger where it was, what she was doing with it. She hardly made eye contact today, and I felt relieved, relieved that I had finally done my job because she could sit and express all sorts of feelings towards me and still know that I was going to be there. This was a real turning point session, where I was letting go of my responsibility to hold her anger and she was owning and expressing it.

> Anna: diary 4: 161

Generally, it was apparent in the therapists' reflections that when the client verbalised anger towards the therapist, this felt more comfortable than detecting its unspoken presence. In fact the therapists reported feeling relieved and feeling pleased that their client was able to take the risk of verbalising their anger, and as though it marked progress for the client.

Anna also showed ambivalence about her client expressing her anger at her. This illustrated a struggle, whilst she showed appreciation of the benefits of the client being angry with her she also acknowledged how uncomfortable it can feel to be on the receiving end of this.

> I was so upset, I was really upset, I was like ooooh you know (hand on heart), ok ow! Umm, and I said to her 'oh that sounds sad to hear, I said that I feel sad hearing that but I can sense from your frustration that might be what you feel right now', but in a way I was also relieved, finally some emotion! (laughs) Some real emotion! Some gut, you know, getting her guts out really, and going for it. That's probably a bad term to use with anorexics but you know (laughs) you know she is letting it go and I thoughts 'yeah go for it!' Yeah I bit mixed again, a bit ambivalent.
>
> Anna: int 15: 359)

Anna's reference to "guts" here is a potential indicator of the therapist feeling as though the client is digesting emotions. She experienced the client as allowing herself to process and express her feelings, which felt encouraging for Anna.

The diary as part of the digestive process

Aspects of keeping the reflective diary have been included in the theme "digesting", as it appeared to become a significant part of the therapists' emotional experience when with their clients. In effect the therapists had been asked to "digest" and process their experience by keeping a reflective diary. This process had been imposed on them and the diary had become part of the digestive process simply because of the methodology.

However, something interesting emerged from the therapists' reflections of keeping the diary. There was variance amongst therapists on how much it did facilitate a digestive process. It appeared that, for some therapists, the process of keeping the diary was influenced by the therapist's emotional reaction towards their client. In essence it became an extension of their emotional experience. Some therapists spoke about the diary as concordant to self-supervision and said that it helped them to manage their feelings.

Chloe talked about how the diary helped her to contain feelings in sessions because she had realised what feelings were important. Her account indicated that she found the diary an aid to her making sense of her client and the therapeutic process and, being able to go back into the room with the client feeling more confident about present dynamics.

> I think it {diary} helped me umm keep her a bit more contained because I took more responsibility for getting her to keep her feelings in the room.
>
> Chloe: int 18: 373

114

Caroline and Lou both reflected on the diary as being particularly useful at certain times when working with a client. Caroline reflected that the diary was particularly useful when her client was suicidal as it aided her to make sense of her feelings in relation to her client.

> It was really useful then to do the diary {when client presented as suicidal} and to think about my emotions and to think about her helplessness and my helplessness and that kind of, the impact that has on her. It was particularly useful then I think.
>
> Caroline: int 12: 245

Lou noticed that the diary was helpful for identifying emerging themes in the work with the client. She reported it being especially helpful when the work began to feel "stodgy" and she felt that something needed to shift. She suggested that this sort of focus on one's feelings may loosen something up in the therapy.

Although Beth generally found it a struggle to keep the diary she acknowledged how much of a relief it felt to vent and rant in the diary. Beth talked about how she enjoyed swearing in it and this suggested that there may be a cathartic process of "venting" and acknowledging the aggression that is present. Anna also used similar words to this, when referring to the diary, because she spoke about ranting and releasing emotion and letting go.

Anna reflected on how she used the diary not only to understand the client but also to understand herself as a way of self-supervision. She acknowledged feeling ambivalent about this self-reflection. She experienced it as both painful to look at herself in depth as well as helpful. In agreement with Chloe, she described the diary as a container in which felt she was able to let go of her feelings and consequently her client after a session.

> I think sometimes a lot of the reflective writing was about what she taps into me and my attachment pattern, and my experience of relationships as well and how that relationship with her brings about all those other things to the surface for me to look at. Am I boundaried with my relationships and do I always go to rescue mode? …this really brought to me that actually there are some things that I still need to figure out for myself in my client work that she has really awoken in me, and the diary really helped me to do that, and I think that although that was helpful, that was also painful, because I didn't want to go there as well (laughs).
>
> Anna: int, 3:54

Chloe also found that the diary helped acknowledge personal factors that might be influencing her feelings and interactions with her client:

> I think that the diary helped me with that actually, one of the clients, she is just the splitting image of one of my mum's sisters, just to look at and I realised that

actually there was an interaction between us at times in the room where umm I found it difficult not to think of her in terms of something to do with a another family member of mine.

Chloe: int 5: 92

Moving onto the second aspect of this theme, few of the therapists had negative responses towards keeping their diary. Mostly this seemed to be about the process of staying with difficult feelings after a session. Therapists described finding it difficult to stay with what had occurred in the session but when they did they felt it was an insightful process.

Sophia explained how she found the process more difficult than it "should" have been which she interpreted as the experience being affected by a dynamic between her and the client. By talking out loud about her experience she was able to make some further sense of her response and wondered if it mirrored how her client related to the therapy. Below is Sophia's response when asked about how she found keeping the diary.

> I hated it, well I didn't hate it I found it really hard (laughs). No, it was it was actually quite unpleasant to do it. You didn't ask me to do something that difficult but I thought 'yeah that's fine I don't mind just how I felt during and after the session'. I just couldn't believe how difficult it was (laughs) because it wasn't really that difficult and the days when I did write something I thought that only took a couple of minutes. But there was something that just, it wasn't about the time it was just something quite difficult about actually writing down how it felt to be in a room with this person or even thinking about how I was feeling during the time that I was with them as well. There was something quite difficult about making myself think about and staying with how that felt I think it has made me realise maybe I, I perhaps don't really stay with how I feel and I want to get rid of those feelings when I come out of the room. So (laughs) it wasn't very nice in terms of staying with it….I suppose it gives me, it's an insight into how it feels for her actually.

Sophia: int 1: 1

Sophia acknowledged that a part of her felt self-conscious about what she had written in her diary. It was as though at the time of doing it she was able to be honest and let her guard down but after time lapsed, and when she had to discuss it with me that she became increasingly self- aware.

> I wonder whether that is partly why I haven't looked at it because I have just thought, maybe if I were to read it I might want to change it. Not that I would (yeah) but I wondered whether there is a slight, I don't know, a bit of embarrassment because I really don't know what, I am sure I have just written a load of you know, garbled stuff but that is how I felt when I came out and I suppose I can't change that because that is how it was. Maybe there is a part of me that makes me want to make it sound a bit more, I don't know, a bit more thoughtful or maybe something a bit more technical in it and I don't think there will be. There will just be like 'ooooohhhh' (laughs) angry. I think that's probably what it is (laughs) you know I think that made my reticent to look at it thinking "oh god that is really embarrassing, I don't want anyone to think that is how I felt", so you know it's hard and slight shame about what I have written in there so maybe I have to kind of hand it, hand over without looking (laughs).

Beth struggled to fill in her diary and she also interpreted this as a therapy process related issue. She described how difficult she found giving more time and energy to the client after a session and how she would just want to find something completely different to do. It seems that this is about how painful and difficult the feelings are that are evoked by the client and her reaction was to escape from these feelings.

> I guess it did become harder to write about her and I think that's because I just was feeling that umm I didn't really want to think about her anymore because it was so hard when I was with her, umm and I think I was feeling so trampled on and duffed up and beated up in our session that I didn't really want to think about her very much outside anymore

> Beth: int 6: 97

An alternative perspective on this desire to relieve oneself of these feelings was offered by Chloe. She reflected on how tempting it was to get distracted after a session and to try and move away from these uncomfortable feelings. She talked about this as recognising her own temptation to do this but actually she noticed that focusing on these feelings, and making sense of them, can actually relieve them from her more effectively.

> It is so easy here to umm just get pulled into something else and not give things that sort of in depth reflection. Which again you know if these feelings are uncomfortable which most of them are, it very tempting for a therapist to, you know, say goodbye to the client and try to say goodbye to the feelings and not to stay in touch with them. The mistake I guess I made in the past is thinking that would mean they would go quicker, but they go quicker if you write them down and discharge the feelings in some way, and then recognise it.

> Chloe: int 19: 395

Furthermore, Chloe experienced positive feelings towards her diary which appeared to be about her feelings towards her client. Her account indicated that she had developed a positive relationship with her diary and she reflected on how handing it over for analysis had a significant meaning for her as it coincided with the ending of her work with the clients. She described it as a container for her feelings and felt that it could become very charged with emotion.

> So the whole process of letting go, umm, is reflected in this {diary} so I think that says more about me letting go of the endings than this particular diary but I could see how the diary would become very, very charged and very like an object that you know, kind of does, hold a lot of meaning and umm.

> Chloe: int 24: 492

Overall, there was a mixed response towards the diary. Interestingly there appeared to be a difference in the amount that therapists were able to separate their feelings

towards their client with their feelings towards their diary. This is what seemed to hinder or facilitate the process of digesting their emotional experience.

It is possible that the therapists used the diary for different purposes. For some, who were rooted in a psychoanalytic frame of reference I got the sense that they did not have such an extreme response to writing in the diary. I wondered if they had used it as a place to integrate theory into their understanding of their client, which seemed to relieve their feelings. Whilst Sophia and Beth showed that they were using psychodynamic theory to inform their thinking, they seemed to use metaphorical language over and above this to describe their experience. Overall, in both their diary and their interview they provided a more descriptive account. They both talked about how difficult they found facing their diary as it meant they had to face the feelings, as opposed to the feelings being relieved. Therefore, it is possible that the psychodynamic interpretation in the relaying of the therapist's experience provided them with some relief from the intensity of their emotions.

Reflexivity on analytic process

I found that engaging in the analysis gave meaning to the debate between the interpretative and phenomenological aspects of IPA (Larkin et al., 2006). I realised that I was not entirely sure where my position was even though I was aligned to both aspects. This struggle was evident throughout my reflexive journal and I noticed that in the beginning of the analytic process that I was more committed to presenting a descriptive account of the therapist's experience. This was based on the assumption that the therapist had already interpreted their experience in a meaningful way, which best presented their reality. It was only when I started to share the data with someone else that I appreciated that reality could also be out of the therapist's consciousness, and that my role was to adopt a double-hermeneutic understanding of the data. I realised that I thought I had been interpretive in my initial understanding of the data but actually I needed encouragement to continue the process of interpretation to think about "why" a therapist had described their experience in a certain way. As well as to think about how much my outlook influenced the sense I made sense of the therapists' experiences.

When I started the analysis I was still not fully aware of my approach as a counselling psychologist and I think that this influenced how I responded to the data. As I developed in my training, I became more established in myself and my approach and therefore more aware of how I had influenced the analytic process.

Due to my interest in psychodynamic theory, I was primed to be drawn towards this way of thinking in the therapists' accounts. I noticed that I did not always find it easy to be critical of theoretical perspectives in the accounts and therefore struggled with thinking about the double-hermeneutics.

A majority of the therapists used psychodynamic terms and interpretation. This required me to rely on some of my pre-conceptions of theory, and therapy models in order to make sense of the data because at times it was jargon and theory laden. Frosh and Baraitser (2008) have highlighted that psychoanalytic interpretation is an example of a heavily theoretically driven mode of interpretation, which was evident in some of the therapists' accounts. This influenced my interaction with the data on two levels, I identified with particular theoretical explanations because they were similar to mine and secondly, I felt unable to interpret beyond the therapist's theoretical interpretations because they felt like a barrier to getting to the crux of their emotional experience.

I found that I was drawn to Chloe's account because she assertively and articulately described her experience from an object-relational perspective. I identified with this perspective and Oguntokun (1998) termed this "the seduction of sameness", which was quite powerful in my initial musing over her data, as well as others, who had used the same theoretical perspective. Furthermore, her conviction in the model and in her experience meant that I struggled to question it or interpret it from outside of her theoretical frame.

This coupled with her being the first therapist meant that I initially gave her account more emphasis and used our "shared" Kleinian perspective to make sense of others accounts. This tended to happen when there was not as much theory in other's data and when I felt overwhelmed by the uncertainty involved in the task of analysing the data. I recognised that I had adopted this un-critical perspective towards theoretical explanations and that I had initially read the data through this lens. I re-visited the data, acknowledging my initial interpretations and attempted to adopt a double-hermeneutic approach in which I was aware of how my sense making was affecting the data. This opened up new ways of thinking, particularly for my understanding of the therapists who did not use theory as much to make sense of their experience.

From this process I have learnt about myself and how I have a tendency to look for truths, and how I take an uncritical approach to certain perspectives. I think that, because I felt Chloe's conviction in her accounts, I initially became powerless to think outside of this. This is interesting as a psychoanalytic lens is often said to adopt a "top-down", expert-knowledge epistemological approach. The psychoanalytic approach hypothesises about the "true" nature of human subjectivity, alongside an interpretive practice that seems to know what is true and claims to know subjects better than they know themselves (e.g., Willig, 2012b ; Wetherell, 2003).

In the early days of data collection, I had attempted to manage "contamination" of my own experiences on the therapist's individual experience by keeping my own reflective diary after sessions with two clients I was seeing for anorexia, in the same way that the therapists were required to do. This gave me a forum to have my own voice instead of trying to be heard through the therapists' accounts. However, I had not realised how difficult it was to bracket off my experience and how much this would influence the process of interpretation within the analysis. This recognition enabled me to notice when I was not taking a double-hermeneutic approach. This shifted my thinking on whether it was ever possible to prevent "contamination" in IPA, because of how much I was involved in the process. Instead I have recognised the importance of disclosing what I have brought to the process. There is a debate within IPA on

whether as a researcher, it is possible to "bracket off" one's own self in the analytic process (see Giorgi & Giorgi 2008; for the differences between descriptive and interpretive phenomenology). My experience was that I could not bracket off parts of myself and make them separate as my experiences were embedded in the way that I understood the therapists' experiences. However, I could identify what parts of me were influencing the interpretations and be mindful of which lens I was looking at the data through. This is in line with Heidegger's belief that we cannot separate our self from interpreting another's lived experience.

From keeping the diary I experienced how challenging it was to do after a session with a client. This paralleled some of the therapists' experiences and it helped me to recognise how it felt to undertake the task that I had requested the therapists to do. This gave me further alignment to the therapists, and more grounds to be considered a "cultural insider".

I initially felt comforted by certain therapist's use of theory because I was being given something that was neatly packaged. As the analysis process progressed I noticed that this changed; I began to feel frustrated and shut out by the interpretations. I often wondered whether I was really getting to the nitty-gritty emotional experience. It felt sometimes that the data was protected by interpretation and that it was difficult to dig any deeper. This may be an indication of the frustration that these therapists' felt because they got so little from their clients in the sessions that all they could do was interpret.

Part way through the analysis I realised that I could take a step back and interpret beyond the intra-psychic level I began to think about what was happening to the therapist in order for them to interpret their experience in this way. This felt empowering and freeing.

Another possible reason for a high level of theoretical jargon is that at some level the therapists may have felt that they needed to prove their ability to be reflective, or interpretative because another (me), or other professionals will read their sense making. Three of the therapists referred to their awareness of what I would make of their experience and their anxiety about being inadequate. As a response to this I have aimed to be sensitive in my portrayal of their experience.

My status as a trainee also needs reflecting on as this contributed to a discomfort at interpreting the therapist's experience, especially when I felt that they were "experts". To interpret their experience felt as though I was undermining their competence. However, I was struck when at the end of the interview most therapists stated that they

would be interested in "what I made of their experience", once analysis was complete. This communicated an expectation that I would interpret their experience and not just take it at face value. I recognised my hesitation was due to my position as an outsider and as a trainee, in comparison to a qualified therapist.

There were occasions when these particular therapists off loaded a less interpreted account of their experience and there were glimmers of what felt like the nitty-gritty emotional experience. This tended to be when the accounts were very emotive, when therapists used metaphors, when there were contradictions in accounts and when the therapist swore. With the latter, it felt like the therapist had let their professional guard down and that they were perhaps responding as themselves.

Or, it could be hypothesised that the use of theory in the therapists' interpretations could have protected them from feeling exposed or vulnerable during the process of being a participant in this research. On reflection, I think at times I felt despondent towards the data because I felt disabled as a researcher. Again, I have wondered whether this indicated a potential parallel process, in which the therapists felt starved of therapy with their client and I felt starved of data in which I could interpret.

The inclusion of only one CBT therapist was an issue that required reflection, particularly at the stage of analysis when looking for patterns across cases. This may have meant that the psychodynamic perspective may have over-shadowed her unique approach. Whilst some of her idiographic experiences have been omitted, as was the case with all the therapists, I was reassured that she too had referred to psychodynamic terms such as 'countertransference'. The feelings that she reported were similar to the others but had been interpreted less with regard to understanding her reaction in relation to herself and her client. The only CBT concept that she referred to was "challenging her client's thoughts".

I found the whole analytic process overwhelming and challenging. There was something very difficult about immersing myself in these accounts. It often felt very intense, heavy and hard to work through which was due to the nature of the emotional reactions that were being disclosed. However, after time I was able to challenge my assumptions and I attempted to look at the data as an unveiling of a therapeutic process, like I would do as a therapist, and approached the data with "hermeneutics of empathy" and "hermeneutics of suspicion" (Ricoeur, 1970). Based on this I viewed the data as a conscious manifestation of deeper structures. This is consistent with my position as a therapist with a psychodynamic interest (Willig, 2012a).

Discussion

Introduction

The majority of the previous research into this area has focused on therapists' feelings when with their clients (Franko & Rolfe, 1996; Satir et al., 2009). However, this current research highlighted that it was insightful to understand therapists' feelings from a wider perspective which involved their physiological sensations, thoughts, imagery and their interpretation of these experiences as well as wider contextual issues. This qualitative exploration resulted in an unexpectedly detailed insight into the complex inner experiences of the therapists in their work with anorexic clients. It exceeded the aim at the outset of the research to capture their emotional experience. What seemed to be underlying their emotional experiences was a difficulty in experiencing and tolerating powerful, uncomfortable feelings towards their clients and within themselves. This research has established a metaphorical and theoretical language to help describe the therapists emotional reactions towards their clients. This appeared to help them to make sense of and relieve their feelings. The idiographic analysis from the group of therapists' descriptive accounts were categorised using the following metaphors; being starved, force fed and digesting their feelings.

Psychodynamic concepts were infused throughout the participants' collective experiences as part of their interpretative process: in particular a Kleinian perspective was prominent amongst the therapists' understanding of their experiences. All the therapists spoke about aspects of their emotional responses towards the client as countertransference; and some referred to transference, projection and projective identification. Waska (2009) stated that the experience of constant shifting emotional states in a session is produced by transference, countertransference, and the dynamics of projective identification. Aspects of these concepts will be portrayed in light of the themes and will be thought about cautiously and critically in relation to the therapists' experiences. The role of interpretation needs further exploration to understand more about the therapists' processes and their experiences.

Aim of Discussion

The themes will be explored in light of existing research and psychological theory. Firstly the themes will be looked at in relation to psychodynamic theory which the therapists referred to in their accounts in order to develop a psychodynamic framework for this research. Then the therapists' experiences will be explored in relation to wider theory, such as the role of interpretation, mirroring, the concept of power and

professional identity. This is to continue the process of interpretation of the therapists' emotional experiences and will shed light on some novel and interesting ways to understand these. Alternative therapy models, such as cognitive behavioural therapy and the person centred approach will be considered in relation to the findings to enable the themes from this research to be applied more generally to therapy, regardless of the psychological model.

The implications of this research with regard to therapy as an intersubjective process will be explored, alongside how the findings can inform training and educational needs of therapists who specialise in this area. Finally, limitations of the research will be outlined and suggestions for future research will be made.

Force Fed Feelings.

This theme emerged as a metaphor for the therapists' descriptions of their experiences using psychodynamic concepts such as projective identification and transference-countertransference responses. The feelings that the therapists experienced appeared to overwhelm them. It is possible that interpreting them as being part of transference-countertransference helped to reduce the emotional impact of their feelings and this will be explored further in the *role of interpretation* section.

There were three important aspects to the idea of the feeling of being "force fed", which were: feeling like a mother which was interpreted as a maternal transference, feeling interchangeably abused or abusive and feelings that were interpreted as "feeling the client's feelings". The linking of feeling "force fed" to these captured the therapists' descriptions of their emotional experience when they felt as though they were coerced into experiencing an emotional response associated with one of these roles (mother, abuser/the abused, the client in the past or present). This has been described by Rizq (2005) in relation to the concept of projective identification, who said, that through this process it is as though therapists feel "recruited" into a role. The quote below from Caper (1999, p.34) summarises the therapists' understanding of their experiences well by conceptualising it as though they were on the receiving end of powerful projections:

> When under the influence of the patient's projective identifications, the Analyst actually feels as though he has been pressed into a role in somebody else's phantasy, no matter how difficult it may be for him to describe the specifics of it. At the same time, through lack of insight, he experiences the powerful emotions connected to this role as belonging entirely to himself, and having nothing to do with the patient's psychological impact on him

As described in the quote the therapists initially experienced the feelings as belonging to them and being about themselves. They noticed how after time had lapsed and after

they had embarked on a reflective process, they were often able to disentangle the experience and recognise whether the feelings that they experienced belonged to them or to their client. Several of the therapists described the experience of their client and the associated responses as being intrusive. The idea that projective identification is a process in which the client projects something that gets "into" the therapist, as suggested by Klein (1946) is alluded to in the therapists' accounts. However, in their reflections they seem to recognise that this projective identification resonates with a part of them that the client has awakened. So whilst it is the client that is projecting, the therapist is using their knowledge about themselves to make sense of this. This idea that the therapist and client are both active in the therapist's emotional experience could be said to adopt an intersubjective position with regard to therapy (Rizq, 2005).

What has emerged from this research is that the therapists' emotional responses were much more complicated than the earlier quantitative research captured (Franko & Rolfe, 1996; Satir et al., 2009). This qualitative approach appeared to allow for a more explicit and detailed understanding of the experiences that triggered the emotional response, as well as to think beyond the content of what the therapists discussed as part of their experience. It also accentuated the complicated enmeshment of the therapist's and client's feelings that the therapist experienced and how they struggled to make sense of this.

Maternal feelings

A profound aspect of the therapists' emotional experiences could be categorised into maternal feelings. Whilst in the analysis this was separated to look at what the therapist felt that the client induced in the therapist through their unconscious (maternal transference), as well as what it was about the therapist that the client tapped into (being a mother). These will be brought together to consider the therapists' responses.

The concept of the therapist experiencing maternal feelings has been documented in the psychodynamic literature and psychiatric papers on anorexia. It has been suggested that the relationship with the therapist will mirror that of the client-mother relationship (Bruch, 1962; Hughes, 1997). Theories on anorexia, particularly family systems thinking and psychodynamic perspectives have focused much of their attention on the mother-daughter relationship. It is difficult to understand how much each therapist is interpreting based on theoretical models of anorexia when thinking about a maternal transference, but it seems plausible that they were drawing from a particular perspective on anorexia.

Previous empirical research on therapists' or practitioners' emotional responses to this client group (e.g., Franko & Rolfe, 1996; Satir et al., 2009) does not document the therapist's experience of maternal feelings. This may be because it is not an easily measurable concept. The emotions that the therapists experienced and interpreted as being an indicator of a maternal transference were guilt, an elevated sense of responsibility, anxiety and a sense of wanting to protect their client.

Zur (2009) pointed out that the idea of a therapist having a more powerful position in therapy is based on the idea that the therapist-client relationship is analogous to the parent-child relationship. Zur (2009) proposed that this perspective assumes that the client is child-like, and consequently vulnerable and helpless. This seems to relate to part of the therapists' experiences. The maternal transference could be an indicator of when the therapists felt that their client was powerless. A major factor could be the feeling that they are the main person in the client's life to ensure their physical safety and to keep them alive, as the therapists felt a huge sense of responsibility. These feelings could be related to the risk of mortality in anorexia; the fear of anorexia becoming chronic; the risk of treatment becoming refractory; and the high dropout rates (Bulik et al., 2007; Mahon, 2000; Steinhausen, 2002; Strober, 2004).

The therapists understood their experience of responsibility and overwhelming guilt, as a countertransference response. It is possible that this is a reaction to a worrying lack of anxiety in the client (Hughes, 1997). One reason, from a psychodynamic perspective, for this could be that the client is projecting unconscious material that coerces the therapist into feeling like a mother, which is akin to Rizq's (2005) conceptualisation of projective identification. Freud (1905:1997) theorised about how in the therapeutic relationship psychological experiences are evoked from the past, but now belong in the relationship towards the therapist. It is believed that this distortion is based upon the client's re-enactment of earlier relationships (Clarkson & Nuttall, 2000); in this case the client's relationship with their mother.

The therapists' interpretations seemed to lack the symbolic aspects of transference and instead felt as though they *were* the client's mother, as noted by Chloe. She spoke about the lack of "as if" quality to this transference, which has been referred to in psychodynamic and developmental literature. Skarderud (2007b) linked the lack of "as if" quality in the transference with anorexic clients to impairment in their capacity for mentalisation. Rogers (1957) specified that empathic understanding in therapy relies on being able to sense a client's world "as if" it is the therapist's own but without ever loosing the "as if" quality. It seemed that the therapists found that their emotional experiences challenged their ability to do this. It required the therapist to embark on a

highly subjective experience to understand her client and to help develop an intersubjective arena, in which the client relates to the therapist.

Those therapists who were mothers drew upon this experience to understand their feelings in relation to a maternal transference. However, Anna who was not a mother still felt maternal towards her client "'I don't have kids, I don't know what this maternal instinct is meant to feel like, but yet, I found myself feeling something quite maternal towards her and again that was the transference and the countertransference."

It is interesting to think about what the influences of working in a specialist service are on the therapists and whether this influenced their emotional responses. Gremillion (2003) found that the philosophy of a hospital was based on trying to set up a family hierachy and a major aspect of this was an attempt to provide maternal substitution. Gremillion (2003) pointed out how this subtly implies a problem at the heart of the mother-daughter relationship. The fact that the maternal transference came up in this research may be because it is a common assumption that people with anorexia have difficult relationships with their mothers and therefore the role of the therapist is to substitute this with a different mother-daughter experience to enable the individual to separate from their enmeshed relationship with their mother. This perspective has been criticised for placing the problem of anorexia as coming from within the mother (Gremillion, 2003).

Chloe's experience was unique because at the time of the research she was pregnant. She reported feeling guilty and it seemed more heightened in her experience than in other therapists. She spoke about being aware of her client's feeling of envy towards her because she was having a baby and envy towards the baby because it would be mothered by her. Person (1982) suggested that a female therapist may experience guilt for neglecting her maternal role, but Chloe has highlighted how this can be a conflicting experience, as she felt both guilt for not being there for her client and for not being there for her child.

Another aspect that may have contributed to the maternal theme was that all the therapists were female and there may have been something about their personality that was maternal. This may be related to a natural female desire to mother. Although Gremillion (2003) has suggested that presuming a natural maternal instinct is an assumption made about women's "gender role" in today's society in which they are expected to manifest a will to want children and to care for others. Therefore the maternal transference in this research could be based upon dominant cultural ideals of motherhood.

To take a sociological or feminist view on the therapists' experiences of guilt, as opposed to their intra-psychic explanations, it could be proposed that the guilt the therapist experiences is due to wider cultural and sociological influences on women and their role (MacSween, 1993). MacSween (1993) believes that it is not only the mother-daughter relationship that oppresses women and generates guilt but that there is an element in the social control over women through the way that women police themselves. She suggests that we look outside to wider social forces that constrain women in a patriarchal society, which may link into the therapists feeling embarrassed or uncomfortable about their true feelings towards their client.

Abusive transference-countertransference: Client sabotage, restriction and withholding

The therapists seemed to experience a response to the clients that felt abusive. Some of the therapists interpreted this as a countertransference response to the client's unconscious attempts to destroy therapy and to refrain from engaging with it. As a reaction to what the therapist experienced as a powerful "withholding" by the client they recorded extreme negative experiences which they described as feeling as though they were being tortured or abused. Consequently they felt angry, guilty (for not being a "good enough" therapist), and exhausted. In Hughes (1997) depiction of "witholding and the implicit refusal to take from the therapist or therapy" she described the therapist experiencing extreme feelings in response to the client witholding. Each therapist spoke about sensing the client's sabotage of them and their therapy. This generated an experience of feeling attacked, punished, and being disabled by their client, which could be representative of feeling like a victim.

The therapists appeared to apply Kleinian thinking to their experience of their feelings of aggression; it can be assumed that their understanding of this can be explained by projective identification. This view sees aggression as innate and part of intra-psychic forces (Lemma, 2003). Other psychodynamic perspectives, such as those rooted in the British Independent School of object-relations do not put as much emphasis on the primitive instinctual impulses and their phantasised effects on internal objects as the Kleinians do. They consider developmental issues that are based in the reality of the baby and the primary caregiver (Lemma, 2003). Therefore, the "independents" could be said to view aggression as a reaction to external factors that impose on the individual's development (Lemma, 2003). This perspective takes into account more environmental factors that affect development and the focus is less on intrapsychic forces and more on the mutually constructed interpersonal space between the therapist

and client. Perhaps the abuse-abusive dynamic in the interpersonal space was related to a battle for control or power between the therapist and their client.

The intersubjective approach to psychodynamic therapy sees the mother-infant relationship as very important in the individual's psychic life, and this puts emphasis on any difficulties in the separation-individuation process (Lemma, 2003). Therefore, aggressive responses are thought to make sense within the individual's experience of relationships and situations and that this influences what they expect from relationships in the here and now, i.e. the therapeutic relationship. It may be that the therapists felt this abusive dynamic because the therapeutic relationship was threatening to the client because of earlier relationships.

The therapists' experiences seemed to accentuate what the past research has found that professionals have felt exhausted, angry, hostile, frustrated and aggressive when working with clients who are being treated for their anorexia (Frankenburg, 1984; Garner, 1985; Satir et al., 2009; Williams & Leichner, 2006). In his paper on countertransference responses to anorexic clients, Erlichman (1998) noted that therapists can leave sessions feeling confused, angry and frustrated. He proposed that these feelings often reflect the patient's own difficulties, through an unconscious and conscious identification on the therapist's behalf. It is possible that the client's had identified with their own aggressor as posited by Zerbe (1992) and the therapist's experience of this was to feel like the victim.

In parallel to this the therapist also felt like the abuser. This seems to highlight a process of projective identification which Zerbe (1992) highlighted as an important aspect when working with this client group. This perspective would see that the client had split off their own unwanted aggression, unconsciously made the therapist feel as if they were the abuser. The therapists felt bad for punishing the client and experienced residual guilt. Interestingly, once they conceptualised that they were responding to an aspect of the client the guilt reduced.   From an intersubjective perspective the aggressive projective identification could have activated an aspect of the therapist's self Rizq's (2005).

In Garner's (1985) early paper on iatrogenesis there were examples of how people involved in treating anorexic clients took out their feelings on the client. The idea was that these people reacted by punishing the client because they experienced such intense anger and despair. Interestingly this research also found that as a response to such difficult feelings that were evoked in therapy with this client group, therapists also acknowledged that at times they had been subtly or unconsciously punishing the client. For example, Chloe and Beth both referred to switching off in therapy as an angry

attack. Joseph (1988) explored how the therapist can be increasingly "nudged" towards acting out the split off and projected phantasies of the patient, which seemed to be how the therapists made sense of their experience.

The experience of being disabled as a therapist, in response to something that the client manoeuvres or controls, fits with Hamburg and Herzog (1990) who spoke about how a therapist can feel paralysed when in therapy with anorexic clients because it can feel like the client holds the control. They continue to say that this paralysis may be partly because of the patient's projective identification, which is how the therapists in this research tended to understand their experience. One of the countertransference responses to this was that the therapists felt useless and ineffectual. A battle for control or power seems to be underlying the abusive and paralysing dynamics between therapist and client.

From this research it could be argued that the intense feelings of despair, anger and frustration so commonly reported with this client group (e.g., Cohler, 1977; Kaplan & Garfinkle, 1999) may be rooted in feeling abused within the therapeutic relationship due to a control and power battle. This could be the grounding for the therapist feeling abusive at times towards their client. The actions which constituted abuse are withholding, restriction and sabotage. This seems to be a severe and damaging dynamic to be present if it is not acknowledged and the therapist is not able, or supported in trying to understand this and manage it in a therapeutic way.

The relationship between maternal transference and feeling abusive/abused

It is possible that two transferences were operating at the same time in relation to the clients. It may be that this is an indicator of a split within the client and consequently a split in the therapist. Sands (2003) refers to this in her understanding of the split response to feeling both concerned about the client and to feeling neglectful, which could be explained as maternal, and abusive transferences in response to the clients attempts to dominate her needs (emotional and physical). Sands (1994) understood this as each part of the client developing its own transference to the therapist, who in turn develops their own separate countertransference responses to each part. She proposed that if therapists are able to hold both parts of the split then it will help the client bring the parts together. From this research it is suggested that the therapist will be experiencing both the client's need and want for mothering but that this will be simultaneous to the client's attack on this part of her and the part of the therapist who can provide it.

Feeling the Client's Feelings: Understood as a Process of Projective Identification

The therapists experienced frustration and fear when with their clients which they interpreted as experiencing the clients disowned feelings, as a direct mirror reflection of their unconscious internal state. This theme seems to relate to Clarkson and Nuttall's (2000) classification of concordant reactive countertransference as the therapists seemed attuned to the feelings that belonged to the client in the present and to one of their past experiences.

Frustration was felt as a response to feeling as though the therapy was stuck. Sophia spoke about a "ground hog day", Alicia spoke about "covering old ground" and Chloe spoke about the client's "story telling". They tended to understand this as the client being stuck and disconnected and therefore the therapists responded by also feeling bored and frustrated.

May reported feeling demanded upon and frightened and she interpreted this as experiencing what it felt like to be her client when she was a child. This type of response seems to have the potential to be empathic if acknowledged by the therapist. Alternatively, it could block empathy if the therapist is consumed by it. In order to be empathic the therapist has to identify these feelings, recognise the origins of them and understand them as a window into the client's earlier and present world, which Brown (2010) would argue could facilitate an authentic meeting of minds.

Starved: A Response to the Clients Restriction in Therapy

The theme feeling starved summarises a psychological and physiological response that the therapists experienced which was categorised as emulating an experience of being starved. In exploring this in relation to Lawrence's (2008) and Hughes (1997) psychodynamic understanding of anorexia, it seems that feeling starved was a response to the clients restriction in therapy, rather than their withholding.

It has been proposed that countertransference can manifest itself as a physiological response, which encapsulates the feelings, fantasies and bodily responses that affect the therapeutic process (Clarkson & Nuttall, 2000). Experiencing a sensation akin to starvation was an induced physiological sensation, as well as the feelings that one may feel if they were involuntarily starving themselves (unlike those with anorexia).

The therapists spoke about feeling tired in the session and after the session, which they related to being a countertransference response to their client. The client's refusal

to take in anything could make the therapist feel as though they are starving. This could be seen in the therapists' descriptions of feeling hungry and needing something particularly filling and stodgy, such as a custard doughnut. It is possible that this feeling of emptiness in the therapist, which they interpret as hunger, is a reflection on the client's emptiness, as understood by Caroline and which could be termed projective identification.

The therapists described feeling exhausted, drained, hopeless, helpless, and desperate. It is proposed that these are sensations that could be experienced if one was starving. These emotional responses fit with previous literature, in particular with Franko and Rolfe (1996) who found that therapists' emotional reactions to patients with anorexia had the highest rating of hopelessness and helplessness when compared to bulimia and depression. This current research suggests that therapists feel this in response to the client's refusal to take anything in from the therapist, as well as their experience of their client taking resources from them. For example, Anna spoke about her client draining her. It seems that when a client is not working with the therapist, the therapist feels that they have to work harder which is exhausting. This could be explained by the concept of concordant reactive countertransference (Clarkson & Nuttall, 2000).

A couple of the therapists spoke about feeling as though they had invested so much in the client's recovery and it felt like a waste of time and energy. Sophia spoke about needing a health warning to work with this client group. This is in-line with Meyer and Weinroth (1957) who talked about the high demand this patient group has on therapists regarding time and energy, which they explained as being linked to frustration. It may be that an aspect of working with this client group, is the feeling of pent up frustration which can result in feeling depleted. This process of the client "starving" themselves from therapy, seemed to induce a parallel feeling in the therapist, and they too felt "switched off" and starved.

A near death experience: A response to experiencing conflicting life and death forces

This is an extreme version of being starved when the therapist feels completely out of control. This was mostly reflective of Sophia's experience with her client; she created a wonderful visual metaphor for her experience of a tsunami. She seemed to describe this experience when she felt out of control of the therapy and the session.

Caroline explicitly spoke about feeling the deathliness of the client in a way that seemed to be formulating her experience based on the concept of a death drive. The

concept of a death drive could be used to describe Sophia's extreme conflicting response to her client as she spoke about needing resuscitation alongside feeling her heart pounding, which could be described as a near death experience. The deathliness was felt to relate to the experience of the clients restriction of everything good. This could be a response to the client's restriction. Hughes (1997) proposed that an anorexic client "deadens" the therapy session by her silence and her restricting, in that she will not take anything in or give anything out. This links to the theme starved, it is possible that there is a parallel process at play, in which the therapist feels "deadened" to any feeling because of the client's lack of emotion and their silence.

Digesting

The therapists experienced a digestive process on three levels, subjectively about self, subjectively about client and intersubjectively with the client. This can be broadly understood as the therapist and/or client gaining understanding by connecting to therapy process related issues.

This required the therapists to be reflexive and appraise their experience in relation to existing information on the client, their self-awareness, academic understanding of anorexia and therapy as well as their past experiences. It appeared that the therapists were reflecting on themselves in the interaction as a way of understanding their emotional response in relation to their client. They used this information to hypothesise about their own experience in relation to their client and about their client's subjective experience, as though they were using the information gathered from this as a tool in therapy. The therapists use of "self" in their work with clients has been identified by Strawbridge and Wolfe (2003) who say that this is a vital part of the therapeutic relationship. The level of reflexivity required by the therapists in embarking on this exploration highlighted the importance of self-awareness in the therapeutic encounter with this client group. It emerged from the analysis that their emotional responses were in relation to aspects of themselves as well as their client.

A therapeutic feed: Therapeutic action

This theme seemed to allude to an awakening of "intersubjectivity" within the therapeutic relationship. The therapists spoke about feeling as though they had more sense of a real relationship with regard to the therapeutic relationship and as though their clients were working through their feelings. They spoke about feeling warmly towards them in these moments. Lawrence (2008) has talked about analytic food when working with anorexic clients, suggesting that she too formulates that the client

responds to therapy in the same way they do to food. The therapists described their experience as though their clients were taking in from them.

This also related to Gelso and Hayes' (1998) breakdown of the therapeutic relationship, which consists of a working alliance, the transference-countertransference configuration and the real relationship. It seems that in the themes force fed and starved, the therapist could be said to be working in the transference-countertransference configuration. There is some reference to a collaborative relationship when the therapist felt that they were working together with the client, was working together and thought that there was development of a "real relationship". This was minimal by comparison to the transference relationship which may be a reason why this client group is particularly challenging to work with.

Summary of the Themes from a Psychodynamic Perspective

In summary the therapists depicted an experience that was full of extreme emotions and that they felt were not for the faint hearted. These experiences were categorised under the metaphorical themes, force fed, starved and digesting. Fischer (1989) description can help understand the therapist experiences from psychodynamic view. He described a "pull–push" dynamic, which can create a hostile transference–countertransference which alongside feeling paralysing (as discussed previously in the section on abusive transference-countertransference) can feel like a double bind. The therapist hears mixed communications from the client, he characterised the communication as following this pattern, "I feel so helpless, inadequate and alone—you must help me to function—but if you do I will feel hurt and enraged—your help will make me feel more helpless and overwhelmed— you must help me" (Fischer, 1989, p.45).

Taking a Wider Perspective on the Themes

A criticism of the predominant psychodynamic and at times Kleinian perspective in the themes from the analysis is that it adopts an objective perspective. This view endorses that the therapist is isolated from their own personal experiences (Lemma, 2003) to enable the therapist to remain neutral and objective. This positivist perspective is based upon a divide between mind/body, subject/object and the person/world (Eatough & Smith, 2008). Postmodern thinking on psychoanalysis introduces the idea of subjectivity and has moved towards thinking about therapy as relational, intersubjective as well as from a social-constructionist perspective. This research has enabled a wider view on the Kleinian thinking which incorporates these wider aspects into the

therapists' experiences. In the next sections the wider issues that influence the dynamics are explored.

Relating the findings to other therapeutic models

Regardless of the model that a therapist practices, this research advocates a focus of the therapists' emotional responses in regard to the development of a therapeutic relationship. In order to enable a wider perspective for the implications of this research, the essence of the themes will be explored from aspects of the person-centred approach and from CBT. Whilst this is not addressing all the possible models, it considers these two as they are distinctly different from each other and should provide some useful ideas for different approaches.

The person-centred perspective on empathy and congruence conceptualises the therapist's inner experience (Omylinska-Thurston & James, 2011). From a person-centred perspective the therapists in the research could be said to be experiencing an empathic response, which is conceptualised in this approach as being one essential component to therapeutic change (Rogers, 1957).

Being congruent relates to the therapist processing and communicating their inner experiencing of the client in a genuine and authentic way (Klein, Michels, Kolden, & Chisholm-Stockard, 2001). When the therapists felt able to do this they acknowledged a sense of relief from their own intense internal response to their client. Therefore, congruence seemed to link to the process of digesting for the therapist, it related to processing and using their internal responses in the therapeutic interaction.

In light of the present findings, it would suggest that person-centred therapists should be aware of the need to empathise with the two strong and contradictory sides of themselves in relation to their client. For example, they may experience this when the client seems demanding of something from the therapist but then not accepting what is offered, as well as the client saying that they want to get better, but it being difficult to see any evidence of this.

It may be difficult for therapists to feel that they can access any desire within their client towards self-actualisation and from this research it could be suggested that the therapist may need to hold the hope in these moments. It is important to take into account the self-actualising aspects of the client alongside the extreme destructiveness that the therapists felt in this research and interpreted as an abusive transference. It is possible that withstanding, understanding and empathising with this experience may be challenging for the therapist because it feels uncomfortable to have such strong and contradictory feelings towards a client.

There has been a movement in CBT towards recognising the value of the therapist reflecting on their own experience when with a client and on self reflection in the pursuit of being empathic (Thwaite & Bennett-Levy, 2007). There is an emerging recognition of the "person of the therapist", referring to a natural tendency in the individual to be empathic which is rooted in an emotional response, alongside the "self as therapist". The latter aspect is referring to a cognitive appraisal ingrained in the therapist's role. Thwaite and Bennett-Levy (2007) suggest that there is another level which combines the two aspects of the individual that is needed when they are attending to more complex emotions, as appears to be the case with anorexic clients.

This concept of empathy from a CBT perspective helps to understand the apparent difference between the theme digesting, in relation to the other themes, which are associated with transference-countertransference. In the theme digesting, the therapists were engaging in a deep level of reflection on themselves as a therapist and as a person in order for them to respond empathically. Whereas, it is possible that the other themes were illustrating how difficult it was to respond empathically because they were struggling to understand their response as being about themselves, or the client.

Although the interpretation of transference is not a central tool of cognitive therapy, automatic thoughts and feelings related to interactions with the therapist are within the scope of exploration and may provide valuable opportunities for investigating and challenging dysfunctional automatic thoughts (Beck, 1995; Prasko, et al., 2010). Prasko et al. (2010) has proposed that countertransference and transference must be an integral component of the complete therapy with any client in CBT, and they recognise that this is particularly essential in complex clients: "Analysis of transference aims to improve interpersonal functioning. Transference elaborations in CBT seem to be especially important for patients with long-standing problematic interpersonal relationships." (Prasko, et al., 2010, p.197)

In light of this perspective within CBT, this current research illustrated how the therapist experienced powerful negative or positive feelings being directed at them. Third wave CBT could be useful in helping the client and the therapist to accept and manage their difficult feelings. This approach is rooted in a contextualist epistemology which aims for experiential acceptance and cognitive diffusion in distressing situations (Hayes, 2004). For example, if the client is trapped, frustrated, confused, afraid, angry, or anxious, the third wave approach looks at ways the client can learn to live with this and accept the experience in the here and now. Feelings are viewed as an opportunity to work on how these powerful events in the here and can become barriers to growth. In exactly the same way, if the therapist feels strong emotions in relation to their client it is

their job to open up to these experiences, recognising the opportunity they provide to put themselves in their clients' shoes and to do the same work without avoiding it (Hayes, 2004). There are several interventions that support a client to change the function of their emotions as psychological events, including acceptance and commitment therapy (Hayes, Luoma, Bond, Masuda, & Lillis, 2006), dialectical behaviour therapy (Linehan, 1993), mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2002), and metacognitive therapy (Wells, 2000).

A mirrored experience

As discussed in the results, the therapists' emotional experiences in therapy seemed to mirror that of their clients'. This led to their experiences being summed up by eating related metaphors. This can be explored from an intrapsychic perspective as well as considering the wider socio-cultural aspects that may have been involved in the therapist potentially having a mirrored experience.

Wright (2005) described a mirrored process as something conscious that the therapist does in order to creatively mirror the patient's unspoken communications and reflect them back in a way that helps the client form an understanding about their experience. Wright (2005) considered this to help with establishing the boundaries and structure needed in order to facilitate the emergence of the client's sense of self. The therapeutic relationship has been considered as a relationship in which early ways of relating can be enacted (Wright, 2005). Therefore, it could be said that the experience of the therapists in this research was an indicator of the client's need for such a mirrored response, and a need for a relationship that allows this mirroring to occur in the way that it does for mother and child.

In essence mirroring is giving back to the client an image of their emotional state. However, the therapists spoke about feeling shut out by their clients and not allowed to be useful or to provide them with what they needed. It may be possible that the therapist felt both the need for this mirroring to occur in therapy and a barrier towards it erected by the client.

From the Kleinian perspective that permeated the therapists' accounts, the mirrored process could be interpreted as a countertransference response; as a reaction to receiving projections from the client. Interestingly, the therapists did not always seem consciously aware that they were responding to their client, and the research task, in a way that paralleled the manner in which they experienced how the client approached them and therapy.

In Kohut's (1971) work with narcissistic patients, which is now applied more broadly to a wider range of clients, Kohut established that there were two transferences that were likely to occur. These are "mirror transference" and an "idealising transference". Kohut (1971) understood the mirror transference as being related to normal development. In particular he felt it was related to the child's need for validation and empathy. He asserted that if this was lacking then the individual would struggle with a sense of togetherness and positive self-esteem, and therefore there would be a difficulty developing in the individual's sense of self.

A parallel process was another aspect of the therapist's experience which indicated a mirror process. This was apparent in the therapist's relationship with the process of reflection on their client, whether that was in the diary or in the interview. A parallel process is a well documented phenomenon which is thought to occur in clinical supervision, and when working with eating disordered clients (DeLucia-Waack, 1999). Whitman and Jacobs (1998) spoke about how the very emotions that arise in therapy can then occur in supervision. For some therapists the diary was used as a device to facilitate self-supervision. This was an active dynamic throughout the research process which might indicate transference.

Gender has been suggested by the past literature to have an impact on the emotional reactions of therapists working in this field (Burket & Schramm, 1995; Franko & Rolfe, 1996; Kaplan & Garfinkle 1997; Satir et al., 2009; Waller & Katzman 1998; Zimmer, 1995). However, it only came up with regard to maternal feelings. Other research would suggest that there are potentially other aspects of being a woman and working with female clients that may have influenced countertransference reactions. For example, issues around the therapists' relationships to food, weight and their body (DeLucia-Waack, 1999) alongside sharing similar conflicts (Frankenburg, 1984). However, such issues were not raised by the therapists in this study.

In general a feminist perspective discusses how women develop anorexia as a response to feeling helpless in a patriarchal society (e.g., MacSween, 1993; Orbach, 1986). It is possible that the therapists also experience the feelings associated with living in a world in which women feel they have to fight for equality, or feel the pressure placed on women to be a "superwoman". These feelings may have been amplified when faced with a client that has found a solution to this by starving themselves. Interestingly the therapists who volunteered themselves in this research were all female. This may have been different had the participants been male.

Interpretation as a way of managing feelings

At times it felt as though the therapists used psychodynamic interpretations to "rationalise" their negative feelings toward the client and therapy. Sometimes their interpretations were presented as though they were fact and they seemed to serve an important function for them. It may have helped them face some difficult thoughts and emotions towards their clients, and possibly prevented them from feeling overwhelmed. It felt as though the interpretations became an attempt to transform their uncomfortable feelings or thoughts as a result of therapy.

There seemed to be an underlying discomfort amongst the therapists about not feeling like a good, effective or helpful therapist which led them to interpret. There were only a couple of the therapists who admitted that they did not feel very effective or who thought about how working with eating disorders is notoriously difficult to effect change. They tended to think about this as being about the client's, or their own pathology, to which they applied psychological theory. This may indicate a discomfort within therapists who hope, and aim, to be helpful to their clients by exploring and managing their distress. In this research the therapists appeared to either feel like a terrible therapist/person or a good therapist/person.

When Sophia spoke about not remembering what she did with her client or how she felt, it seemed as though she was able to let her guard down and be honest and transparent. However, afterwards she reported feeling anxious about not being "expert enough" and reported feeling embarrassed and shameful for how she felt. This may be an indicator of how the group of therapists experienced sharing their true feelings. It is possible that it created a dissonance between how they felt they should be as an empathic, effective therapist against how negative or uncomfortable they truly felt about their client and about themselves.

Cognitive dissonance theory proposes that if an individual holds two inconsistent cognitions at any one time then they experience the pressure of an aversive state (Festinger, 1957). It is proposed that this will be dealt with by the removing or altering one of the cognitions (Festinger, 1957). This became apparent when the therapists were reflecting on their experiences within their diary. To apply this to the therapists' experiences it could be that psychological interpretation, or avoidance of completing the diary and therefore not confronting their feelings, could have been ways of dealing with such cognitive dissonance.

Power

The therapists seemed to experience feeling powerless and out of control. Within the literature on anorexia, it has been proposed that anorexia is a way of enabling one to feel in control and powerful in a situation in which they feel the opposite; helpless and disempowered (e.g. Lawrence, 1979; Williams, 2009). For the therapists there could have been different levels to how they experienced power and how this influenced their emotional responses. This can be thought about in the context of the therapeutic relationship and therapy within a specialist eating disorder service, as well as in the political and societal context.

As discussed in the analysis, it is possible that the therapists also felt helpless, disempowered and out of control when working with their clients. Interestingly the participants who explicitly used Kleinian language to make sense of this experience seemed to embrace keeping the diary and being reflective. This was not the case for Beth and Sophia, who seemed to be drawing from psychodynamic concepts but adopted metaphoric language to explain their experience. They both reported "hating" keeping the diary and often felt like they didn't want to do it. If this is thought about from a position of feeling powerless or out of control this could be a way of them further resisting being controlled both by their client and by taking part in the research.

I struggled to question participants' interpretations of their experience when rooted in a Kleinian perspective, as I found it hard to critique and contest what appeared to be given "truths" that the participants provided. This is a further example of feeling powerless which seemed to be a consistent thread throughout the research. Psychodynamic thinking may have been a way for the therapists to feel more empowered in their role. Within this model there is a tendency to look for definitive explanations of the ''true'' nature of human subjectivity. This is accompanied by an interpretive practice which can take an expert stance on assuming that the therapist knows best, or that they know their clients better than they know themselves (Frosh & Baraitser, 2008).

<u>Power in the specialist eating disorder service</u>

The therapists' emotional experiences could have been influenced by wider political issues. This was not a significant feature of the verbal aspects of the participants' accounts because the task of the research was focused on micro process issues. However, Chloe spoke about her work not feeling valued by the management. She referred to valuing process notes but not keeping them because she did not feel that they were appreciated by the organisation. She also spoke about the pressure she felt

to ensure she had done all the bureaucratic paperwork that was required for the organisation. This may have contributed to the therapists' emotional experiences and how they felt completing the diary after their sessions. In particular some of the therapists may have felt more pressure to prove their value and show that they were competent. It is possible that this influence is on a more unconscious level and something that the therapists did not realise was impacting on how they felt towards their client, or that they did not feel was relevant in the task of talking about their emotional reactions towards their client.

Psychological therapy and psychotherapy within health services, private hospitals as well as the NHS are going through major changes and are feeling under threat by other professionals being trained to offer "therapy", who do not cost the organisation as much as psychologists. There is pressure to integrate evidence-based practice into clinical work thereby demonstrating their ability to work within a therapeutically sound and empirical approach. There is a new largely political agenda that has been implemented through the document New Ways of Working (Department of Health, 2007), and through the IAPT initiative (Rizq, 2010), this may put pressure on therapists to assign to the medical model and abandon their more humanistic and phenomenological approach. This may heighten feelings of powerlessness and helplessness.

In specialist eating disorder services there are likely to be hierarchies of power that might influence the therapists' emotional experiences when with their client. Gremillion (2003) conducted an ethnographic study at a well established inpatient unit in the USA and found that although all professionals were encouraged to have a voice about a client's treatment the decision lay with the psychiatrist who was at the top of the hierachy. It is interesting to think about how being in a hierarchial system within a unit and being female may affect one's experience of power and this may influence the therapist's emotional experience at work and consequently whilst they are with their clients. This highlights the importance of thinking about contextual issues when considering one's experience of their client and how this may be embedded in a much more complex web of factors other than just the therapeutic relationship.

The therapists in this research did not offer information about the ethos or the structure of the specialist service in which they worked. If this research was repeated it would be worthwhile to have this information available as well as how the therapists feel that this may impact their emotional responses towards their client. Gremillion (2003) found that within a hierarchical service with male psychiatrics at the top and a majority of female psychologists and counsellors, the females felt they were put in a more motherly role and that they did feel protective over the clients. However, it is possible

that this may result in women feeling even more powerless in their therapeutic work because they feel impotent within the structure of the team. They may feel that their individual work with their clients is the only place that they get to assert any power and therefore this may relieve feelings or increase their negative, more aggressive, feelings towards their clients.

Power in therapy models

Within therapeutic models there are proposed power imbalances. Kanefield (1981) examined the therapist-patient power hierarchy for different theoretical models and concluded that humanistic psychotherapy, existential psychotherapy, and feminist psychotherapy promote a democratic relationship between the therapist and the patient. Kanefield (1981) concluded that psychoanalysis can promote a hierarchical relationship between the patient and therapist, because the therapist holds the answers more than the client does, and the therapist is assumed to have the knowledge. She expressed how, in psychodynamic therapy, the therapist identifies what they think are the "real" issues that need working on and this is not always shared with the client.

Bury and Strauss (2006) suggest that therapists must be sensitive to the inevitable power differential, and the inherent vulnerability of the client. They suggest that the focus on the client's issues can interfere with therapists' abilities to see how their countertransference can influence their work with the client. DeVaris (1994) focused on how the concept of countertransference can also shape power distribution within the therapeutic relationship. This impact of the power imbalance can result in the client not being in a position to make informed decisions about what is in their best interests. Devaris (1994) identified this area as having significant potential for abuse of power by therapists.

Within the therapists' accounts they referred to power by describing feeling as though they were being controlled by their client, in relation to feeling that the client was withholding or restricting. Zur (2009) established eight non-mutually exclusive types of power and thought about them from both the therapist and client perspective. The ones that seem relevant will be looked at in light of the themes found in this research, with regard to maternal transference, abused/abuser and feeling starved. These categories are expert-knowledge power, legitimate power, coercive power, professional-positional-role power, imbalance of knowledge (of the other) power, reward power, and manipulative power.

Expert-knowledge power is related to the individual's expertise and knowledge gained through education and training. In this research the therapists were all trained or in

training and therefore had more expertise on therapy and mental health than the client. It could be argued by some disciplines of therapy that the client is the expert of their experience, in which case this power may try to be balanced out by emphasising this in the therapeutic relationship. Therapists who are rooted in a humanistic approach may differ to a therapist in a psychodynamic perspective on this. However, the therapist does have the power to contribute to a diagnosis; to label what is normal, abnormal, healthy or pathological. This bestows therapy with social control and a power advantage. Alicia spoke about how uncomfortable she felt when having to bring up a child protection issue with her client as this emphasised a power imbalance in the therapeutic relationship. This relates to what Zur (2009) referred to as legitimate power which is the power that a professional license gives to a therapist; they can report to other agencies if they are worried about something to do with the client's welfare. This is a position, in which a client may feel powerless. It is interesting to think about how therapists deal with this in the relationship

Coercive power is described by Zur (2009) as the therapist's ability to influence decisions over the client's sanity and capacity. Zur (2009) argued that some clients can hold this power because they are physically stronger or because their pathology is more intimidating. Although the role of being a professional to the client contains power, for example, the therapist can assert their profession and their professional opinion, the client has the power to attend sessions, to turn up late or file a complaint towards the therapist. The therapist tends to know details about the client and their distress whereas the client will know very little about the therapist. Zur (2009) suggested that in order to balance this out clients may withhold information or ask therapists personal questions. In this current research the therapist tended to feel powerful emotions in response to the client being silent and withholding. It may be that they felt powerless in this situation.

Zur (2009) also referred to reward power that the client can have when they resist the therapist's suggestions, interpretations and help. Zur (2009) spoke about manipulative power in which a therapist is powerful in the way that they encourage their clients to behave in more normal and healthy ways. Clients can manipulate therapy for strategic reasons. In the research it was evident that the therapist felt that the client used manipulative power and this has resulted in the therapists' exhibiting strong emotional responses.

Identity as a therapist

The therapists' different professional identities seemed to influence how they responded to the research task, how they interpreted their experience and the language that they used. This has highlighted how the different professional statuses influenced the therapists' understanding of their therapeutic work. It is important to acknowledge that there are differences between the philosophies behind different therapeutic approaches. They have unique histories and consequently the emphasis on certain aspects varies in training.

McNamee (1996) thought about how identity is to some degree dependent on the language used in particular contexts and relationships. With regard to this research the therapist's identity is based within their role as a therapist with that particular client, in that moment, but this is also influenced by their history, culture, and relational experience. May's professional background was as a psychiatrist who then trained and was practising as a psychoanalyst. As a result of this journey it is possible that she was rooted in a medical model, as well as a psychoanalytic model, which both adopt an expert frame of reference.

The language that the therapists adopted communicated aspects of their professional identity. Lou spoke about the life-death drive which she seemed to own as her position when working with people with anorexia; it was as though this defined who she was as a therapist. Other therapists also seemed to define themselves by the therapeutic model that they associated with or trained within, e.g., both Chloe and May were clear that a traditional object-relation model was their approach. Anna was a counselling psychologist so had more generic training in psychological models but her approach was clearly based from within the psychodynamic model and thinking about herself in the intersubjective nature of therapy. Interestingly the clinical psychologists did not tend to assert a particular model as their identity but did refer to their "therapist hat", or "clinical psychology head", which was more vague. They also talked about their use of self, which also seemed part of their professional identity. Due to this variety of training and different epistemological positions, some therapists would have been rooted in modernist philosophy whilst others would be more influenced by post modern ideas (McNamee, 1996).

All the therapists spoke about the importance of what goes on between them and their client and acknowledged the intersubjective and relational nature of therapy. This suggests that whilst the therapists drew on psychological theory they also paid attention to, as Chloe referred to it, the "here and now relationship" or the "real"

relationship. Therefore they appeared to understand their reponses from a relational perspective as well as from a traditional psychoanalytic perspective.

As discussed previously the therapists seemed to struggle revealing their negative feelings towards their client, and some therapists separated their feelings from their professional self. It seemed to tap into some anxiety about not seeming expert enough. For Sophia there appeared to be a conflict when revealing her true feelings between how she actually felt and how she should have felt professionally (her "clinical psychology head"). This can perhaps shed light on why Sophia found it so difficult to fill out and look back over her diary because she experienced cognitive dissonance towards her client. She acknowledged her temptation to make the diary sound "more technical", but coped with this by not looking at it. Alicia took a "non-expert" stance to being part of the research. It is possible that her trainee status enabled her to approach this from a stance of "not knowing", although she still showed anxiety about how her experience was going to be interpreted by perhaps someone she viewed as an expert, i.e., the researcher.

> I feel a bit unsure about what you are going to make of it, I guess. Like I said it's difficult sometimes to be honest in your negative reactions to people. So, I suppose I kind of feel a bit like, oooh (laughs) you know, how are you going to interpret (yeah) that
>
> Int 6: 406

Others such as Chloe, May, Louise and Anna reported finding the diary more helpful to make sense of their experience. These therapists tended to interpret their experience from a psychodynamic perspective, specifically Kleinian, and appeared to apply their "expert" opinion of the dynamics at play in their diary. It is possible that just revealing one's feelings towards their client feels too intolerable, as shown by Sophia and that interpretation through a lens helped them to feel more experts in an area and to deal with the uncomfortable feelings caused by the dissonance of their experience. It is possible that, for all of the therapists, the experience of not feeling like a therapist who was helpful, useful or appreciated felt very uncomfortable, so they counterbalanced this by feeling more expert when using what they know i.e., their profession.

Chloe took the perspective that she had the potential to be the expert of her client, which is congruent with her theoretical stance as a psychodynamic therapist who is influenced by Kleinian theory. In using her diary she was able to "work out" what was going on and therefore what needed saying to the client, which can be seen in the quote below

> more assertively say to the client, this is definitely about, well, definitely about you and we need to work with it

Int 6; 137

This shows Chloe formulating the problem as being with her client. This is in line with the medical model in which the source of the distress is placed firmly in the individual (Larsson et al., 2012). This perspective has been criticised for not considering how social influences or interpersonal relationships may have been the cause. It is possible that Chloe was trying to make sense of some difficult feelings on her behalf, and trying her hardest to be useful for the client.

Implications and Application to Practice

This research has categorised themes to describe one's emotional experience when working with anorexic clients. The therapists appeared to use language, whether metaphorical or theoretical, to make their experience manageable and help them to make sense of the overwhelming nature of the feelings they had. Therefore, it highlights the potential for therapists working with this client group to use the language and concepts adopted in this research to help express and make sense of their experience. However, it is not claimed that these concepts or ideas are absolute truth, but it may help if it is used cautiously to provide descriptive explanations for the way that they are feeling.

The existing literature, discussed in the introduction, documented feelings that have, in this research, been categorised under feeling abused/abusive, such as anger and frustration. What is unique about this research is the categorisation of feelings such as responsibility and guilt which have been labelled as "maternal transference". The category force-fed highlights the potential for therapists to feel two categories of feelings which can be described by an abusive or maternal experience.

Suggestions for practice

The research highlighted how difficult it is for people to stay with and share their true feelings before interpreting them, or trying to forget them. It is suggested that people need time and space after sessions to reflect and digest their own emotions, whether this be in a reflective diary, discussion with a colleague or as an internal dialogue with oneself. It is proposed that this is a crucial part of therapy with a client group that has been found to evoke such feelings in the therapist. In light of how full of feelings the therapists could feel after a session with a client, it is suggested that clients are not seen back to back, in order to provide the therapist time to digest their experience of their client. Seeing clients closely together may result in the therapist carrying difficult feelings (or projections) from one client to a subsequent session with another client.

Such carrying around may be detrimental to both the client and the therapist as it can be experienced as burdensome.

It is important to recognise that such time management may not always be feasible in services especially in such a target driven culture within the NHS (Rizq, 2010). There may be a conflict between the amount of clients a therapist feels is manageable to see in a day and the organisational pressure. Trying to find ways to offload or digest a session before the next may be a necessary compromise.

This research emphasised the importance of the therapist paying attention to their feelings in relation to their client, and to regard them as an indicator of something important occurring in both the intersubjective field as well as within the two individuals involved (therapist and client). The therapist can use their own emotional experience with their client as a compass to guide therapy. It is proposed that acknowledgement, reflection and processing of these emotions can provide a key to open up possibilities in therapy and understanding of the dynamics in the therapeutic relationship.

In order to help one reflect and engage with their own emotional reactions towards their clients, it is proposed that therapists wrestle with the question "why do I feel this way?", and to both reflect on aspects of themselves, as well as aspects of their client. This is an aspect of self-supervision which seems to be an important part of therapy when with this client group.

Therapists can use the findings from this research to help understand and aid their interpretation of their emotional experience. For example, if experiencing sensations akin to hunger during or after a session (when not prior to a meal time), one may ask whether their client is refusing to take what the therapist is offering. If there is an elated sense of responsibility, anxiety, or over-protectiveness for the client, one may ask why this may be, is it something to do with the client, themselves, or the service that is contributing to their emotional response.

It may be that the therapist notices that they have started to switch off in a session with a client, or begun acting in ways that are outside normal practice e.g., changing session times. This may be an indicator that the therapist feels a victim, which may be related to the client or may be about an aspect in their life, or the wider context that makes them feel this way. Furthermore, it is important for a therapist to note how they present a client in supervision. Is the client often presented or does the therapist avoid presenting them? This research indicated that there may be an important parallel process at play which needs exploring. These are some of the questions that

therapists could ask themselves to try and understand their emotional responses in light of this research.

The research also suggests that the therapist considers power dynamics within their relationship with their client and in the wider context and how this may influence their emotional responses. This has been explored in relation to the therapists' experiences of power, the potential for them to experience cognitive dissonance and therefore want to act in a way that manages this, as well as how this impacted on their sense of being a therapist. The following is worth considering:

- Are you feeling blocked by the client? If so, how are you coping with this feeling of not being able to do your job?
- Are you feeling unable to do your role in another situation to the best of your ability, which could be further impacting on your feelings of ineffectiveness?

This research highlights the importance of the process of digesting one's own emotional reaction in response to the client in therapy. If the therapist encourages the client to tolerate a range of emotions and make sense from this, then it is important that the therapist models this. It is proposed that if a therapist is able to withstand and work with their own paradoxical experience of being force-fed and starved then this may increase the client's capacity to withstand their own emotional experience, and digest it for themselves, rather than projecting or denying such feelings. Erlichman (1998) talked about the importance of therapists working in this specialism taking care of themselves and not neglecting their own emotional well being. He said that neglect of this is not only detrimental to the therapist but to the clients that they are treating.

Supervision

Finally this research has illustrated the importance of therapists being giving a space where their emotions can be voiced and heard when they experience such powerful feelings in relation to their clients. This is essential for the therapist because of their need to be looked after but also because it will inevitably impact on their work with clients. Garner (1985) proposed that supervision should be offered by an experienced clinician with an enthusiasm about working with eating disorder clients.

In line with Garner (1985), I propose that staff should be encouraged to share and explore their emotional responses towards their client in areas other than supervision. This could help manage feelings within services so that they are not taken out on each other and the client. As well as to manage splitting which is so common in these client groups (Hamburg & Herzog, 1990).

Outside of the specialist services for eating disorders therapists may be required to work with clients who are seeking help for an eating disorder. In the development of the IAPT service within that National Health Service (NHS) clinical supervision has been constructed to provide case management (Rizq, 2012). With the focus on reviewing caseloads and meeting targets there is potentially little space for these practitioners to reflect on their feelings towards their clients. This is worrying considering how powerful the therapists' emotions were in this study, who work in specialist services. This is an important area that needs reflecting on in supervision when working with complex clients, neglect of this is potentially neglecting the client's complex psychological needs as well as the therapist's.

Summary

Limitations

It is important to outline the limitations of this research so that the findings can be generalised and transferred appropriately by the reader. The sample was purposive and was essentially self-selected therapists from specialist eating disorder services. The sample had a majority of psychodynamic orientated female therapists in specialist eating disorder services which enabled a homogenous sample for this research which was beneficial in gaining insight into a specific experience. The sample does fulfil IPA's aim at understanding this phenomenon in a particular context, and it could be argued to provide "theoretical transferability" whereby the reader can evaluate the findings in relation to their context or situation (Smith et al., 2009).

There are potentially two limitations to this. One is that such a homogenous group means that it is difficult to generalise these findings to all therapists working in this field and to therapists working outside of the "specialist" arena. Secondly, the level of homogeneity achieved in the sample does require reflecting on.

Choosing to recruit "specialists" was a decision made to gather data from a homogenous sample. However, this impacted on the data that was collected. Throughout a couple of the accounts there was an expert undertone alongside the therapists disclosing their difficult inner experiences. There is a possibility that carrying out the research on "non-specialist" therapists working with anorexia would have created different dynamics. It is interesting to consider whether the expert dynamic in the research would have been so pronounced

For this particular research, it was beneficial to recruit therapists broadly as it highlighted differences in the way that particular professions interpret their

experiences, and it allowed for more participants to take part. Smith et al. (2009) suggest that participants should be selected based on a perspective rather than a population. The intent in this research was not recruit a majority of psychodynamic therapists but this ended up being the case. Perhaps this was a result of the topic of the research: it is possible that the nature of the research was what attracted therapists with a tendency to formulate psychodynamically and it could be the case that people interested in this topic had strong opinions on therapy with people with anorexia.

A possible implication of this sample are that the therapists may have reported negative responses more freely because exploring countertransference is encouraged. Their responses reflected their beliefs about therapy and about how therapists should use these feelings in therapy with anorexic clients, rather than a more raw sense of their experience. In an attempt to minimise this, therapists were asked to complete a diary in order to extract particular examples rooted in their clinical experience. A drawback from the psychodynamic perspective in this research is that it was difficult to approach the data and findings from any other approach.

Suggestions for future research

To understand more fully the overall phenomenon of therapists' emotional responses to anorexic clients, this research could be repeated on different gendered dyads, such as female therapist-male client, male therapist-female client, and male therapist- male client. DeVaris (1994) pointed out in the dyad of therapist-patient; the gender of each pair may play an important role in the therapeutic relationship. She argued that there is a socially prescribed power differential when a therapist and a patient are of different genders. She proposed that the male in the dyad has more social power than the female. She wondered whether this power differential may be balanced when the therapist and the patient are of the same gender.

I propose that future research is conducted in a similar way using qualitative methods, to contribute to this understanding. Future research may develop into these areas in order to gradually build a picture on this phenomenon from a broader perspective. This would enable a movement from this particular understanding to a more universal understanding (Eatough & Smith, 2008).

It would be interesting to consider what themes would have emerged within other therapeutic models and other settings that treat anorexic clients and to contemplate whether these metaphors would have emerged if the participant group was re-defined as working with bulimic clients, EDNOS, or binge eating clients. Moreover, it would be

interesting to see if such food related metaphors would have occurred when working with people with a different mental health diagnoses such as anxiety or depression.

It is possible that the use of food related metaphors may be found in therapy with other client groups who struggle to "take in" from others. Their difficulties may have manifested in a different presentation. It could be argued that "therapy" generally is a process of giving and receiving between client and therapist, regardless of client group. With regard to intimacy, Orbach (2004) reflected that some women can have "difficulties with receiving, with taking in and digesting the love and attention of others" (p.400). She highlighted that men can also have difficulties with being emotionally available. This opens up the possibility that these findings are not necessarily because the therapist was engaged in therapy with an anorexic client, but perhaps an indicator of issues regarding relationships. It is also possible that the use of such metaphors is unique to the participant group in this research.

The implications of how and why the therapist chose the particular client as part of the research need to be reflected on. It could be considered that there was some selection bias in that there was not put a restraint around which client on their caseload they chose. This was done to enable them to use this experience in the most helpful way for them and it would have been prescriptive to do so. However, this means that they may have chosen their most complex, or most straight forward cases.

It is important to consider that there may be something about the people that are attracted to eating disorders that make them more able to tolerate working with this client group, which may be especially pertinent in a specialist service. For example, a therapist working in a community mental health team with someone being treated for anorexia may have a different experience of having to withstand such powerful emotional responses. Burket and Schramm (1995) found that in a sample of 90 therapists, 31% indicated that they did not want to treat patients with an eating disorder, which is quite a striking figure. In particular, it would be interesting to see whether a maternal response would be so pertinent in females that did not specialise in this area.

To compare it to other specialities in mental health it is not often that people are drawn to working with depression or anxiety. However, you do hear of therapists wanting to specialise in eating disorders: I regretted not asking the therapists what attracted them to specialise in this area. In response to this I decided to ask my colleagues, who were therapists working in an eating disorder unit, what attracted them to this area. I received two responses via email which have been included in the appendix (*see* Appendix BB: Accounts from therapists on reasons for choosing this job). Both of

them alluded to there being obvious practical reasons and other aspects about their personality. One therapist spoke about her first experience of this client group and she described being "INSTANTLY sure" that she wanted to work with them. She understood this as being because there were aspects that she could relate to and others that were totally alien. She also recalled her own history of body shame and incessant calorie counting.

The other therapist spoke about her unconscious leading her to an area that was more closely related to her own previous development than she had been fully acknowledging. She disclosed that this area is particularly challenging because it relates to her personally but that through a supportive system she has continued to work in this area. Both of their conscious decisions were based on practical reasons as well as a chance to practise their preferred model. It is possible that for some, aspects about the nature of working with this client group is both personally appealing and challenging.

There is an emergence of qualitative research in patients' experiences of their anorexia and their recovery (e.g., Lamoureux & Bottorff, 2005). Further qualitative research into the therapeutic process is needed, not just in the world of eating disorders. Whilst psychotherapy research in the UK has been influence by Government funded evidence based initiatives, the USA has focused on relational aspects of therapy (Ross, 2010). This has been noted by several authors and perhaps indicates that research in the UK may move towards understanding more about the process of therapy to enhance its effectiveness (e.g., Orbach, 2004). As Rizq (2010) stated that there seems to be a reappearance of interest in reflective practice for all health professionals, who are feeling scrutinised by the demands of the targets set by the Government.

Whilst this research offers a novel perspective to therapists' emotional responses it does so in a particular context and within specific remits. Further research into this area from a broader prospective could provide a more rounded understanding of the therapist's emotional experience. This would inevitably inform training in this area as well as in practice, about the complication in therapy with this group, as well as to emphasise the importance of the therapist's self-awareness in relation to their client

Reflexivity

In this section I would like to further consider how I have been involved in shaping the findings of the research, which Willig (2001) acknowledged as imperative in qualitative research. I will also reflect on what I have learnt from the research process.

What attracted me?

I have reflected on the possibilities of why people are drawn to working in this area as therapists. I cannot exclude myself from this, as I am also attracted to working in this area, and researching the therapist's perspective in this area. My curiosity in this area has shaped the research.

I have recognised aspects of myself and my interpersonal and developmental struggles which resonate with those difficulties that have been documented in people with anorexia. I would propose that I am attracted to this area because of this but I feel that I am able to get the distance that I need. For example, whilst some of my struggles may be similar to the client group I do not restrict my intake of food as a way of coping with this. It is possible that it is this that enables me to be more interested and resilient to working with this client group.

Personal learning - Role of therapist and qualitative researcher

During this process the gap between researcher and therapist narrowed as I gained more insight into qualitative research and confidence in my identity as a counselling psychologist. It became apparent and useful to reflect on the similarities between these two roles. In particular both roles rely on the following as Drisko (2004) and Waldrop (2004) highlighted, self awareness, insight, empathy and identification as being necessary qualities in qualitative researchers

Both the role of a qualitative researcher and a therapist, require self-reflection, self development and ongoing reflexivity. The process has required thinking about me, and what I brought to the research continuously, in order to be transparent on my understanding, perceptions and interpretations. I was not always explicitly aware what these were, and I think at times because it was not always a conscious awareness, I struggled to document my rationale for decisions.

I had not realised the extent at which this level of self-reflection was required, but by investing into this aspect of this research I feel that I have also been on a journey of self-discovery, alongside my therapists. There has been a parallel in my discovery of myself as a researcher and as a therapist, alongside their discovery of themselves as a therapist. This process has also shaped and refined my beliefs about being a counselling psychologist.

The process forced me to confront my outlook on therapy, treatment and how anorexia is construed. This required me to break down my views and reflect on how they had developed, and why. Through this process I realised that I struggle to question those

views or thoughts of people in authority, or who I deem more powerful than myself. It revealed my own struggle with power and how I can often feel powerless. I am pleased that I had this revelation because it has opened up my eyes to a much wider world and given me the agency to find my own position in this world and to question why things are the way they are instead of just being accepting. I believe that I have the research process to thank for this as it pushed me to really think about "the double hermeneutics" which gave me new insights into myself and how I want to approach understanding other's worlds. Most importantly I think it has highlighted how I could feel more comfortable taking an "expert" view which was an unexpected realisation. I have reflected on my relationship to power and I feel as though I have been empowered in my personal and professional life.

The process revealed how much I still struggle to stay with uncomfortable feelings, whether it is reading a therapist's emotive diary, sitting with a client or writing a reflective diary after a session. It is much easier to move away from those feelings to make a session feel more comfortable or to avoid writing in a diary. For me, this may be a phenomenon that exists for all uncomfortable feelings, or it could be reflective of the types of emotions that working with anorexic clients stir up. This is something that I am going to continue to reflect on as a developing therapist, qualitative researcher and on a personal level.

I have learnt that that in therapy dealing with the feeling in the room as it arises is important regardless of what therapeutic approach I align myself to. Relying on theory can be a comfort blanket for me, and a way of trying to gain some power when I am feeling helpless. It can act as a way of getting distance when the dynamics feel uncomfortable or overwhelming.

Finally, I believe that research regarding therapy and any attempt to improve the quality of therapy needs more qualitative research. In my opinion, this approach offers depth and insight into a complex and phenomenological process. I have learnt so much from this process. It has inspired ways of thinking, developed my skills, taught me new tools and overall improved my own "internal supervisor". I hope that the therapists also felt that they have benefitted from taking part in the research.

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Appendices

Appendix A: **Demographic Information**

Participant	Gender	Theoretical Orientation	Years working	Professional status	Maternal status
Chloe	F	Psychodynamic	6	Nurse Therapist BACP accredited	Pregnant and mother
Alicia	F	Integrative	0 (placement)	3rd year Clin Psych trainee	Mother
Caroline	F	CBT	6	CBT Therapist working towards BABCP accreditation	Mother
Anna	F	Integrative/ psychodynamic	3	Chartered Counselling Psychologist	Not mother
Lou	F	Psychodynamic mostly.	10	Psychotherapist BACP accredited	Mother
Sophia	F	Psychodynamic/ Integrative	3	Charted Clinical Psychologist	Unknown
Beth	F	Psychodynamic/Inte grative	5	Chartered Clinical Psychologist	Unknown
May	F	Psychoanalytic	20	Psychiatrist/psychoanal ytic therapist	Unknown

All names have been changed to preserve anonymity

	Age (if known)	Amount of time seen in therapy	Treatment history	Additional Information
Chloe-1	29	38 sessions	Long history of treatment	Inpatient
Chloe-2	45	35 sessions	First episode of treatment in this service	Inpatient
Caroline-1	45		2nd admission	20 years of anorexia Daypatient
Caroline-2 dropped out after three diary entries	19	Initial sessions	(unknown)	Outpatient
Alicia-2	77	Initial sessions	First episode of treatment	Late onset Outpatient
Alicia-2	40	Initial sessions	First episode of treatment	Outpatient
Lou	31	43 sessions	Been seen in service since 2008	History of OCD Outpatient
Sophia	40	3 years of therapy	Long history of treatment in the service	Inpatient
Beth	32	4 years	Long history of treatment	History of sexual abuse Outpatient
May-1	20	6 months	First contact with this service but a history of treatment.	Inpatient
May-2	In her 40's	1 year	Long history but first episode of treatment in service	Inpatient/outpatient

Appendix B: **Pre-Study Questionnaire**

Thank you for volunteering to be a part of this study. In order to begin the research process I need to gather a few more details about you and your role as a therapist.

Please complete the following questions.

Name:

Sex: M   F

Age:

Occupation:

Registered professional body:

Qualification:

1. How many years experience do you have working with anorexia?

2. How many anorexic clients do you have on your caseload at present?

3. What is your theoretical orientation?

4. Have you got a history of an eating disorder?

5. What setting do you work in?

6. Do you work in isolation or as part of a multidisciplinary team?

7. What is your role in the management of the anorexic clients on your caseload? E.g. Are any other professionals involved, if so, what is their role? Are you responsible for dietary and weight management of your clients?

8. Have you undergone any specialist training in the treatment of eating disorders?

9. Is there any other information that you think is relevant to your participation in this study?

Appendix C: **Research recruitment email**

Dear ....,

I am contacting you because I noticed on the BACP website that you have experience of working with people suffering from anorexia. I am currently conducting a piece of doctoral research on therapist's emotional experiences when working with this client group of therapists who work in specialist eating disorder services.   I am capturing this through a reflective diary as well as a short interview. I would be interested to know if you are currently working with someone who meets the criteria for anorexia and if you would consider being part of my research.

I am a 3rd year counselling psychologist in training. I have worked with this client group for several years now and personally have become interested in how strong my emotional reactions to this client group have been when at times it appears the client is so detached from their emotions.

If you are experiencing this at the moment and would like to share this, I would be more than grateful and fascinated to hear about your experiences.

Thank you,

Vanessa Holbrook
Counselling Psychologist in Training

Department of Psychology
City University
London EC1V 0HB

E-mail-   Vanessa.Holbrook.1@city.ac.uk   or counsellingpsychologyresearch@googlemail.com

Appendix D: **Research Advertisement.**

RESEARCH INTO THERAPIST'S EXPERIENCE OF ANOREXIA

I am looking for participants to take part in my qualitative study, researching therapist's experience of emotional reactions to anorexic clients, during and after therapy.

I am a Counselling Psychologist in Training on the doctoral training programme at City University, London. For my doctoral thesis I am conducting a study entitled "Therapists' experience of emotional reactions to anorexic clients in individual therapy". I am currently looking for accredited therapists willing to explore their emotional reactions.

This study has ethical approval from City University and is being supervised by Dr. Maggie Mills, Consultant Clinical Psychologist (retired) and member of the British Psychoanalytical Society who is contactable at the Department of Psychology, City University by calling: 020 7040 8500.

I have worked with this client group for four years and have an interest in developing knowledge on the role of emotions in therapy with people suffering from anorexia. With the hope to support therapists working in this field!

As a participant, you would be required to document your reflections on your emotional reactions during and after therapy in a personal diary. You will be required to do this for at least one client over at least six sessions. Then you will be interviewed on your experience of keeping a diary, this is an opportunity to voice your opinion and to share your experiences.

The results will provide important insight into process issues and the role of emotions in therapy with anorexic clients. The results of the research study will be written up as a doctoral thesis. I will protect the anonymity of all the people who take part in my study; this will ensure that they cannot be recognised by people who read the study. confidentiality and anonymity of any client work you may discuss will be maintained as rigorously as possible.

Please contact me via email if you would be interested in participating, or want more details. If you want to speak to me on the telephone, please e-mail me your telephone number and a convenient time to call and I will contact you.

Vanessa Holbrook

Counselling Psychologist in Training

Department of Psychology

City University

London EC1V 0HB

E-mail: counsellingpsychologyresearch@gmail.com.

Dear sir/madam,

I am a third year counselling psychology trainee at City University. I was wondering if you would be able to send around details about my research to fellow trainees at Wolverhampton to see if they would be interested in taking part in my study. I am offering a 10 pound book voucher to participants. The details are below.

Thank you,

Vanessa Holbrook

Counselling Psychologist in Training
Department of Psychology
City University
London EC1V 0HB

Anorexia Nervosa Research

Are you interested in taking part in a study which explores therapists' experience of emotional reactions towards anorexic clients in individual therapy?

 My name is Vanessa Holbrook and I am a Counselling Psychologist in training at City University. I am looking for therapists who work with adult clients who have been diagnosed with anorexia and who are willing to explore their emotional reactions towards their clients. My research will involve you keeping a diary of your emotional reactions, towards at least one client, during and after a therapy session, for at least 6 sessions. As well as a face-to-face interview at a location convenient to you. I would be grateful for your participation. This process aims to be complete by December 2010.

I am offering a 10 pound book voucher to those who take part.

If you would like to take part in this research, or would like further information, please contact me at counsellingpsychologyresearch@gmail.com. This study has ethical approval and is being supervised by Dr. Maggie Mills.

Appendix F: **Information Sheet**

Who is the researcher?

I am a counseling psychologist in training, currently on placement at a Priory hospital but have a part time job in a specialist eating disorder service where I have worked for several years. I am conducting this research as part of my doctoral thesis in counselling psychology at City University, London, under the supervision of Dr Maggie Mills.

What is the aim of the study?

The aim of the study is to explore explicitly the emotional reactions therapists have to clients being treated for anorexia and to examining the experience of keeping a diary. This is to expand research into the role of emotions in treating this client group, and to offer interesting and important information for therapists working in this area.

Who can take part in the study?

Therapists accredited, or who are working towards accreditation, by a recognized professional body and working with at least one patient in treatment for their anorexia nervosa.

What would taking part in the study involve?

You will be required to keep a diary of your emotional reactions, to your anorexic clients during and after a therapy session, for at least 6 sessions.

You will be required to fill the diary out immediately after your session. You will also be required to have a short interview about your experiences in filling out your diary. This process aims to be complete by May 2010.

What are the potential benefits and risks of taking part?

The diary will provide you with the opportunity to explore your own emotional reactions to your clients, and to think about the source of these reactions. Engaging in this may offer you a containing experience and will provide you with an opportunity to share your experiences of working with this client group with other professionals. When the research is complete you can reflect on the experiences captured from all the participants, this will give you the opportunity to develop a greater understanding of your experience, and therapy with this client group. The interview will offer you an opportunity to voice your experience of keeping a diary to think about these issues and it may provide you with a helpful tool.

You may find that the process of documenting and reflecting on emotional reactions may be difficult at times. You may experience reporting negative feelings as difficult, or the process may intensify your feelings. Reporting all feelings, even the negative ones is really important for this research. If you do experience any difficulties from this process, I encourage you to speak to your clinical supervisor.

Confidentiality and your rights

The study has ethical approval from City University.

- confidentiality and anonymity of yourself and/or any client work you may discuss will be maintained as rigorously as possible
- the data will be stored securely in a locked filing cabinet and electronically on password protected files
- you may stop keeping your diary at any point.
- you may turn off the tape recorder at any time during the interview
- you may decline to answer at any point in the interview
- you will be given the opportunity to amend your transcript
- you have the right to withdraw from the interview at any time

- you have the right to destroy the diary and audio-tape after completion of the research
- you have the right to withdraw from the study before analysis commences in May 2010

Research Declarations

- the data is intended for use in the researcher's doctoral thesis and may be offered for publication in academic journals
- supervision cannot be offered by the researcher.

Contact me via email if you have any further questions or want more details. If you want to *speak to me on the telephone, please e-mail me your telephone number and a convenient* time to call and I will contact you.

Vanessa Holbrook

Counselling Psychologist in Training

Department of Psychology

City University

London EC1V 0HB

E-mail: counsellingpsychologyresearch@gmail.com.

Appendix G: **Advertisement in the Division of Counselling Psychology**

Anorexia Nervosa Research

Are you interested in taking part in a study which explores therapists' experience of emotional reactions towards anorexic clients in individual therapy?

My name is Vanessa Holbrook and I am a Counselling Psychologist in training at City University. I am looking for therapists who work with adult clients who have been diagnosed with anorexia and who are willing to explore their emotional reactions towards their clients in a reflective exercise and interview. This process aims to be complete by January 2010.

Please contact me at counsellingpsychologyresearch@gmail.com for details. This study has ethical approval and is being supervised by Dr. Maggie Mills.

Appendix H: **Reflective Sheets**

Reflective Sheet 1

Session No:

Client:

- <u>What were your emotional reactions during the session?</u>

- <u>What are your emotional reactions after the session?</u>

- <u>How do you make sense of that?</u>

- <u>What impact did that have on the session?</u>

- <u>What will you do with this information?</u>

- <u>Any further reflections?</u>

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.
- The published ethical guidelines of the British Psychological Society (2004) <u>Guidelines for minimum standards of ethical approval in psychological research</u> (BPS: Leicester) should be referred to when planning your research.
- **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 that 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

Therapists' experience of emotional reactions to anorexic clients in individual therapy.

2. Name of student researcher (please include contact address and telephone number)

Vanessa Holbrook

3. Name of research supervisor

Maggie Mills

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

5. Does the research involve the use of human subjects/participants? Yes
If yes,

a. Approximately how many are planned to be involved? 5-8

b. How will you recruit them?

Participants will be recruited through email contact, their e-mail addresses will be found on Counselling and Psychology professional body websites. The email will contain a participant recruitment letter. An advertisement will be posted on beat website

c. What are your recruitment criteria?

Participants will be required to be an accredited therapist, that is currently working with at least one client that is being treated for anorexia nervosa. (see Appendix 2)

(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).*

The participant will be required to fill out a diary after at least 6 sessions with a client; they will be required to complete at least a paragraph for each entry. They will be required to take part in a 20 minute semi-structured interview to discuss their experience of keeping the diary.

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 (see Appendix 3)
(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 (see Appendix 4)

(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)?

Pre-study questionnaires, contact details, diaries, computer records, tape recordings and transcripts.
----

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

The diaries and other hard copies of information will be stored in a locked cabinet. Electronic copies of data will be password locked.

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

Participants will be given the opportunity to decide that happens to their diaries and other records at the end of the study. If they do not want them back they will be destroyed.

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

Identifying information, such as names and locations will not be included in the research. Pseudonyms for names will be used and participants will be required to use pseudonyms for referring to their client's in their diaries.

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

A de-brief meeting will be set up once the data has been collected, this will be an opportunity for the participant to ask questions about the study and to feedback on their experience. They will be given a sheet which thanks them for participation in the study, and provides contact details of the researcher and research supervisor. The debrief sheet will remind them of their rights as participants. Throughout the research participants will be encouraged to seek clinical supervision, and/or personal therapy should any issues have arisen for them regarding them personally or clinically, this will be re-iterated in the debrief handout.

(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:

Signature of student researcher ___V. Hotwork___ Date 28/01/2009

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 ___Carle L. Reg___ Date ___12.02.10___

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 ___Maggie Mille.___ Date ___18:3.'10___

Appendix J: **Consent Form**

Participant Consent Form

(Attached to Information Sheet)

I have read the Information Sheet given to me by the researcher, Vanessa Holbrook, a Trainee Counseling Psychologist at City University, London.

I have had all the necessary information required for my participation in this study, and I understand my right to ask questions throughout the study.

I understand that my interview will be audio-taped and that I have the right to switch off the tape recorder during the interview. I understand my right to decline to answer a question in the interview

I am aware that my participation is voluntary and that I have the right to withdraw from the study before December 2010

I understand that the demographic details in the diary and the interview are confidential and pseudonyms will be used in the data

I understand that parts of the diary and the interview transcript will be used in the researcher's thesis or in articles based on the thesis

I understand that the audio, the transcript, the informed consent form and this debrief will all be stored separately in accordance with the Data Protection Act (1998), during the time of analysis.

I understand that once the study is completed and the results have been ratified, I will have the choice if this data will be destroyed or if I keep it.

Participants are reminded only to share information that they feel comfortable with and are asked to not reveal details that could lead to identification of third parties.

Please circle below

I agree to participate in this study out of choice   YES   NO

I agree to return my completed diary to the researcher   YES   NO

I agree to have my interview audio recorded   YES   NO

Participants Signature: _____Today's Date: _____

Researchers Signature: _____Today's Date: _____

Appendix K: **Consent for the Release of Diary and Transcript Data**

- I confirm that I have been given the opportunity to read and amend the transcript of the audio-tape interview.

- I am satisfied that all identifiers have been edited out and/or pseudonyms have been used in the diary information extracted and in the transcripts.

- I agree that the edited diaries and transcripts can be used in the current research and any publications arising from the research.

Please circle the following:

At the conclusion of the research I would like my diary
returned   destroyed
At the conclusion of the research I would like my tape
returned   destroyed

Participant's name
(printed**)**_____

Participant's signature_____

Date_____

Appendix L: **Debrief**

Therapists' experience of emotional reactions to anorexic clients in individual therapy.

Thank you very much for taking part in this research, and for your time and effort. Your participation is greatly valued.

As stated in your informed consent form the purpose of this study is to explore your experience of emotional reactions towards clients being treated for anorexia, and how you make sense of this. Your participation will contribute to a greater understanding of therapy with this client group.

Your anonymity will be ensured. The audio, the transcript, the informed consent form and this debrief will all be stored separately in accordance with the data protection act 1998, during the time of analysis. Once the study is completed and the results have been ratified, you will have the choice if this data will be destroyed or if you want to keep it.

If your participation has raised any discomfort or if you feel concerned about some of the information you have disclosed with the researcher I have included a contact, below, for your convenience. You may want to discuss some aspects of the interview with your personal therapist or your supervisor. You are welcome to discuss with the researcher about other sources of support, should you require them.

Please be aware that you have the right to withdraw from the study before analysis commences in January 2010.   If you would like to see a copy of the final theses it will be located in City University library from September 2011.

I agree that this study was conducted in a professional and ethical manner.

Participants Name................................. Participants Signature...........................

Researchers Name............................. Researchers Signature...........................

Researcher: **Vanessa Holbrook**

Email: counsellingpsychologyresearch@gmail.com.

Research Supervisor: **Maggie Mills**

Department of Psychology, City University by calling: 020 7040 8500.

BPS Find a therapist:

Website:http://www.bps.org.uk/bps/e-services/find-a-psychologist/psychoindex$.cfm

Appendix M: **List of contacts**

List of Contacts

Researcher: Vanessa Holbrook

Email: counsellingpsychologyresearch@gmail.com.

Research Supervisor: Maggie Mills

Department of Psychology, City University by calling: 020 7040 8500.

City University Contact Number: +44 (0)20 7040 8500

BPS Find a therapist:

Website:http://www.bps.org.uk/bps/e-services/find-a-psychologist/psychoindex$.cfm

BPS Find a Supervisor

Website:http://www.bps.org.uk

Appendix N: **Extract from participant's diary transcript**

6/4/10

<u>Feelings in the session</u>

'I must keep P's feelings towards me in this room'- conscious though going into the session! Aware of my own temptation to settle into a comfortable session would be letting her down. P's story making me feel sympathetic towards her. Increases my temptation not to be too challenging. My conscious effore to stay with the transference only felt very uncomfortable but was rewarded with P talking about new information from her past- triggered a memory of her anger being out of control at age 10.

<u>Feelings after the session</u>

Relief! A good reminder that she is more afraid of her anger than she needs to be and that I am not helping her if I collude with her wish to avoid angry feelings within our relationship. Feeling a sense of having survived something intense, actually I'm exhausted now! I don't feel I fully understand what happened in the room but confident that C got something she needed out of it which is leaving me feeling quite calm about her when on recent sessions I have felt much more full up of feelings after the session.

<u>Note after ward round</u>

Ward round was straight after the session today and I spoke out quite confidently about our need to continue containing P's anger.

Example of Initial Notes and Coding from Chloe's diary

Line Number	Emergent Themes	Exploratory Comments		
		Descriptive	Linguistic	Conceptual
		Contrast to last week when anger had been unspoken.		
250-252				To stay with clients feelings towards therapist (abandonment).
252-255			Has felt less confident because of uncertainty about what is her/client.	Comfortable would be not focusing on difficult feelings in the therapeutic relationship.
255-258	Feeling sympathy increases temptation not to challenge client.	Sympathetic feelings increases temptation to not be too challenging.		
259-260		Conscious effort to stay with transference felt uncomfortable.		
262-265		T felt rewarded by staying with transference- triggered a memory		Therapeutic benefit by staying with discomfort.
266	Relief at not colluding with avoidance	Relief. Reminded that she does need to help client confront her anger in the therapeutic relationship.		Relief that her therapeutic aims were met.
272-273	Facing feelings feels like surviving something intense.	Feeling a sense if surviving something intense.		

Line Number	Emergent Themes	Exploratory Comments		
		Descriptive	Linguistic	Conceptual
	Confronting feelings and surviving			
273-274	Exhaustion and confronting feelings	After the session: Exhausted now!		
274-275	No words for the experience (primitive)	Not fully understood what happened in the room		Uncertainty
276-279	Calm when client accepts therapeutic feed (maternal?)	Calm because confident that C got something from session	'Confidence'- second time used that word to talk about clients.	
281-282	'full up' of feelings after session when client does not accept therapeutic feed	Full up of feelings after session	'full up- food?	
282-285	T need for client to get something from session. (nutritious feed)	Was able to speak confidently in meeting about client's needs	Confidence	
285-287		Containing anger through sticking to boundaries		
287-290	Concern about being destructive.	Worries about being 'too harsh' and not therapeutic Feelings after being confident in meeting.		

Pt-So umm

RR-I think it is really important what you said about keeping
the diary in your work role it does reveal stuff about, about
yourself and how did you feel about revealing your own
stuff in the diary? In your personal, I suppose you didn't go
into too much depth about it but you were kind of teetering
on it?

111 Yeah, teetering, yeah basically and umm I suppose it made
112 me umm, it made me much more aware of where I might
113 have been noticing things before but

Hmm

INADEQUATE THERAPIST
GOING OFF

114 But not really thinking them through so my first thought
115 when personal things came up in the diary was ooh you
116 know kind of inadequate therapist alarm going off, i should
117 have thought about this before. This is kind of umm

You felt caught out almost,

118 Yeah I felt like I hadn't been doing enough thinking about
119 the client and it it made me realise how much more thinking
120 you can do, umm, and need to do at times. So yeah, I
121 suppose at that level I was a bit threatened by that you
122 know, opening up so many different potential avenues
123 within the therapy and umm, but, but basically being

RELIEF AT
NOTICING DYNAMICS

124 relieved that I had noticed it so that I could then take it into
125 account, and feeling very helped by it and umm, aware that
126 that would be a healthy that would could improve things in
127 my relationship with the client because I would either be

NOT ⊥ REACT
TO FEELINGS

128 able to realise that it was me and not them. and not take it,
129 not bring it back to them or to be much more clear where it
130 was about me and something that needed to stay in the
131 room.

FEEL MORE
CLEAR ABOUT FEELINGS.

Ok

USE IT
POSITIVELY

132 Umm, so yeah initially perhaps a bit kind of, feeling a bit
133 exposed by it and then sort of settled, settled on well I just
134 need to use that positively

Right-hand margin handwritten notes:

By noticing own personal experience "inadequate therapist alarm going on"

Difficult to acknowledge because not good enough. feeling inadequate

GUILT not thinking enough about client.

threatened about too showing her working outs. Inadequate therapist as it opened up avenues in therapy.

Relieved that noticed a dynamic diary was helpful.

Initial response to feel exposed but then recognition that it is healthy to acknowledge all feelings +

Acknowledgement could improve relationship with client. Acknowledgement of feelings belonging to C [enacted?] meant that feelings were not taken back + felt more clear where feeling

exposed
settled
use it positively :) } Process

Bottom handwritten note:

← me asking them to complete a diary and then interviewing them on it. [semantic] [interviewing]

Appendix Q: **Example coding from Chloe's Interview**

Line	Emergent Theme	Descriptive	Linguistic	Conceptual
126-127	Helped by noticing dynamic	Healthy Could improve things in relationship with client.		Noticing own personal feelings and owning them can help the relationship between her and client.
130-131	Authority	Distinguishing what feelings belong to her and the client gives her authority in making interventions.	'something that needed to stay in the room'	Taking responsibility of own feelings means you feel more in control and able to help client.
132-134	Process of revealing a personal feelings	Initially exposing to notice but then can use it positively. Exposed-settled-use it positively.		Prevents contamination
135-136	Benefits of exposing personal feelings	1. To prevent contamination 2. Assert what client needs to work on.		
141	Diary heightened awareness of emotional reactions			
143 149 153-155	**Self-supervision**- time and space to reflect on each session.	Supervision is the place to reflect on feelings but there is not enough. Can't hold onto what is happening week to week by saving it for supervision. Really valuable sitting down and thinking about every session.		Limits of supervision= can't take every client weekly. Self-supervision is essential because of limits of supervision. Requires time and space to think and reflect.
156-158	Complimented supervision	Had done some of the sense making prior to supervision. Less general in supervision.		Less time consuming making sense in supervision because that had been done through self-

Appendix R: **Example of emergent themes from Chloe's diary on client 1**

Powerful Maternal Feelings
- Physical well-being
- Maternal instinct
- Parental response
- Immature defences felt like a mother abandoning her child

- Emotional well-being
- Urge to remove anxiety
- Maternal instinct to soothe

- Responsibility
- Underlying conflict about responsibility
- Responsibility
- Feeling literally and absolutely responsible

Unconscious communication
- Pre-verbal
- No words to name something real and alive in therapy
- No words for the experience of therapy
- Acting out
- Communication through lack of wt gain
- C acting out feelings

Became the container for feelings
- Disowning feelings
- When consumed by C's feelings was less able to be therapeutic
- C's disowned feelings stayed with T for days
- T dustbin for feelings

Sabotaging of therapy
'full up' of feelings after session when the client does not accept therapeutic feed.
- Sabotage
- C need to destroy good
- C sabotaging containment
- T feeling as though she is being turned into the bad object
- T feeling C's destructiveness
- T concern about herself being destructive (belongs here because its a response to client not taking in)
- C takes in but without reflection induced feelings of sadness

Surviving something Intense
Facing feelings feels like surviving something intense
Confronting feelings and surviving
Exhaustion from confronting feelings
Full of adrenaline- drained
Nervous anxiety
Emotional impact on therapist

Anger
Felt anger when client did not own feelings
Feeling angry when ineffective
Feels angry and ineffective when shut out
Feels angry on reflection not in session
Anger at client's sabotaging

Felt nothing towards androgynous shell (where does this belong?)

Guilt
Impact of self on C
Guilt at leaving to give life to a new baby
Guilt intensified as sense of doing something to client
Enormous guilt and responsibility
C communicated feeling abandoned by inducing guilt in her
Enormous guilt relieved by recognition of C's unconscious communication

Emotional reactions as a therapeutic opportunity
Therapeutic opportunity
Therapeutic to not give into maternal instinct
Therapy is to face the loss
T needs to digest C's unspoken feelings and hand them back to client
Reflection in diary increased awareness of process
Address the avoidance of loss with client
'good enough' therapist
Interpretation helps manage feelings
Interpretation helps prevent a battle
Interpretation is a conscious process

Client's expression of feelings reduced negative feeling.
Felt encouraged as C voiced her feelings
Felt natural and not anxious when client voiced her feelings of abandonment
Felt warmth towards C when less destructive
Emotional connection when client uses therapy
Reduction in responsibility and guilt when C communicates feelings
When C owns their feeling it stays with them
T feelings are less intense when C talks about anger
T feelings less intense when not a dustbin for C's feelings.
Encouraged as C voiced her feelings
Relief at client's honesty about anger

Positive feelings linked to 'real' or therapeutic relationship
Honest reflection aided a deepening of the alliance
Feeling sympathy increases temptation not to challenge client
Relief at not colluding with avoidance
Awareness of real relationship has reduced anxiety, guilt and induced calm
Hopefulness for client overtook sense of loss
C digesting and verbalising feelings enabled and strengthened the real relationship
More mature defences being used enabled therapist to work through loss
T recognises own guilt/regret at ending prematurely
Feeling sad about the real relationship, as it feels too early to leave C when she is just coming into being
Sadness is linked to real relationship
Relief linked to awareness of 'as if' quality of relationship
Feeling useful
Warmth linked to seeing client's vulnerability and bravery
Feeling effective induced positive feeling
T need for client to get something from session
Positive vibe at weight gain
Feeling warmth towards C as looked more of a person
Calm when client accepts therapeutic feed
Feeling positive when client trusts treatment
Ending as a therapeutic opportunity.

Appendix S: **Superordinate Themes from Interview and diary – Chloe**

Diary and Interview combined themes

- Anger- feeling clients sabotaging
- Difficulty in balancing the 'as if' quality and reality
- Powerful Maternal Feelings as unconscious communication
- No Words for feelings/Felt unconscious communication
- Guilt linked to maternal transference
- Container for feelings- feeling dumped on
- Surviving something Intense
- Positive feelings linked to real relationship- mutual conscious awareness.
- Process of emotions as unconscious to conscious impacts on therapists experience
- Emotional reactions used as a therapeutic opportunity (bring feelings into consciousness)
- Real relationship
- Client's expression of feelings reduced negative feeling.   (conscious communication)
- {Diary} Conflict between value and priority
- The diary as a container for feelings
- Transitional object: Emotional attachment to diary
- Inspired
- Self-supervision
- Feelings exposed dynamics in the room
- Therapist as a container for feelings
- Live feelings: most important but most uncomfortable.
- Responsibility as therapist
- Absence of feeling in client
- Feel, reflect, name it, use it.- process of therapy.
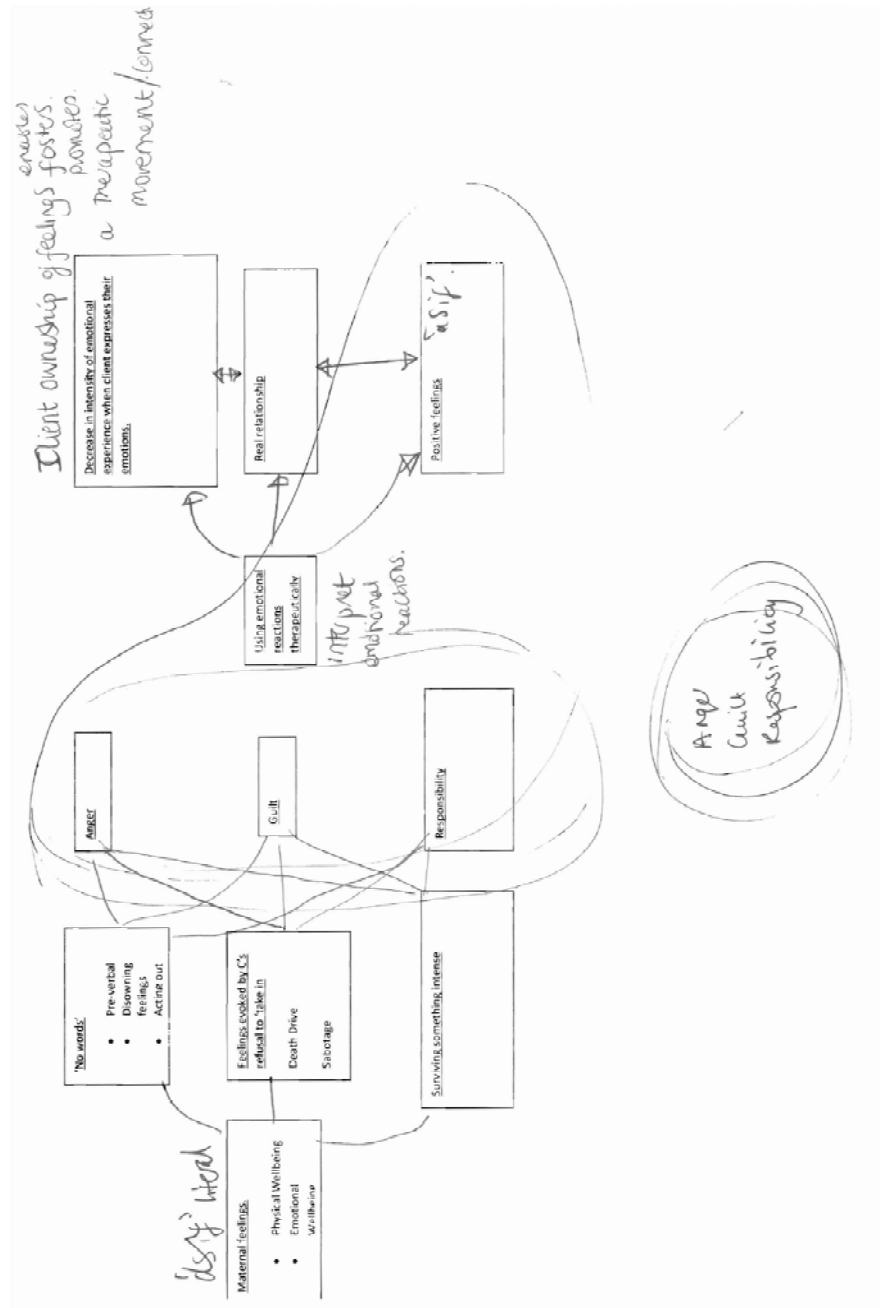
Appendix U: **Superordinate themes - Chloe**

Participant 1 Superordinate themes.

Theme	Line	Quote
Anger		
Felt ineffectual		
	Diary 1; 188	Evoked a feeling of ineffectiveness and therefore anger in me
Anger on reflection not during session	Diary 1; 87-89	I feel more angry with her now writing this than I was aware of in the session.
Anger at clients restriction (emotional, therapeutic and food)	Diary 1; 84-86; 183	Feeling of ineffectiveness and therefore anger in me.
Incresed when client does not own feeling		My anger towards her did go up as she was not owning her feelings
	Diary 1; 366	My anger towards her did go up as she was not owning her feelings
	Diary 1; 360-363; 369	
Guilt		
Impact of pregnancy	Int:	
Punishing client/client attacking therapist	Diary 2; 238	No wonder I have been feeling so guilty I have been punishing her
	Diary 2; 480	Why bother?
Feels as though she is abandoning the client.	Diary 1; 39-43	I still feel guilty about this client as if she never gets my full attetntion
	559	It feels too early to be leaving her
Shift in feeling guilt as therapist to interpreting guilt as a projection from client. RELIEF	Diary 1; 65	Which was quickly followed by enormous guilt and feelings of responsibility.
	Diary 2; 349	My feelings were relieved slightly after this as I was more aware of the 'as if' quality to our relationship rather than feeling literally and absolutely responsible for her. Ok I don't feel so guilty now I realise I can address this in the room.
	Diary 2;426	I didn't feel so guilty I knew that I wasn't actually being a bad therapist/mother!
Powerful maternal tranference		

205

Participant 1 Superordinate themes.

Responsibility/guilt		
	Diary 1; 44-48	Promise; equally excellent; step in; 'all would be all right'
	Int 198	Maternal transferene because that is what a mother would feel, that sort of level of responsibility.
	Int 240-243	It kind of confirms that ti is a maternal transference not reality because they havr convinced me that I am the only person that can help them.
Punishing		
No 'as if' feeling	Int 485	It's just really hard to be on the receiving end of strong maternal transferences.
	Int 524	Whether there is a strong maternal transference or whether I was doing more harm
Therapeutic use of emotional reactions: self-supervision		
Interpretation		
	Diary 1; 58-62	
	Diary 1; 370- 372	consciously take a step back from this to interpret rather than get into a battle.
	Int 263	I use it to inform my whole formulation
Naming it to client		
	Int 381	Naming them; named by therapist
Reflection reduced feeling		
Resisted temptation to give into making it more comfortable		
	Diary 1; 43-53;71-73;	I felt an urge to make the future seem better...but managed to stop herself and tried to help her stay with the paingful feelings
	Diary 1; 252-258	Temptation to settle into comfortable session
Positive feelings linked to connection with client.	Diary 1; 174-182; 183; 455	Positive vibe, I felt a warmth; induced further feelings of postitivity
Client owning own feelings enabled a connection	Diary 1; 200 471-474; 525	Strenghthening alliance...zara was then able to offer freely an admission that she was angry with me
Sadness linked to real relationship	Diary 1; 551-567	I feel sad myself now when I think of her

Participant 1 Superordinate themes.

Reinforced the importance of reflection	Int 150	It really helped to just sitting down and thinking about every session and what it was, and what had gone on, was was really valuable.
Surviving something intense/ Live feelings are most uncomfortable		
Confronting feelings and surviving		
Facing feelings feels like something intense. Exhausting!	Diary 1; 272-274	Feeling a sense of having survived something intense, actually I am exhausted now!
Responsibility		
Maternal transference	Diary 1	Feeling literally and absolutely responsible.
Responsibility as therapist.	Diary; 290-295 Int 34-35	'good enough' therapist You have kind of got to keep on top of that.
	INt 371	I have some responsibility, responsibility as a therapist
Therapist's use of self: self-supervision	Diary 1; 39-43;	
Self as a therapeutic instrument (listening to self)		
Therapist's 'real' feelings	Diary 2:156	My own 'real' feelings could be harder to separate from my feelings as a therapist.
	Diary 1; 457 Diary 2; 117-123	
Embraces reflection on impact of self		So why am I so worried about this? Could I be afraid of this being a trigger for her anger?
	Diary 1; 4-6	She has not progressed as far into the programme as I would have predicted when I first announced my pregnancy. Unless you are paying attention to your own feelings they could be completely lost
Importance of reflecting on own feelings	Int; 249	
Becoming the bad object		
Full of feelings when client refuses therapeutic feed.	Diary 1; 65-66	

Participant 1 Superordinate themes.

Concern about being destructive	Diary 1; 53-57; 287-290; Diary 2; 289	I continued to feel as if I was damagin her
		I am again being 'too harsh' rather than therapeutic
Feeling as though being turned into a bad object	Diary 1; 90-93	I fear she wll try to make me look 'bad' rather than experience me as 'good'
Feeling C's destructiveness	Diary 1; 460	
		I had to hold onto the 'as if' very consciously
Difficulty in maintaining the 'as if' quality	Diary 1; 363	
Bad therapist	Diary 1; 31-33; 37-39	
Reacting to the unspoken	Diary 1; 274; 382	
	Diary 1; 381-385	I have a sense of something real and alive taking place without being certain how to name what it was.
No words to name something real and alive in therapy		
Noticed C's acting out		
Feeling full or empty when client is keeping therapist out		Nervous anxiety; full of adrenaline;extremely draining
	Diary 1; 374-378	
Feeling drained and full of adrenaline		
When consumed by C's feelings felt less able to be therapeutic		
C's disowned feelings stayed with her for days		
	Diary 1; 281-282	I felt much more full of feelings after the session.
Feeling 'full up' of feelings after session when client does not accept a therapeutic feed.		
Exhausted from confronting feelings.		
A dustbin for c's feelings		
Switched off- punishing client.	Diary 2; 321-345	I fund myself switching off. Aware of my own life intruding into my mind and I find that I am not actually listening to carrie now

Participant 1 Superordinate themes.

		My own feelings not so intense today but Zara talking more openly about her anger.
Real relationship resulted in a reduction in negative feelings	Diary 1;357-360 572-576	
Therapeutic alliance	Diary 1; 190	Aware of a deepening of our alliance
		She admitted feelings which made me feel closer towards her
	Diary 2; 428-442	Satisfied that she has had a good feed today.
Therapeeutic feed	Diary 2 625	
Diary as part of digestive process	Int 4-6	It really useful...I did find it harder to keep going
Conflict between value and priority		
	Diary 1- 93	
	Diary 2 160-173	That's what I need to say to her. Three possibilities now exist....
Self supervision	Int 16	Thinking about feelings opened up so many ways of thinking
- **Aided supervision**	Int 159	I was much more able to go back the next following weel and sya, you know, sor of really pick that up,
		It worked hand in hand with
Connected her to process	Int 164	supervisdionI felt more comfortable talking about my feelings having done that thinking myself.
	477	Primarily to help me contain my feelings
Diary as a container for feelings		
Transitional object: emotional attachment to diary	Int 503	I can see how the diary would become very, very charged and very like an object that holds a lot of meaning
	506	Tangible evidence
	Int 413	Discharge the feelings ... I didn't get stuck with feelings as much in that respect/ I had put things down in the diary I had put that to rest.
Digestive Process(working through feeling		

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Appendix V: **Frequency of themes across participants**

Row Labels	Count of Participant
Ignore	**10**
Inspired	1
Positive feelings linked to real relationship- mutual conscious awareness.	1
Client factors influencing emotions	1
Focus on content	1
Immunity	1
Inconclusive- no certainty	1
Pleased	1
Shame and embarrassment about feelings.	1
Useful and Important	1
Wariness	1
Anger	**9**
Abused	1
Anger	2
Anger and frustration	1
Angry	1
Annoyed	1
Feelings towards other	1
Irritated	1
Irritation	1
Self supervision	**6**
Aided and accelerated supervision	1
Focused on the interaction	1
Self-supervision	1
supervision	1
Tendency to reflect on own process	1
Use of self	1
Diary	**6**
{Diary} Conflict between value and priority	1
Difficult to keep diary	1
Found the diary useful	1
Helpful to vent	1
The diary as a container for feelings	1
Transitional object: Emotional attachment to diary	1
drama triangle	**6**
Abused	1
Abuser	1
Abuser or the abused- BAD THERAPIST	1
Attacked and rendered powerless	1
Difficulty in balancing the 'as if' quality and reality	1
Drama Triangle	1
Anxiety	**5**
Anxiety	1
Anxiety about doing something wrong	1
Anxiety about risk	1
Confronting C's avoidance generates feelings.	1
Low confidence = anxiety	1
Sad	**5**
Sad	1
Sadness	4
Projective Identification	**5**
CUT OFF- Parallel Process	1
Experienced how it feels to be client	1
Feels the clients feelings	1
Projective identification: cut off	1
Queries whose feeling she is experiencing.	1
Frustrated	**5**
Frustrated	2
Frustration	3
Countertransference	**5**
Countertransference	1
Lack of C's responsibility generating feeling	1
Parallel Process	1
Personal experience influenced feelings	1
Therapist being a mother	1
Guilt	**5**
Abuser	1
Difference of feelings in the transference and the therapeutic relationship.	1
Guilt	2
Guilt	1

Row Labels	Count of Participant
Interpretation	**5**
Attempt to interpret clients communication	1
Attempts to interpret client	1
Emotional reactions used as a therapeutic opportunity (bring feelings into consciousness)	1
Interprets feelings	1
Interprets her experience with client	1
Mirrored process	**4**
Difficulty in identifying , explaining emotional processes	1
Parallel Process	1
Parallel process between client and therapist	1
Parallel Process- difficulty to reflect on emotions	1
emotionally drained	**4**
Client drains therapist	1
Emotional Burden	1
Emotionally Drained	1
Exhausted	1
extreme experience	**4**
Chaotic like a tsunami (effect)	1
Lifeless and full of life.	1
Primitive process? Powerful?	1
Therapist holding hope and feeling hopeless.	1
Externalising	**3**
Directed Negative Feelings towards ED	1
Feelings towards other	1
Strong feelings directed at 'other'	1
hopeless	**3**
Overwhelmed and Hopeless when not able to help her.	1
Questioning effectiveness of therapy.	1
Sadness and Hopeless	1
resentment	**2**
Resentful	1
Resentment- wasting time	1
maternal transference	**2**
Maternal Transference	2
Relief	**2**
Relief	1
Relief when client expressed feelings	1
frightened	**1**
Frightened	1
Sympathy	**1**
Sympathy towards client	1
self-supervision	**1**
Aids supervision	1
painful	**1**
Painful process	1
uncomfortable	**1**
Uncomfortable	1
controlled	**1**
Out of control- client in control	1
ambivalence	**1**
Ambivalence	1
(blank)	**1**
Highligh(ted Significant Themes	1
suspicious	**1**
Suspicious	1
Denial	**1**
Keeping own feelings out the room	1
Time	**1**
Impact of time	1
reponsibility as therapist	**1**
Desire to be a good therapist	1
Unconscious communication	**1**
Powerful Maternal Feelings as unconscious communication	1
confused	**1**
Confused	1
Confronting feelings	**1**
Difficulty in identifying , explaining emotional processes	1
Relapse	**1**
Relapse increased feelings in therapist	1
Grand Total	**112**

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Appendix W: **Example for quotes for cluster one from Beth**

<u>Powerful and difficult feelings</u>

Diary 2: Bloody hell- that was totally and utterly fucking torturous!!

Diary 17- 40: Instead we had another session of her holding her head in her hands, silently sobbing, body turned away from me like I am one malevolent, bulldozing therapist/abuser. I am so tired of this. What made things worse today is that I feel quite unwell today also so I don't feel on the ball. I told her that she needs to either communicate or not for the time being but that we have to step outside this (awful) withholding dynamic. She said that she "felt so alone" (I felt **FURIOUS** with her for saying this! What am I? Chopped liver???!) after we had spent yet another entire session with me waiting and hopefully being supportive. I'm so tired.

Beth is feeling tortured, abusive and abused- subject to unspoken aggression and anger? It is possible that Beth feels tortured, this generated anger and therefore she felt like the abuser.

A liver is something that aids the digestive process and this is perhaps Beth's function in this case to be the clients liver and make sense of all the poision/toxins. However, it seems that these feelings are so poisonous that they are unbearable to withstand. Furthermore, the idea of a chopped liver seems to be symbolic of a feeling of the therapists disconnect to the client, through the client's withholding. Therefore it seems possible that is very difficult to digest these feelings in the therapeutic relationship and in the therapist's self because of this disconnection. In the same way an anorexic is disconnected from their feelings and unable to digest them and/or food.

Feeling abused and being the abuser:

Interview 28-50: So a lot of the time our sessions would be spent with her in, with her being silent and turned away from me with her head in her hands silently crying and I would be there like a big open, doing everything that I could do to try and encourage her to talk to me and sometimes that would mean that I would be sitting there in silence too so I tried not to pressurise her and not to fill the silence by asking questions umm but she would be sitting there like I was umm, like I and therapy was some horrible monster. Umm so I have made sense of it that actually that when I originally used to think she is a woman who has had incredibly awful things happen to her where she has been abused by somebody and our sessions started to feel like she was actually abusing me and she knew that she was and I even brought that into our work and said that seems to be a dynamic that is between us which she could see but still either chose to or couldn't do anything about so I think eventually my, I was aware that my feelings, my emotions towards her started changing because she was doing this and I always felt when I was with her like I was doing something terrible to her, and then I started to realise that actually she is doing something pretty terrible to me in our sessions. She wont allow me to help her and

that's probably one of the most powerful things you can do to your therapist, to not allow, to not be allowed to help somebody but to not realise for a long time that that is what is happening.

Feeling manipulated/ controlled/force fed?

Interview 1-17: Umm the emotional experience I suppose is predominately frustration and, and umm frustration and irritation sometimes anger although not, I don't normally feel that when I am in the session with her because she is somebody who its, its really hard to mmm its really hard to put it into words. I think I have just been feeling, she is someone that I have been working with for a really long time and I have been feeling more and more aggressive. It frustrated and pissed off with her. Umm I used to feel very warmly towards her for a long time. … however working with her as an outpatient it is mostly me that sees her and I have been feeling really angry with her, umm and I found that when umm I get the phone call through from the secretary to say that she has arrived my heart sinks.

I think that heartsink is an interesting word. What does it mean? Does your heart sink after being stuffed full of feeling??

ANGER, HOPELESS, DESPAIR- feelings associated with being the victim. When she experiences a shift to being the victim she also experiences these new feelings towards the client.

Example of Super-ordinate themes and master themes across participants and justification (Sophia)

PT6

SUPERORDINATE	MASTER	RATIONALE
IRRITATION	STARVED .	Irritation at client's avoidance. Irritation linked to feeling starved. Irritation and agitation can be associated with feeling hungry
ANGER	FORCE-FED- countertransference *abused*	Response to clients sabotaging and refusal, therapist feels the feelings. (projection) as well as feeling angry towards others- feeling the client's feelings.
SADNESS	DIGESTING- connection to client	Connected to the client's emotions.
OVERWHELMED/HELPLESS /HOPELESS	FORCE FED- countetransference *abused*	Feeling punished- on receiving end of c's unspoken anger. *Coerced into the role of the victim*
BAD THERAPIST	FORCE FED- countertransference *abusive*	FEELING CLIENTS ATTACKS ON THERAPY as well as feeling as though she is being cruel- feeling unspoken feelings from client. *Feeling as though she is the bad therapist, either the abuser or the victim of the client's anger.*
FRUSTRATED	STARVED *Frustrated at deprivation.*	Frustrated at clients avoidance and being deprived of therapeutic work.
EXHAUSTED	STARVED *Exhausted because of expansion of energy and not getting anything to take in- like the process of starvation.*	Doing all the work and client is avoiding. Starved of a 2 way process.
CLIENT WORKING REDUCED THERAPIST'S NEGATIVE FEELINGS	DIGESTING- connection to client	Client digesting their feelings meant that therapist could too. *The therapist was able to connect to the client when the client was digesting their own feelings, allowing a connection to be made between therapist and client*
DESIRE TO BE A GOOD THERAPIST	DIGESTION- connection to self.	Process of self-regulation- she is recognising she wants to do her job and is feeling unable feels frustrated when cant be (starved of the experience) *When feeling as though she is being made to be the*

SUPERORDINATE	MASTER	RATIONALE
		bad therapist. This is a connection to her need and desire (countertransference) and making sense of it.
LIFELESS Or FULL OF LIFE	**Starved** *Near death experience*	Anxious as a response to a paradoxical experience-feeling full of anxiety but as though she needs resuscitating.
GUILT	**FORCEFED-countertransference** *abuser*	Feels like she has done something abusive
HOLDING HOPE AND FEELING HOPELESS	**Conflict: digesting and starved** *Feeling both a connection to the client as well as feeling starved of therapeutic progress/change*	Glimmers of hope when the client is working. Flits between feeling like the victim that is staved of therapeutic progress and where there is therapeutic work happening.
EMOTIONAL BURDEN & HEALTH WARNING	**Near death**	The impact of being force fed or starved is that it affects your health- could be lethal/ poisonous.
MIRROR PROCESS- difficult to reflect on emotions.	**STARVED** *Being completely empty- having an empty stomach with nothing to digest.*	Questioned whether it was emptying but participant talked about staring into the 'abyss' and not being able to hold onto anything because there was nothing there. Mirrored in the therapy where the therapist feels nothing real is being worked through.
EXPERIENCED HOW IT FELT TO BE CLIENT	**FORCE FED Countertransference** *Feeling clients feelings*	
Confused	**Conflict: feeling force fed and starved**	Struggled to make sense of what was happening.- is it useful or not? Is she changing or not?
SHAME AND EMBARASSMENT	**Digesting-connection to self**	Therapist's reaction towards their emotional revelations and being honest about their struggle.
QUESTIONING THERAPY	**FORCE FED-countertransference** *abused*	Result of feeling the attacks on therapy because client is refusing and avoiding. *In a position where she ends therapy because the client is not working. Feeling that they have been put in this position.*
Anorexia akin to a TSUNAMI	**Starved** *Near death experience*	Spoke about desolation (starved), sadness (digesting) and guilt (force fed). Connecting to both the destructiveness and emptiness. *This theme is quite unique and seems to be a metaphor for the therapist's experience of anorexia/ her client. It captures all three of the themes.*

SUPERORDINATE	MASTER	RATIONALE
REDUCTION OF FEELING WHEN CLIENT WORKING	**DIGESTING-** **connection to client**	**Does not feel as starved because client is digesting, this enables a reduction in overwhelming feeling.**
USE OF SELF	**STARVED** **Giving up her personal resources- draining and depleting**	**Depletes her- takes its toll on her being involved.**

Appendix Y: **Example of table of theme for 'starved'**

Starved- physical and psychological experience	
Switched off	1
Frustration (x3)	2,3,6
Attempt to keep own feelings out of the room	Self- starvation 2
Irritated (x2)	3,6
Emotionally drained	3
Mirror process: starved	5, 6
Deathly experience	4
Exhausted	6
Use of self: depleting	6
Cut off (x2)	7, 8
Resentment (at being drained and not getting anything back)	8
Considering ending therapy	5 (this has also come up in force fed but felt different, this is about being starved of therapy)
Drained	4

STARVED		Participant
Conflicting experience/ near death experience		
Feeling controlled by client:- *feeling both force fed and starved.*	Feeling drained and encroached on at the same time.	4
Drama triangle;- *feeling abused and an abuser*		4
Anxiety;- paradoxical experience	Full of adrenaline and needed resuscitating.	6
Lifeless or full of life	Feeling starved and force fed.	6
Holding hope and feeling hopeless	A container for feelings such as hope (this is a positive experience perhaps related to feeling a connection) and feeling starved.	6
Emotional burden and need a health warning:- *response to feeling force fed and starved*	A result of feeling such a push/pull	6
Confused		6
Contradiction in experience	Flitting between anger and sadness. Conflict between digesting and feeling force fed.	8

Master Theme with Quotes: Force Fed- countertransferential experience

Sub themes	Participant	Line	Quote
Feelings associated with being punishing/punished	1	Diary 1 21-31	The realisation she may not even be at target {weight} hit me today and was very guilt inducing. I know that it will be difficult to identify an individual therapist to take over and have been seeing this 'uncertainty' as something to be worked with by the client but it felt much more intensified today and harder to hold onto the idea that I am not doing this to her!
Feeling the client's feelings	1	Dairy 1; 357-385	My own feelings not so intense today but Zara talking more openly about her anger. I certainly felt 'prickled' as she spoke literally about feeling the care she is getting is not good enough and I had to hold onto the 'as if' very consciously in order not to get too defensive. My anger towards her did go up as she was not owning her feelings but 'blaming' others, notably me. Natural response in me was to meet anger with anger and I had to consciously take a step back from this to interpret rather than get into a battle. Feelings after the session: Nervous anxiety...realised I was full of 'adrenaline'. I am aware of working really hard to keep feelings in the room and this is extremely draining. I have a sense of something real and alive taking place without being certain how to name what it was.
Feeling the client's feelings	1	Diary 2 478-487	Carrie (client) has lost over 1kg in the last week and has gone ahead with moving house- feeling of 'why bother' going into the session as it feels like C is unwilling to stay with feelings on an emotional level and will just moan about the problems of moving when this is all her own doing. So actually feeling irritated/angry with her.
Feeling the client's feelings	2	Diary 1 Diary 1-15	: My feelings were of frustration at her not making the changes that we have discussed each - week – worked with her for some years (starved) – some {frustration} at her being a mother (anger?) (force-fed) too strong and the eating disorder coming before her children - I am aware that this comes from my own beliefs and difficulties (digestion- connection to self) around children was aware that I felt tired before the session-? Timing bed time own child. Frustration- I think comes from her, frustration- of the ED coming in between her relationship with her husband (force fed-feeling client's feelings)

Sub themes	Participant	Line	Quote
maternal			Working with Cara for 5 months now and she has never missed a session. More recently I have started to go over the hour. I am noticing that I am allowing her to go over the boundaries. I planned to start this reflective diary last week and because the last session was too overwhelming I avoided writing about it. Instead I spent the next day going over and over it, which was not helpful either. After Cara's sessions it takes me a long time to unwind and let go of her. I feel like she has encroached upon my being. We have a very strong therapeutic bond and I feel very maternal in my transference towards her. Sometimes I feel that I want to protect her just like a child. Last week's session was the peak of this feeling for me. Last week we talked about her fear of abandonment. She had written me a letter the week before explaining her fear that I would one day turn around and say I hate her. She fears that I will reject her. Last week was about staying with that despair and hopelessness that she feels and I was drained.
Feelings associated with being punishing/punished	4	Diary 58-68	However something awful happened today I was meant to inform her at the beginning of the session that I was taking a break for one week in two weeks time, so we would have one more session and then one weeks break, however I had forgotten and informed her towards the end instead! It was awful, her face fell and she said "What am I going to do without you? I am not getting out of bed all week!" I realise now how dependent she is upon me and how I need to be very careful now with what I say and do to manage her separation and loss from me. I need to be careful that I continue to repair the ruptures, she needs a corrective experience and I have a lot of responsibility, I feel now, to manage this break with her. I am nervous when I tell most of my patients but this was more heavily weighted!
Feelings associated with being punishing/punished	4	Diary 32-83	I felt angry at first when I heard that she was considering missing the therapy to go elsewhere. I started to wonder why it felt like an attack to me and why she chose to do something that she could have done on another day again, or at the weekend on her long leave. She went out and missed the session. I

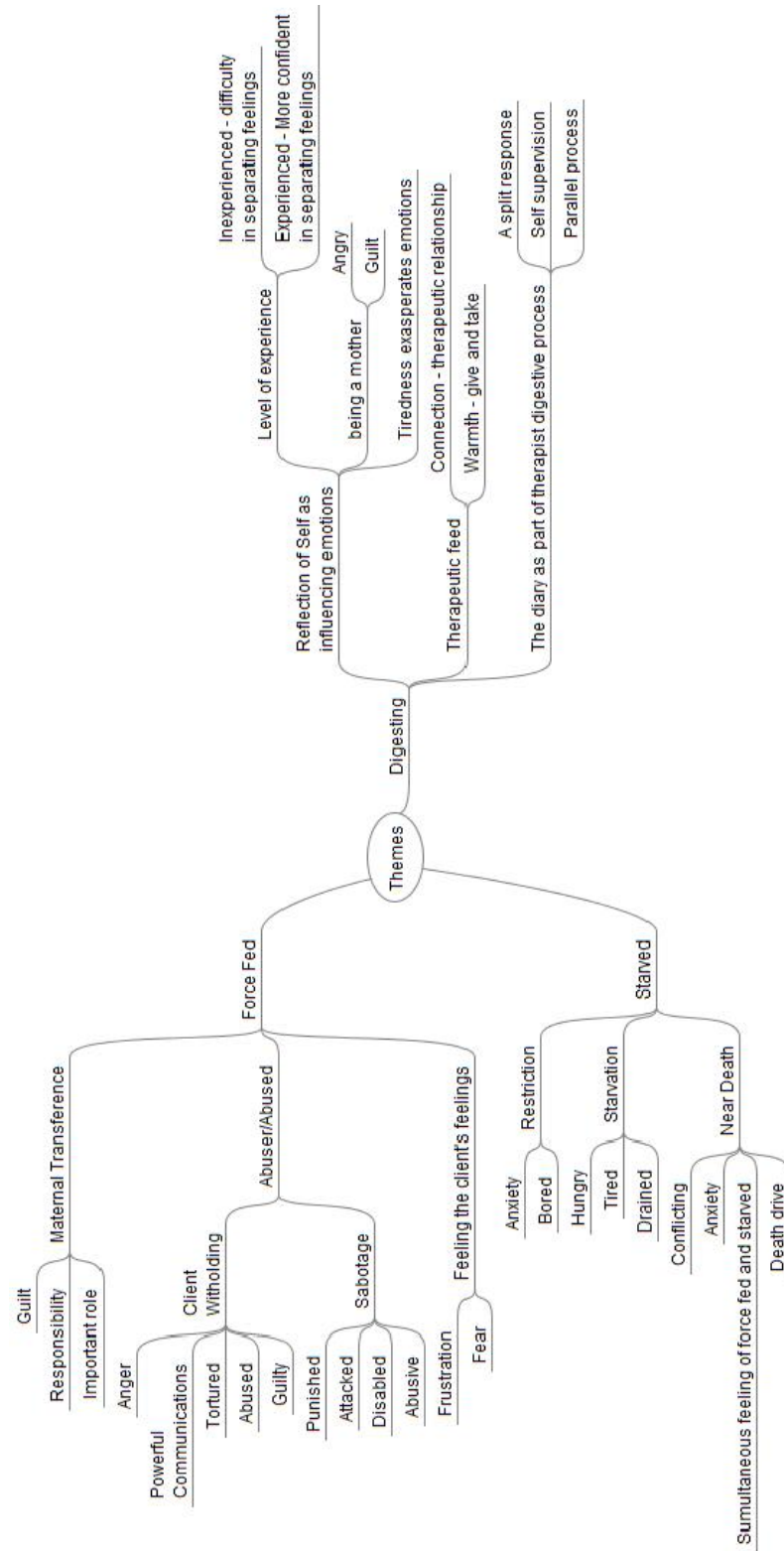| Sub themes	Participant	Line	Quote
Feeling the client's feelings	2	Diary 1 Diary 23-49:	Very broken record- again feel frustrated and felt myself feeling slightly angry that she wasn't able to enjoy her children and their activities. Boys tennis became about her social anxiety and about her husband's relationship with other people. Children go to other people's houses and go out for meals. The reason she gave that they do not go out for meals is the money, however it is clear that it is not the money but the ED challenged her re: this. Does it make you angry at the ED? But still sees the ED as the only security in her life. Feel very strongly that the anger? And frustration that I feel is <u>her</u> anger and frustration and her sadness. I have worked with this lady before as an inpatient and daypatient and I notice that my feelings regarding her children are now stronger and I am aware of this. My understanding of this passage is that Caroline has interpreted her experience as feeling the client's disowned feelings. She appears to be pulled into feeling all the anger towards the ED in the session, however in her reflection it seems she is aware that actually this anger tjhat she is not sure if she is or isn't experiencing and this frustration is actually the anger and destructive feelings of the client. This shows a process of feeling force-fed and attempting to make sense of the feelings she is left with. They seem powerful feelings and difficult to make sense of.
Feeling clients feelings	3	Diary 82 -88 Diary 139-151:	I was surprised and disappointed to hear that C had felt very anxious during the week as a result of some of the things we had talked about last week. During this session I felt anxious that maybe I had explained things badly or given C an impression that I had not intended C very anxious at the thought of trying this. Noticed in the session that I felt anxious too- worried that she might actually gain weight and fearful about how she would cope. Tempted to back out of experiment, not challenge her. However, v keen- then I felt excited prospect of a real shift in her thinking. After session feel confused- why was I so worried about what might happen if she gains weight- transference? After all, that is the <u>aim </u>of our work! Think I am experiencing her fear about weight gain.
Feelings associated with being	4		Diary 1- 16: Before today's session I felt nervous about seeing Cara our last session was really difficult and I was left feeling very drained. I have been

Sub themes	Participant	Line	Quote
			thought to myself wow she's making a brave statement. I felt annoyed with her because she was rejecting me. She was rejecting me before I rejected her. She wants to punish me before she experiences the punishment maybe? My feelings of frustration come from the same place as my maternal instincts towards her. I am thinking now that the anger that I feel could be projective identification, could it possibly be the anger that she experiences towards me that she is not allowing herself to feel towards me and therefore avoids facing me to talk about it.
Feelings associated with being maternal	4	Interview 81-88	:But before it would just used to be," you are it" you are my internal figure and that is a lot of pressure on me, and I felt a lot of responsibility. Like 'I don't have kids, I don't know what this maternal instinct is meant to feel like', but yet, I found myself feeling something quite maternal towards her and again that was the transference and the countertransference that I was getting pulled into something with her, and she was, well she was powerful in creating that between us, and umm, I talk about the power within her to be able to do that as well.
	4	Int; 15: 346-348	Maybe I am a bit sick of her (laughs) that is what it is. I do feel a bit sick of her sometimes. Tired of thinking about her, sometimes. Its kind of ambivalence really, yeah, yeah.
Feelings associated with being punished/punishing	4	Diary 100-104	I was sitting on the edge of my seat today, urging her to talk and come forward. I felt like I was doing all the work again just like a few weeks ago. I was tired by the end of the session, exhausted with her withholding. It's such a powerful tool, quite manipulative and possessed with anger.
Feelings associated with being punishing/punished	6	Int; 323- 364	323- It just feels very squashing of therapy. It feels like it is just completely stamping on the work and just a lock down really on moving forward and I don't know whether its, its kind of timing because it has happened when she is in a place where she has

Sub themes	Participant	Line	Quote
			been and actually by doing this she has totally, it feels like, reared in that by holding onto that mindset and it seems very difficult to kind of think with her about why she might be doing that. Again it's the not hearing and not listening and just not wanting to hear something and you are just like this is really going to be, and I felt very heart sink the other day with that because I just thought like there is enough to work on her and adding that kind of dimension, its quite, it feels quite, poisonous to have that into her in a way. It feels like she has been infected with this way of thinking…..(357-364) I felt quite angry actually because I thought its really, like it wasn't hard enough already and we were just it felt like we were just making some progress although I don't know whether we were. But this is something that feels like it has just landed like a , well its dumped on everything really and it's just flattened all, oh like the tsunami thing, its just totally laid it out and how can you, I can't see a way through that so. I am feeling depressed now thinking about that (laughs)
	6	Diary 185	I think I feel guilty 'abandoning' her for a week while I go on holiday.
Feelings associated with being punishing/punished		Diary 30	Moved patient onto a a difficult topic of being sexually assaulted as she had raised wanting to speak about this at the end of the last session. Even though I wasn't pushing her for details/information, I felt cruel for asking her to think about talking to me about the incident. She struggled to manage her feelings and it was difficult to end the session on time as she was very distressed. This left me feeling incompetent and that I had gone about the session in an unhelpful way.

Sub themes	Participant	Line	Quote
Feeling the client's feelings	7	Interview 67-72:	Yeah, so maybe I am starting to feel a bit like she used to feel as a child, and I am very demanded upon and wondering what is going to come next and that's quite frightening. SO I am getting an idea of how she used to feel as a helpless little child which is quite frightening.
Feelings associated with being maternal	7	Interview 43-54:	Um currently she frightens me a little bit because umm having wanted to trash me umm and get really angry with me she now has me on this wonderful pedestal. It actually makes me feel 'oh my goodness when is the time that I will fall from that?'. And I think that I have quite a distance to fall because each of the last three sessions she has said to me something as I have just said to her 'that's the end of the session now Amy you know I will see you next week' each time she has said something like 'I wish I could have taped that session', or umm, umm, she said the other day 'oh its happened again you know I am only just getting into it and I really need more time' or something like that. So she's certainly feeling that she is not getting enough. She is not getting enough of this ideal woman that she is making me out to be the ideal mother, that is giving her the kind of feel maybe that she feels she didn't get. So, I think it is quite frightening that the idealisation is probably about her insatiability.
		Interview 130-137:	It feels like I am being a bad mother. You know it feels quite

Sub themes	Participant	Line	Quote
		Interview 141-146	difficult just to maintain the silences and just to wait. She is often so sulky about it that I can feel her anger and therefore sometimes I can get angry about it. So it makes me feel angry and I do quite frequently feel angry and I wonder how her mother feels about her because she is very very demanding of her mother, and she wants her mother to sit with her whilst she is eating and Lizzie feels that she can't feed herself. I wonder if she is trying to make me feel like a bad therapist that's what I was wondering. Like she tries to make her mother feel like a bad mother but I don't really get involved in that I just kind of let it go over my head as much as I can and let her say what she needs to stay, say whilst still keeping in mind her mother.
Feelings associated with being punishing/punished	8	Diary 2: Diary 17-40:	Bloody hell- that was totally and utterly fucking torturous!! Instead we had another session of her holding her head in her hands, silently sobbing, body turned away from me like I am one malevolent, bulldozing therapist/abuser. I am so tired of this. What made things worse today is that I feel quite unwell today also so I don't feel on the ball. I told her that she needs to either communicate or not for the time being but that we have to step outside this (awful) withholding dynamic. She said that she "felt so alone" (I felt **FURIOUS** with her for saying this! What am I? Chopped liver???!) after we had spent yet another entire session with me waiting and hopefully being supportive. I'm so tired.
Feelings associated with being punishing/punished	8	Interview 28-50:	So a lot of the time our sessions would be spent with her in, with her being silent

Sub themes	Participant	Line	Quote
			and turned away from me with her head in her hands silently crying and I would be there like a big open, doing everything that I could do to try and encourage her to talk to me and sometimes that would mean that I would be sitting there in silence too so I tried not to pressurise her and not to fill the silence by asking questions umm but she would be sitting there like I was umm, like I and therapy was some horrible monster. Umm so I have made sense of it that actually that when I originally used to think she is a woman who has had incredibly awful things happen to her where she has been abused by somebody and our sessions started to feel like she was actually abusing me and she knew that she was and I even brought that into our work and said that seems to be a dynamic that is between us which she could see but still either chose to or couldn't do anything about so I think eventually my, I was aware that my feelings, my emotions towards her started changing because she was doing this and I always felt when I was with her like I was doing something terrible to her, and then I started to realise that actually she is doing something pretty terrible to me in our sessions. She wont allow me to help her and that's probably one of the most powerful things you can do to your therapist, to not allow, to not be allowed to help somebody but to not realise for a long time that that is what is happening.

A diagram to illustrate the themes

Themes

Digesting
- Reflection of Self as influencing emotions
  - Level of experience
    - Inexperienced - difficulty in separating feelings
    - Experienced - More confident in separating feelings
  - being a mother
    - Angry
    - Guilt
  - Tiredness exasperates emotions
  - Connection - therapeutic relationship
  - Warmth - give and take
- Therapeutic feed
- The diary as part of therapist digestive process
  - A split response
  - Self supervision
  - Parallel process

Force Fed
- Maternal Transference
  - Guilt
  - Responsibility
  - Important role
  - Anger
  - Powerful Communications
- Client Witholding
  - Tortured
  - Abused
  - Guilty
  - Punished
- Sabotage
  - Attacked
  - Disabled
  - Abusive
  - Frustration
- Feeling the client's feelings
  - Fear

Starved
- Restriction
  - Anxiety
  - Bored
- Starvation
  - Hungry
  - Tired
  - Drained
- Near Death
  - Conflicting
  - Anxiety
  - Death drive
- Sumultaneous feeling of force fed and starved

Accounts from therapists on reasons for choosing this

job

<u>Consciously</u>

I had recently completed my psychodynamic counselling diploma when I applied for a post. It was both nearer to home and a promotion. I left a role in a CMH therapy team to go into thins specialist area and this appealed to me. The team I was working in was being split up so single therapists would be based within general mental health teams. I had already left two previous jobs in psychotherapeutic settings where the services had been cut and I was beginning to get the sense of psychotherapy being under threat in the NHS and I was heartened to find a speciality where is was still possible to provide therapy. In addition I find out the consultant worked psychodynamically and I had been finding it difficult to get it recognised that I required regular psychodynamic supervision and I knew he would be supportive of this. I also liked the idea of working in a trust with a psychotherapy dept. I gave very little thought to the area of 'eating disorders'; to me it was a 'therapy post' primarily things I did draw on were a few bits of knowledge but nothing in depth:

The material covered in the psychodynamic course and my previous work experience gave me enough insight to know that I found it an interesting area. I knew I was a female of similar age to the majority of the clients I would be seeing and I considered that there would be areas of overlap between them and my own personal development. I thought having been in personal therapy that I would manage this with the right support / Supervision in place.

- Phone contact with a friend who was a ward manager on a private ED unit and a psychotherapist I had worked with, didn't put me off.

Unconscious

My unconscious led me to an area that was more closely related to my own personal development than I had been fully acknowledging. I became aware of the reality of working with clients in a similar stage of personal development to me, which while I had worked through a lot in my own therapy did lead to me gaining new insights into aspects of myself and more broadly my 'family system'. This led me to do some further work in my own personal therapy and I gave a lot of thought to leaving the field. I opted to continue to work as a therapist in this very challenging area as I believe I had gained a lot of insight and as long as I continued to be properly supported/ supervised to take this seriously I felt I could do the work, I think it was essential to reflect on my own relationship with food and I think any therapist working in this field has to and I realised that there is an emotional component to this. I believe it has equally helped and hindered me to be so close to my clients and their difficulties and had made doing the job rewarding and emotionally exhausting.

When I joined the team I found myself in a very supportive/nurturing team and they are a big part of the reason that I felt I could take on the challenge as I found I could share things with them. The key is to be able to keep the distinction between my own self and my client's internal world. This can be challenging for anyone working with clients with anorexia who have a natural tendency to want to fuse with 'the other', and who use primitive defense mechanisms such as projective identification, it becomes impossible if an emotionally drained therapist who is not well supported in a challenging environment!!?!

I remember very clearly how my life in eating disorders came about. When I was doing my undergraduate degree (at the age of about 30), I did a course in Year 2 about "abnormal psychology", and it included a lecture on eating disorders. Through that, I started reading feminist writers on the subject – Marilyn Lawrence, Kim Chernin, Susie Orbach. I became angry when I began to understand the politics of the female body, because I recalled my years of body shame and my intense focus on calories.

I went on to do my dissertation on body dissatisfaction and gender role in (private) school girls.

Much later, after my PhD and Research Fellow work in autism, I wanted a local job. I was told of an opportunity in eating disorders and I attended one ward round, to see if I might be interested. I met 2 or 3 anorexic patients. and I also talked to Maureen (whom I didn't know then.) I was INSTANTLY sure that I wanted to work in the service I was fascinated from that day onwards.

Recognition + Strangeness

A Critical Literature Review: A Counselling Psychology Perspective on Alexithymia in Anorexia Nervosa.

Introduction

Rationale for Review

Treating people with anorexia nervosa is notoriously complicated and so it is useful to explore ways in which knowledge of this area can be increased. Impoved knowledge will lead to better training and more competent professionals and therapists. People suffering from anorexia are difficult to engage in treatment because of their reluctance to change (Roth & Fonagy, 2005), and this may be related to alexithymia.

Garner (1985) suggested that there is a risk of iatrogenesis in the therapeutic treatment of anorexia in psychotherapy. The therapist's poor understanding of eating disorders is thought to be an influencing factor, as are the negative reactions that are widely reported to be evoked when working with the anorexic population (Garner, 1985). Furthermore, alexithymic traits may contribute to countertransference responses and difficulties in the therapeutic relationship which are also considered to impact on the effectiveness of therapy with this client group (Thompson & Sherman, 1989), as well as whether the client is deemed appropriate to be offered psychological therapy.

Williams and Haverkamp (2010) stated that the demand for treatment of eating disorders exceeds the availability of appropriately trained professionals. Jones and Larner (2004, p.22) stated that, "there remains a general lack of training, competency and confidence in working with eating disorders across disciplines". This is important for counselling psychologists as they could be required to work outside their specialist area as people with anorexia could present to any counselling/psychology service.

Counselling psychologists need to be aware of the concept of alexithymia as it has migrated into medical discourse and may be used as a way of labelling individuals' difficulties, especially in the National Health Service (NHS), and in private health providers, where medical discourse prevails. It is important to note how this phenomenological construct has become a diagnostic tool that provides a quantitative measure and now features in psychiatric/medical publications. This needs exploring from a critical perspective to consider the implications of stating that people with anorexia are more likely to be alexithymic and to consider how this fits in with the philosophy of counselling psychology.

The literature review will explore the therapeutic meaning of alexithymia by reviewing, evaluating and critiquing the construct. Consideration will be given to how this knowledge might be considered from a subjective rather than an objective stance. This will highlight how counselling psychologists can approach the concept of alexithymia

and how this understanding may help or hinder their therapeutic work and interventions with clients.

Anorexia Nervosa

Anorexia nervosa is a severe psychiatric illness (National Institute for Clinical Exellence (NICE), 2004) and is on the increase. Approximately 11 people in 100,000 develop anorexia nervosa each year (B-eat, 2011). It is a complex illness that encompasses biological, social and psychological factors (Clinton, 2006). Anorexia is reported to be a difficult illness on which to conduct empirical research because of its complex nature, and therefore there is little quantitative evidence to guide treatment in adults (Fairburn, 2005).

Anorexia is widely considered as a "solution" for individuals who feel powerless, out of control, and unable to cope with their emotions and their development into adulthood (Bruch, 1978; Orbach, 1986). Research continues to explore the psychological characteristics at its core in order to gain more knowledge about its aetiology (Iancu, Cohen, Yehuda, & Kotler, 2006). Skarderud (2007b) proposed that treatments should be tailored to target the psychological aspects of anorexia.

Recovery from anorexia takes a slow and unpredictable course, but it can be assumed that this process is aided by early detection, intervention, and appropriate action (Rosenvinge & Mouland, 1990). The course of recovery requires exploration of the individual in the context of social, psychological and biological aspects, in order to help manage medical implications and to help the individual understand these areas of their life and how they link to their eating disorder. It is important that anorexia is identified early and the variables that predict treatment outcome are considered in order to support the individual on their journey through recovery (Speranza, Loas, Wallier, & Corcos, 2007).

Alexithymia as a Component of Anorexia Nervosa

Alexithymia has been described as either a reaction to an emotionally distressing situation or a personality trait. This has implications for the type of therapy that is considered appropriate for an individual's social and psychological well being. Sifneos (1973) believed that the development of alexithymia was either biological or developmental. Biogenic alexithymia has been described as being a result of the brain not functioning properly due to either damage or abnormal development (Thompson, 2009). It is thought that if alexithymia is biogenic then therapy should focus on learning compensatory strategies instead of psychological change (Thompson, 2009). This was

referred to by Nemiah, Freyberger and Sifneos (1977) as state anorexia and by Taylor, Bagby and Parker, (1997) as primary alexithymia. In this case it is thought to alter little over time and to be entrenched in one's personality.

Psychogenic alexithymia is thought to be caused by emotional trauma (generated by experiences such as sexual abuse, neglect and physical abuse), developmental delay or cultural and parental conditioning (Thompson, 2009). This is what Nemiah et al. (1977) called secondary alexithymia which has also been referred to as trait anorexia by Taylor et al. (1997). In this case alexithymia is thought to be a reaction to emotional trauma and is described as defense or block towards emotions experienced in these situations (Thompson, 2009).

Anorexia has been proposed to be a disorder of self-regulation; in particular affect regulation which has resulted from an underlying need to restrict affective experience as well as to restrict desire (Taylor, Parker, Bagby, & Bourke, 1996). From a psychodynamic perspective anorexia is believed to develop as a way to cope with early difficulties in affect regulation. Clinton (2006) has proposed that the anorexic re-creates the situation of an un-attuned caregiver as they misread and deny their body signals and emotional needs. He proposed that food may represent the individual's needs and desires, and the restriction of it can be a way of managing disorganised and overwhelming internal states. Therefore, starving oneself could be considered a response to an attempt to modulate distressing emotions.

Developmental process and attachment issues are consistent themes in both anorexia and alexithymia research which is one of the reasons why alexithymia is linked to anorexia (Bruch, 1982; Clinton, 2006; Parker, Taylor & Bagby, 1998; Petterson, 2004; Taylor, Bagby, & Parker, 1997).

Taylor, Ryan and Bagby (1986) approached the phenomenological concept of alexithymia and developed a scale called the Toronto Alexithymia Scale (TAS). This was devised to administer to patients as a way of measuring their levels of alexithymia in treatment. It is important to note that the classifications, definitions and scales of alexithymia are rooted in a positivistic model.

The construct alexithymia has received particular interest as a psychological feature of anorexia as it has been shown to predict a poor treatment outcome (Speranza et al., 2007). Bruch (1973) was the first person to report interoceptive awareness as a consistent difficulty in people suffering from anorexia because of a deficiency in their capacity to identify and articulate their feelings. Around the same time, Sifneos (1973) coined the word "alexithymia", as a clinically-derived phenomenological construct,

which was used to organise various clinical observations of patients experiencing psychosomatic disturbances, into a framework for understanding and to aid clinical work. Over the past few decades the alexithymia concept has been refined theoretically, where it has been characterised by the following clinical features (Taylor et al., 1997):

1. Disturbance in emotional processing,

2. Difficulty in identifying and describing one's own emotions,

3. A pre-occupation with bodily symptoms and an inability to distinguish these from emotional states,

4. A lack of fantasy,

5. Externally orientated thinking style (Nemiah et al.,1977).

Summary of the Research on Alexithymia in Anorexia Nervosa

There has been extensive research into whether there is a link between anorexia and alexithymia. The overall conclusions from this research will be outlined here before moving onto think about how this positivistic/empiricist approach can be viewed from a counselling psychology perspective.

Overall the research suggests that restricting eating and loss of appetite is a way of managing disorganised emotions in people with anorexia. In the majority of the research in this area, the Toronto Alexithymia Scale (TAS; Taylor et al., 1986) was used to measure the individual's level of emotional awareness, fantasy and externally orientated thinking. Or the more up-to-date version called the TAS-20 was used (Bagby, Parker, & Taylor, 1994) which had the factor for paucity in fantasy removed as there were not consistent findings of it being a constant facet of the alexithymia construct. Alongside this the Eating Disorder Inventory (EDI; Garner, Olmstead, & Polivy, 1983b) was used to measure aspects of eating disorders such as: drive for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, interoceptive awareness and maturity fears.

The use of psychometric testing and psychological testing is contentious in counselling psychology (Sequeira & Van Scoyoc, 2004). Therefore the research that uses the TAS and EDI need critiquing and interpreting as this approach is in conflict to counselling psychology's humanistic roots (this will be addressed in *Counselling Psychology and Diagnoses*). However, as the Guidelines for the Professional Practice of Counselling Psychology (BPS, July 1998; p.1), outline, counselling psychology is evolving and

adapting; "it continues to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry". It is important to question what knowledge can be extracted from the outcomes of psychological measures.

In the first research on this, Bourke, Taylor, Parker, & Bagby (1992) administered both of these measures to a small sample of patients. The study found that people with anorexia had a high percentage of alexithymia even when duration of illness, weight differences and depression were accounted for. Troop, Schmidt and Treasure (1994) also found that people diagnosed with an eating disorder were more alexithymic but, in particular, they found that anorexics score lower on the paucity of fantasy. This was the only study that reported these findings. They suggested that people with anorexia use their imagination less. They related this to their clinical experience of trying to engage clients in brainstorming solutions and doing problem-solving therapy and how difficult this was. This suggests that alexithymia is not just a barrier to interpretations in psychodynamic therapy, as Bruch (1973) had suggested, but also other aspects of therapy which require the clients to think creatively, such as free association or some CBT tasks which require the use of imagery such as in mindfulness (Segal, Williams, & Teasdale, 2002).

Skarderud (2007a) proposed that rigidity and concrete thinking were aspects of anorexia. Therefore, it may be possible that this aspect of anorexia could be related to alexithymia. If the therapist is unaware of this as a common factor and something that is related to their eating disorders, then they might feel as though the client is not working with them and is failing at therapy. Alexithymia indicates a concrete way of functioning mentally and may represent paucity or absence of the words for such inner states (Skarderud, 2007a).

Rastam, Gillberg, Gillberg and Johansson (1997) found that alexithymia could not predict anorexia, and that it was only present in a sub-group of people with anorexia. Taylor et al. (1996) conducted another study to gain more insight into the psychological characteristics of anorexia, using the TAS-20 (Bagby et al., 1994). They found that the alexithymic quality "difficulty identifying and distinguishing between feelings and bodily sensations" was the factor that made the strongest contribution to anorexia. They used these finding to draw the conclusion that the lack of close relationships noticed in people with anorexia could be explained by the difficulties in expression of feeling, and not their reluctance to express their feelings.

Other research that controlled for depression also found that only "difficulty in identifying feelings" was significantly high in restrictive anorexics (Eizaguirre, Saenz de Cabezon, Ochoa de Alda, Olariaga, & Juaniz, 2004; Sexton, Sunday, Hurt and Halmi,

1998; Speranza et al., 2005). Speranza et al. (2007) found that the factor "difficulty in identifying feelings" was found to be a negative prognostic factor for long-term outcome in eating disorders, regardless of the treatment received. This is important for counselling psychologists to know as it may be an aspect that could prevent an effective outcome in therapy.

Lawson, Waller, Sines and Meyer (2008) found that narcissism was associated with difficulties in describing feelings to others and that narcissistic defences were associated with difficulties in identifying feelings and distinguishing them from somatic experiences. Therefore, they conclude that aspects of alexithymia are associated with narcissism. It could be suggested that working with clients with alexithymia involves focusing on the emotions that lead them to their eating behaviour (e.g. Meyer, Waller, & Waters, 1998).

In summary, the findings have consistently suggested that the alexithymic feature, "difficulty identifying and describing feelings", is a common personality trait amongst people diagnosed with anorexia nervosa. It can therefore be concluded that there were observable and enduring structures within these individuals in the research which could be labelled as "alexithymic".

Counselling Psychology and Diagnoses

The findings discussed in the literature so far should be treated with caution as they are rooted uncritically in a medical model. Interest in the concept of alexithymia has grown since it was originally proposed by Sifneos (1973) as a phenomenological construct which was defined as a way to support people clinically in their therapeutic work with clients. It very quickly transformed into something to measure (TAS; Taylor, Ryan & Bagby 1986) within people and consequently to label them as "alexithymic". The quantitative research adopts an empiricist perspective and this is based on the assumption that there is only one reality. Whereas counselling psychology has an affinity to a critical realist perspective which asserts that reality can only be imperfectly understood (Ponterotto, 2005).

The essence of counselling psychology is to respect the personal, subjective experience of the client over and above notions of diagnosis, assessment and treatment (Bury & Strauss, 2006). Counselling psychologists are both scientists and practitioners who tend to prefer phenomenological methods for understanding human experience. The philosophical position was a natural objection to the medical model of psychology and the use of the American Psychiatric Association's

(APA) Diagnostic and Statistical Manual of Mental Disorders (APA, 2000), because it pathologises clients' distress (Larsson, Brooks, & Loewenthal, 2012).

Some of the arguments for and against psychological testing are outlined by Sequeira and Van Scoyoc (2004) in a discussion about testing in counselling psychology. One of the arguments for testing is that measures, such as the TAS, could be used alongside other ways of carrying out assessments for therapy to support counselling psychologists' thoughts and to add "objective weight" (Sequeira & Van Scoyoc, 2004). This could aid communication across different professional groups and, if writing therapy summaries or discharge letters, it might provide a language for other medical professionals to understand. It is possible that a client might find the experience of completing a measure and having a concrete diagnosis or label assigned to them empowering when they feel helpless to understanding their difficulties. It could also have the opposite affect which will be discussed next. It may also be helpful to measure therapy progress and to monitor if the client's symptoms are improving. The results of tests can provide an objective basis for practice.

The use of psychological tests implies that norms for distress and well-being exist outside the client's subjective experience, and has a focus on the client's experience as being symptomatic. This could have an unfavorable impact on the client as it is pathology orientated and could reinforce the therapist as powerful and encourage dependency on them. As a result, this could be damaging to the therapeutic relationship because it objectifies one's experience (Sequeira & Van Scoyoc, 2004). Such categorising may provide the basis for discrimination or abuse when used out of context. Testing can communicate to the client a model of "doing to" and "deciding for" by an 'expert' (Sequeira & Van Scoyoc, 2004)

However, counselling psychologists work within settings where diagnoses are used in the context of people being "sick" and therefore "treated" (Bury & Strauss, 2006). Strawbridge and Woolfe (2003) distinguished counselling psychology from a more clinical model by emphasising the more subjective approach, and the focus on the quality of the therapeutic relationship. Because of the scientific-practitioner dualism there can be two epistemological perspectives in counselling psychology as outlined by (Larsson, Brooks, & Loewenthal, 2012).

1. Counselling psychology values the phenomenological experience of the client and does not make any assumptions about them, such as through the use of diagnoses. Counselling psychologists attempt to understand a client's subjective world without imposing objectivity and labels onto them (Bury & Strauss, 2006). It is a challenge for scientific research to be understood and

transformed within counselling psychology where there is a recognition of "science", but an emphasis on the therapeutic relationship. Goldsworthy (2004) stated that it is counselling psychologist's duty in society to challenge psychiatric categories and diagnoses. He pointed out that through the use of the therapeutic relationship counselling psychologists must question their own assumptions and any supposed superiority of knowledge that they might have related to labelling someone.

2. The second epistemological position assumes a more empiricist view, whereby counselling psychology should be more willing to engage with the medical model whilst still retaining its critical perspective (Larsson et al., 2012). Taylor et al. (1997) suggested that the label alexithymia can help therapists and clients to rationalise why they fear their emotions and can help therapists make sense of their client and their experience of them. The wider social and political implications of labeling someone as alexithymic and alongside an already existing label of anorexia will be considered.

According to Taylor et al. (1997) alexithymia as a concept is a personality construct that reflects a problem in an individual's affect regulation, and therefore is a stable trait. This means that there is a "disorder" in how someone is affected by an event. The ideas of "state" or "trait" are based within the medical model and are looking for a causal relationship. This is an attempt to fit people into categories. An alternative perspective is that alexithymia is not a disorder but a coping strategy, an adaptation to psychological trauma, developmental difficulties, sociocultural factors or psychodynamic factors. Thompson (2009) stated that by categorising "symptoms" as part of an "illness" it obscures the psychological and social origins of the difficulties, and places the "problem" within the individual. It is possible that this approach gives the message that the answer to the problem lies in the professionals who treat symptoms. This could reinforce any feelings of powerlessness that an individual may already experience, if they feel helpless to their symptoms. It also reinforces social constructions of mental health.

Psychiatric diagnoses such as anorexia nervosa have been argued to have developed as a way to control, exert power and "governmentality" (Foucault, 1978). Therefore, diagnoses are constructed within the powerful scientific and medical model which conceives mental health as an "illness". This could be considered a way of social control in order to maintain a status quo in society. The problem with this is that the individual who needs empowering and helping will not get the geniune help that they need.

As anorexia nervosa is mostly diagnosed in females (Strober, 2004), the sociological and feminist explanations for alexithymia in anorexia need to be considered. An explanation of alexithymia from a feminist perspective explains the difficulty in identifying and labeling feelings as a response to women's struggles in a patriarchal society in which "feelings" are viewed as soft, weak and womanly. The following quote by Levant and Pollack (1995, p. 239) can highlight society's view on emotions in males and females:

> Men are genuinely unaware of their emotions. Lacking this emotional awareness, when asked to identify their feelings, they tend to rely on their cognition to try to logically deduce how they should feel. They cannot do what is automatic for most women- simply sense inwardly feel the feelings and let the verbal description come to mind.

Lawrence (2008) proposed that an anorexic woman feels that she has to deny that she has any appetite for anything, denying herself of having any needs or feelings because she feels that she will be too much for anyone. This in itself could be viewed as "alexithymic". Historically the woman's role has been to take care of others emotionally before her own needs; this has fulfilled society's roles. Therefore, alexithymia might be a result of women developing sensitive emotional antennae to tune in to others feelings and tune out of their own feelings or needs. It is possible that many women in society could show signs of alexithymia, and therefore could be labelled accordingly. The medical model is influenced from the patriarchal society and the label of alexithymia could be said to be imposing male standards onto females (MacSween, 1993). Some women may adapt to ignore their feelings in order to compete in a patriarchal society; this message could be communicated to females at an early age through their experiences of their own female role model, e.g., their mother. We need to be careful that we are not beginning to pathologise normal human behavior or our response to societal pressures (Turner-Young, 2003).

If such labels are given to a population that have already been categorised as anorexic then this could reinforce these social norms and/or political interests. This in turn could exacerbate the "symptoms" of either alexithymia or anorexia because it may compound an experience of feeling out of control of one's own life and destiny, as well as feeling as though they do not deserve their feelings. This may reinforce an experience of being marginalised in society.

Implications for Therapeutic Practice

Therapy is appropriate for clients with alexithymia and anorexia

Counselling psychologists are under increasing pressure in the NHS to have more clients on their caseload and to offer time-limited therapy (Rizq, 2012). These factors might influence the decision around offering someone therapy who may seem unable to make use of it or show psychological change in a short amount of time. If alexithymia is understood as a personality trait, then therapy might be thought to be ineffective. It is possible that a client's inability to articulate or reflect on their feelings in a therapy session might generate a negative response in the therapist because this is something that therapists may expect to be the normal course for a therapeutic interaction.

From the research discussed it highlights how much it may feel as though the client is difficult to engage. Taylor et al. (1996) suggested that instead of working with their perceived reluctance the therapist would need to support the individual to be able to recognise their own feelings. However, Becker-Stoll and Gerlinghoff (2004) provided the only research that measured alexithymia in a treatment programme for eating disordered patients. They found the same that alexithymic scores improved over the course of the treatment. This was mostly accounted for by changes in scores for "difficulty identifying feelings" and a reduction in "externally orientated thinking". They concluded that even highly alexithymic patients benefit from psychological treatment, suggesting that it is worth persisting with even when changes may not be quick to happen.

To take a wider perspective on these issues, if therapy becomes increasingly inaccessible to clients with alexithymia and anorexia then it could be argued that society and mental health services could be discriminating against these clients. In this case such labels may have a negative impact on the client, and a consequence of this may be exacerbation of the client's disconnection from their own needs and feelings. The counselling psychology perspective advocates empowering an individual, as the Guidelines for the Professional Practice of Counselling Psychology outlines, it is the counselling psychologist's aim to "to recognise social contexts and discrimination and to work always in ways that empower rather than control and also demonstrate the high standards of anti-discriminatory practice appropriate to the pluralistic nature of society today" (BPS, 1998; p. 2). This might be an indication of a need to help such an individual to feel empowered in allowing and accepting their feelings, so that they no longer feel a need to control their basic needs or desire, as seen in anorexia.

Therefore, clients with alexithymia and anorexia should be supported in finding and expressing their own voice when they feel emotionally distressed.

Proposed therapy models for alexithymia in anorexia

This section will review the therapeutic approaches proposed in the literature to address both alexithymia and anorexia. These approaches advocate offering therapy to clients with alexithymia and anorexia but working within particular models. It also highlights the challenges that may present in the therapeutic relationship.

Skarderud (2007b) presented a new outline for treatment of anorexia based on the model of mentalisation. He proposed that alexithymia is linked to an impairment in mentalisation and that such psychopathological processes should be addressed in psychotherapeutic interventions. The deficits in the ability to understand oneself and others impacts on the self organisation and one's capacity to regulate affect.

He proposed that the presence of alexithymia contributes to the potential of transference re-enactments, because of the client's and sometimes the therapist's impairment in mentalisation (this impairment can be context specific). Skarderud (2007b) stated that both therapist and client factors (e.g. alexithymia) can have a positive and a negative contribution to the therapy encounter. Regarding alexithymia, he suggested that the client's incapacity to verbalise their inner states may contribute to long and frustrating silences in therapy.

Skarderud (2007b) stated that the therapist's difficulty in understanding the psychopathological processes, such as alexithymia, can lead to a lack of commitment and patience, coercive behaviours and can provoke aggression and rejection in the therapist's response toward the client. The lack of insight may also enhance the discomfort of a silent and restrictive session. Therapists may consequently experience this as being excluded from the clients inner experience because of their lack of sharing. It seems important for counselling psychologists to be aware of the impact of an individual feeling unable to identify and articulate their emotional world to their therapist. A lack of understanding of this could have a negative impact on their ability to build a therapeutic relationship with their clients and may evoke negative emotions within them. A sense of the importance of supporting the client to express their emotions in the therapy relationship is emerging from the literature. A possible way of coping with these negative feelings may be to want to get rid of them, which could result in the therapist or services discharging the client. This experience may reinforce the client's defenses and fears of rejection or abandonment. It is possible that this may mirror early experiences instead of providing them with an empathic response.

Skarderud (2007b) proposed therapy ideas as part of the model on mentalisation for anorexia. The ideas considered specifically pertinent to alexithymia will be discussed. He suggested "working in the here and now" (p.333) to work with the client's mental state as it arose in the session and work with the emotions about the past in the present. He proposed the importance of "marked mirroring" (p.333) which refers to mentally following the client and providing them feedback on the understanding of their experience. Fonagy and Bateman (2006) emphasised that the therapist must be able to recognise the separateness of their client's experience to their own. Skarderud (2007b) also suggested that the therapist is active in the session, not by interpreting but offering their tentative understanding of the client's experience. Bruch (1985) expressed that she felt being unresponsive in a session with these clients can be experienced as threatening; in a similar vein, being too active can be experienced as intrusive. Therefore, it seems being actively involved during sessions requires balance and Skarderud (2007b) suggested in line with Bruch (1985), that the classic psychoanalytic interpretation would not be as helpful as showing an awareness of the clients current internal state.

Finally, he identified the importance of exploring the context specific emotions in the therapeutic relationship and treating the transference as real, as opposed to it being phantasy, as it feels real to the client. Clinton (2006) reported that transference is fundamental in treating people with an eating disorder. If there has been a history of responses from the caregiver that have lacked being able to identify the individuals internal experience, then the individual may struggle to differentiate what feelings are theirs and what are the therapists. Likewise, the therapist may struggle to separate their feelings from their client's and, at times, the therapist may have to rely on their own experience to enlighten the client's.

Dolhanty and Greenberg (2009) proposed another model to address alexithymia in anorexia is "emotion focused therapy" (EFT; Greenberg, 2002). This approach involves processing emotional experience in order to deal with difficulties in affect regulation which has been found in the alexithymia research. EFT offers specific techniques to help individuals who have a tendency to inhibit their emotional experience in order to reduce alexithymia. It aims to encourage the reowning and expression of emotional experience.

Horton, Gewirtz, and Kreutter (1992) said that people with alexithymia attempt to soothe themselves in vigorous and physical ways, which can be seen in the attack on one's body in anorexia. Dolhanty and Greenberg (2009) proposed that clients need to be helped to "work through" their repressed painful experiences. Their ultimate goal is

to help the individual to tolerate and regulate their own experience. In order for this to happen the therapist needs to increase their awareness of their internal experience and encourage the client to reflect, symbolise, make meaning from and transform it into a positive form. They suggest that the individual needs an experiential process in order to fufill this process.

In a case study, Dolhanty and Greenberg (2009) practised this model on a female anorexic client and measured her alexithymia before and after the therapy. They found that her score on the TAS reduced from 'intermediate' to 'non-alexithymic'. On the interoceptive awareness subscale of the Eating Disorder Inventory (Garner et al., 1983), her pretreatment score fell within the range for anorexia, while her score at 18 months was in the normal range. This shows a marked improvement over the 18 months that the client was engaged in therapy but it is impossible to ascertain what it was about this experience that improved the results.

To understand this further, it needs to be compared to an alternative model of therapy in order to claim that the model is successful in improving quantitative measures of aspects associated with the client's illness. A larger sample is needed in order to be able to generalise this finding. However, it offers an interesting insight into a therapeutic approach with anorexia and alexithymia.

Both the models, EFT and mentalisation model reinforce the importance of the here and now acknowledgement of feelings in the session even when they may appear hidden. They both suggest that paying attention to the subtle indicators of emotion is important in therapy with these clients. This may be manifested in more concrete forms, or perhaps in the therapist's own emotional response to their client. It is proposed that counselling psychologists could draw from these models when working with an anorexic client, which could help to reduce alexithymic traits.

Challenges in the therapeutic relationship

In counselling psychology there is an emphasis on the quality of the therapeutic relationship (Goldsworthy, 2004; Strawbridge & Woolfe, 2004). The research so far has suggested that there may be a lack of a close therapeutic relationship when working with someone who is alexithymic and anorexic (e.g., Skarderud, 2007b; Taylor et al., 1996). This may impact on the outcome of therapy as the therapeutic relationship has been proposed to be an important predictor of a good outcome in therapy with the anorexic population (Thompson & Sherman, 1989).

Selvini-Palazzoli (1974) referred to the strain that alexithymia can have on the therapeutic relationship when working with an anorexic client. She said that the client

can appear uncooperative, distant and aloof. Such negative responses have been commonly reported with this client group which Garner (1985) proposed as a reason for iatrogenesis in therapy. Williams and Haverkamp (2010) found that developing and establishing a therapeutic relationship was a very important skill which was considered by a group of experts to be among the most critical required for minimally ethical practice with this client group. This suggests that neglect of this area is not practicing ethically with this client group.

Petterson (2004) provided a psychodynamic case study to illustrate how to focus on countertransference responses when faced with difficulties in a client exploring their feelings. She explained how shut out and uninterested a therapist can feel; the more the therapist tried to encourage the client to explore innermost feelings, the more unresponsive the client became. This is relevant as the research on alexithymia and anorexia concluded that therapy should be about helping clients to express their feelings. In light of Petterson's (2004) depiction, the therapist's attempts at this may result in the client's retreat, or an increased acting out of their feelings onto their bodies, as suggested by Skarderud (2007b).

Conclusion

The consistent finding from the studies on alexithymia in anorexia is that "difficulty identifying and describing feelings" contributes most to the prevalence of alexithymia in anorexia nervosa (Bourke et al., 1992; Taylor et al., 1996; Sexton et al., 1998; Speranza et al., 2005; Speranza et al., 2007). It can be concluded that this aspect of alexithymia is a stable trait as it has remained consistent even when depression was controlled for, and it suggests that alongside other biological, psychological and sociological aspects, anorexia may also be a solution to a difficulty in managing and describing feelings.

Anorexia is a complex illness and that there are many factors that contribute to its development. This review has highlighted that the concept of alexithymia in anorexia could be helpful for counselling psychologists to think subjectively with their client about their difficulties in identifying their feelings and how anorexia may be a way of dealing with this. It has been highlighted that this can be considered from outside of the medical model, to explore the possible psychological and sociological factors implicated in this for the individual.

The review has considered the impact of labelling somebody with anorexia as being alexithymic and how this might affect their treatment. Counselling psychologists endeavor to work subjectively with clients and in a way that empowers individuals

therefore the implications of labelling someone and using this to decide on the best course of psychological therapy needs considering on an individual basis. In the current climate within the health service it may feel difficult to assert subjectivity as a priority. It is possible that offering a space to be heard and empowered may be a step in the right direction for people with alexithymia and anorexia.

The therapeutic relationship is at the core of counselling psychology and this perspective can enhance the scientific research on alexithymia in anorexia. Whilst this area is developing in the psychological and psychiatric literature, and contributing to the understanding of anorexia as an "illness", it is helpful to re-focus and think about what this means for the client. As well as how the counselling psychologist can focus on the therapeutic relationship and the intersubjective field to support individuals in experiencing emotions.

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