

**FEMALE EATING DISORDER CLIENTS' BELIEFS ABOUT
FEMALE THERAPISTS' BODY SIZE AND EATING
BEHAVIOURS: AN EXPLORATION USING THEMATIC
ANALYSIS**

NICOLA M. RANCE

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Department of Psychology

Faculty of Health and Life Sciences

University of the West of England, Bristol

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Abstract

Although people with an eating disorder are known to observe and assess body related stimuli, research has yet to explore these behaviours in the therapy room. Consequently, little is known about clients' feelings about, and responses to, a therapist's body, or the potential for a therapist's body to have an impact upon the process and outcome of treatment. This lack of knowledge is problematic given client preferences and expectations can affect their willingness to engage in, and be influenced by, their therapist and the therapy process, and the fact that a fundamental part of the intra- and interpersonal experience of people with an ED is that of feeling invisible, unheard and worthless. It is also problematic given the poor recovery rates and high levels of drop out in eating disorders treatment and the fact that clinical guidance providers, researchers in the eating disorders (ED) field and individuals who have recovered from AN, all advocate psychological interventions as part of AN treatment.

This study begins the process of redressing this omission by exploring ED clients' beliefs regarding what is important about an ED therapist's body weight and shape, eating behaviours and relationship with food. Twelve women who self-identified as recovered or on the road to recovery from AN, and had received counselling for their ED from a female therapist, participated in semi-structured interviews. Thematic analysis was used to analyse the data and three overarching themes were developed. The first theme – “Wearing Eating Disorder Glasses” – described the women's observational tendencies. The second theme – “You're Making All Sorts of Assumptions as a Client” – illustrated the women's tendency to place great

emphasis on body-related visual information when forming their opinions of, and beliefs about, a therapist. And the third theme – Appearance Matters – demonstrated the ways in which the women’s observation-based assumptions seemed to have potentially far-reaching implications for their attitude towards the therapeutic endeavour.

Accordingly, the analysis offers preliminary evidence of a potentially important process taking place in the therapy room; namely, ED clients’ tendency to both observe their therapist’s body and eating behaviours, and make assumptions and judgements based on what they have seen. The analysis also suggests that ED clients’ assumptions and judgements may influence both their beliefs about their therapist’s ability to help them, and their willingness to engage in the therapeutic endeavour. Possible limitations of this study, areas for future research, and implications for practitioners in general and for counselling psychology and counselling psychologists in particular, are also discussed.

Introduction

When a body meets a body, no formal introductions are made ... As therapists, we focus on words but our bodies also speak Yet most accounts of therapeutic process mention very little of what the bodies mean to each other (Petrucci, 2008, p.237).

Although people with an ED are known to observe and assess body related stimuli (Lowell & Meader, 2005), and therapists working with ED clients have reported feeling that their appearance was being “monitored, examined or evaluated” (Warren, Crowley, Olivardia & Schoen, 2009), little is currently known about ED clients’ beliefs and preferences regarding a female therapist’s body size and relationship with food. As such, it is difficult to know if a client’s feelings about, and possible responses to, their therapist’s body can have an impact on the therapy process. This is problematic given that treatment success rates for AN¹ are currently poor (Bulik, Berkman, Brownley, Sedway & Lohr, 2007; Berkman, Lohr & Bulik, 2007; Fichter, Quadflieg & Hedlund, 2006; Löwe et al., 2001; Steinhausen, 2002), and drop-out rates are high (Fassino, Pierò, Tomba & Abbate-Daga , 2009; Mahon, 2000; Wallier et al., 2009). Consequently, client beliefs about, and responses to, their therapist’s body – and, in particular, the possibility that these beliefs and responses might have a negative impact on therapeutic outcomes – are a pertinent topic for investigation.

¹ Although it is acknowledged that not all approaches to eating disorders use the term ‘anorexia nervosa’, and that within the feminist literature in particular the term ‘anorexia’ is preferred, the former has been adopted in this thesis in recognition of its use throughout the majority of the literature in the ‘Literature Review’.

The lack of knowledge in this area is also problematic given that client preferences and expectations can affect their willingness to engage in, and be influenced by, their therapist and the therapy process (Arnkoff, Glass & Shapiro, 2002). It is thus possible that clients are not engaging with, or fully benefiting from, the therapeutic process due to their preferences and expectations regarding their AN therapist's body going unmet or unaddressed.

Furthermore, it is problematic that ED clients' views in relation to their therapist's body have gone unsolicited for so long given that a fundamental part of their intra- and interpersonal experience is that of feeling invisible, unheard and worthless (Reindl, 2001; Shelley, 1997). Additionally, the lack of knowledge is also problematic in light of the Government's long-standing commitment to both eliciting service user views (e.g., National Health Service (NHS) Institute for Innovation and Improvement, 2012; United Kingdom (UK) Department of Health, 2001, 2006) and improving the experience of care for people using mental health services (National Institute of Clinical Excellence (NICE), 2011).

Accordingly, this study was designed to begin the process of redressing the lack of research in this area by exploring female ED clients' beliefs about a female therapist's body size and relationship with food. In light of the current paucity of literature in the area, it was anticipated that the findings would provide new insights about female ED clients' experiences in the therapy room. It was also hoped that the results would provide clinically relevant information for practitioners regarding the ways in which they are being

perceived by their clients and the possible impact that these perceptions might be having upon therapy.

Literature Review

The literature review begins with the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5, 2013) definition of AN. Although it is recognised that psychiatric diagnosis has been criticised for such things as low reliability, overlap between categories, reductionism, and having unclear links with aetiology, prognosis and treatment (Bentall, 2004, 2010; Boyle, 2007; Harper, 2013; Johnstone, 2008; Moncrieff, 2010; Pilgrim, 2000, 2007; Weller, 2009), the DSM-5 (2013) criteria are presented at the beginning of the review because they are currently the "leading" scheme for classifying and diagnosing EDs (Fairburn, 2008). Moreover, the DSM-5 (2013) criteria are often referred to in the AN treatment outcome research literature and they are frequently used in NHS AN treatment settings.

Next, the body mass index (BMI) – a numerical heuristic proxy for human body fat based upon an individual's weight and height – is introduced. Like the DSM-5 (2013) criteria, the BMI is also commonly referred to in diagnostic, treatment and research discussions of AN (e.g., NICE, 2004). It is recognised, however, that the BMI is not without its problems. In particular, it has been criticised for its tendency to overestimate fat levels in athletes, underestimate fat levels in the elderly and 'thin', and, due to the fact that it does not distinguish between bones, fat and muscles, its inability to provide direct measurements of total body fat percentage (Bruen, 2011; Carlos Poston & Foreyt, 2002).

The stance taken in this thesis is that diagnostic criteria such as those in the DSM-5 (2013), and numerical instruments such as the BMI, can be helpful when clinicians and researchers require simple ways of communicating information to those around them (e.g., fellow clinicians, researchers, and supervisors). That notwithstanding, the view taken in this thesis is that reliance on such diagnostic criteria and numerical instruments can lead to the oversimplification (e.g., Boyle, 2007; Harper, 2013; Johnstone, 2008; Weller, 2009) of what is a very complex, multifaceted phenomenon. Accordingly, the DSM-5 (2013) criteria and BMI are seen as just one element of an ever-evolving body of theories and literature which are continually being developed to enhance our understanding of AN.

After the definitions section, research relating to the epidemiology of AN is reviewed. This section underscores the high mortality associated with AN and supports the importance of further research into treatment-related factors.

The most up-to-date UK treatment recommendations are then presented and an overview of the treatment outcome research is provided. This is done to both outline the treatment context of the study participants, and to summarise the existing research base pertaining to treatment. Furthermore, on the basis of the review, it is argued that while formal treatment recommendations exist, the research evidence for the efficacy of AN treatment is not compelling and that further research is needed in order to better understand the treatment process and improve treatment outcomes.

The review then looks at recent research which has sought to increase our understanding of AN by exploring the views and experiences of those who have recovered from it. In particular, this research highlights the importance of relational aspects of treatment and the provision of guidance, modelling and validation by therapists. Accordingly, it is again contended that clients' perceptions of, and responses to, their therapist's body and relationship with food may be an important area for future research as these perceptions and responses might be having an impact on the therapeutic relationship and the therapist's ability to be a respected model, guide and source of validation.

Theoretical conceptualisations of AN are reviewed next. These are discussed in terms of the degree to which they provide individually-, relationally- or socioculturally-focused explanations of the causal and maintenance factors involved in AN. Furthermore, it is posited that each theory (or group of theories) highlights factors which suggest that, in work with AN clients, it may be important to consider client's perceptions of, and responses to, their therapist's body and relationship with food. It is also proposed that such research might help enhance the theoretical models and, potentially, the treatments based upon them.

Lastly, the limited research and theory on the therapist's body in ED therapeutic contexts is reviewed and it is argued that there is a need to explore this area further. It is then contended that, due to the gendered nature of EDs, this research should begin by focusing on the perceptions of female clients who have received counselling from a female therapist.

Defining AN: The DSM-5 (2013) Diagnostic Criteria and the Body Mass Index

As discussed above, the stance taken in this thesis is that EDs can best be understood when they are conceptualised from multiple perspectives. That notwithstanding, as the DSM-5 (2013) criteria are currently the “leading” scheme for classifying and diagnosing EDs (Fairburn, 2008), and the BMI is an oft used tool in both treatment and research settings (e.g., NICE, 2004), both are presented here as constructs commonly used to ‘define’ AN.

According to the DSM-5 (2013), a diagnosis of AN can be made when three criteria are met:

- Restriction of energy intake relative to requirements, leading to significantly low weight in the context of age, sex, developmental trajectory, and physical health. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected;
- Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight;
- Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Furthermore, two subtypes of AN are specified in the DSM-5 (2013): ‘restricting type’ and ‘binge-eating/purging type’. ‘Restricting type’ is

specified when, during the last three months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour (e.g., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). In contrast, 'binge-eating/purging type' is specified when the individual has, during the last three months, engaged in regular episodes of binge eating or purging behaviour.

Some diagnostic, theoretical and research discussions of AN also refer to the BMI, a numerical heuristic proxy for human body fat based upon an individual's weight and height. The BMI is widely used in the UK NHS and is described on the NHS Choices website (the online 'front door' to the NHS which provides information on conditions, treatments, local services and healthy living; <http://www.nhs.uk/Pages/HomePage.aspx>) as: "a good way to check if you're a healthy weight." Furthermore, the website informs users that: "A normal BMI for adults is 20 – 25. People with anorexia generally have a BMI below 17.5" (<http://www.nhs.uk/Conditions/Anorexia-nervosa/Pages/Diagnosis.aspx>). The BMI is also referred to in the NICE ED Guidelines (2004) and is often used for assessing progress and recovery in ED treatment and research settings (e.g., Bulik et al., 2007; Crisp, 2006; Fairburn, 2005; Goss & Allan, 2010; Treasure, 2005). And in the DSM-5 (2013), the BMI is used as the basis for specifying the level of severity of AN in adults (Mild: BMI ≥ 17 kg/m²; Moderate: BMI 16-16.99 kg/m²; Severe: BMI 15-15.99 kg/m²; Extreme: BMI < 15 kg/m²). Though it is noted that the level of severity may be increased beyond that indicated by the BMI in order "to reflect clinical symptoms, the degree of functional disability, and the need for supervision" (p. 339).

Epidemiology

The average prevalence rate of AN for young women in Europe has been estimated at 0.29% with an incidence rate of eight cases per 100,000 head of population (Hoek, 2006; Hoek & van Hoeken, 2003). The incidence of AN in the UK in particular is 19 in 100,000 females per year, and two in 100,000 males per year; female teenagers aged 13 – 19 have the highest rate at 51 cases per 100,000 per year; the mean age of onset is 16 – 17; and around one in 250 women and one in 2,000 men will experience AN at some point in their lives (NICE, 2004). Additionally, 'b-eat' (2009) (the UK's largest national ED organisation) has estimated that 1.1 million people in the UK have an ED.

In Harris and Barraclough's (1998) meta-analysis of 152 published studies on the mortality of mental disorders in the 1990s, AN had the highest mortality risk – the 'all causes of death risk' was five times that expected (in a general population sample of similar age and gender), the 'unnatural causes of death risk' was 11 times that expected, and the 'natural causes of death risk' was four times that expected). Additionally, in Arcelus, Mitchell, Wales and Nielsen's (2011) meta-analysis of 36 published quantitative studies, the weighted crude mortality rate (i.e., the number of deaths within the study population over a specified period) for AN was 5.1 deaths per 1,000 person-years (the equivalent of 0.51% per year). Furthermore, one in five of the individuals with AN who died had committed suicide, and the standardised mortality rate (i.e., the ratio of observed deaths in the study population to expected deaths in the population of origin) was 5.86 with a mean follow-up period of 14 years. Finally, in a recent study of mortality in a

cohort of patients presenting to an UK ED Service, Button, Chadalavada and Palmer (2010) found that AN had a ten-fold increased risk of early death.

Evidence from epidemiological studies thus underscores the high mortality rate associated with AN and provides a powerful argument for further research which may help enhance outcomes and thus reduce the risk of death.

AN Treatment Recommendations

There are no formal treatment recommendations for private practitioners and counsellors working in non-statutory organisations. As a result, they can work with ED clients in whichever way feels most appropriate given their theoretical background, understanding of AN and the unique needs of their client. In contrast, in the NHS, ED treatment is guided by the NICE (2004) recommendations encapsulated in 'National Clinical Practice Guideline Number CG9'. This guidance covers the identification, treatment and management of EDs and was developed by a multidisciplinary team of healthcare professionals, patients, patient representatives, and methodologists after consideration of the "best available evidence" (p.7). As the NICE recommendations constitute the most formal treatment recommendations available to ED practitioners (those in private practice and non-statutory organisations can also choose to be guided by them), their recommendations in relation to the psychological treatment of AN in particular are summarised in Box 1. When considering these guidelines it is important to note that in the introduction to their recommendations regarding AN treatment, NICE state that:

Overall, the body of research into the treatment of anorexia nervosa is small and inconsistent in methodological quality. The conclusions that can be drawn are limited because many studies have no follow-up data, lack the statistical power necessary to detect real effects, and use different study entry criteria and outcome measures (NICE, 2004, p.81).

- Therapies to be considered include cognitive analytic therapy (CAT), cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT), focal psychodynamic therapy and family interventions focused on EDs
- Patient and, where appropriate, carer preference should be taken into account in selecting the type of therapy
- The aims of therapy should be to reduce risk, encourage weight gain and healthy eating, reduce other related symptoms and facilitate psychological and physical recovery
- Management should usually be on an outpatient basis
- Treatment should normally be of at least six months' duration
- Dietary counselling should not be the sole treatment
- For inpatients, a structured symptom-focused regimen with the expectation of weight gain should be provided
- Psychological treatment which focuses on both eating behaviour and attitudes to weight and shape, and wider psychosocial issues with the expectation of weight gain should be provided
- Following inpatient weight restoration, outpatient psychological treatment which focuses on both eating behaviour and attitudes to

weight and shape, and wider psychosocial issues with regular monitoring of physical and psychological risk should be provided

- The length of outpatient psychological treatment and physical monitoring following inpatient weight restoration should typically be at least 12 months

Box 1 Summary of NICE recommendations regarding the psychological treatment of AN

A common theme running through the guidelines is the recommendation that psychological treatment (both inpatient and outpatient) should encourage weight gain at the same time as focusing on both eating behaviour and attitudes to weight and shape, and wider psychosocial issues. In order to achieve this, practitioners will necessarily have to engage their clients in discussions about eating, body weight and shape. It thus seems intuitive that the therapist's body – whether it is explicitly spoken about or not – will come under the client's gaze (and perhaps even their scrutiny). As a result, it is important that research – such as that in this study – which explores client's feelings about, and responses to, their therapist's body, be undertaken. For only then will practitioners be informed about the possible impact of their body on their client, and the things they may need to do in order to facilitate successful treatment outcomes.

AN Treatment Outcomes

Systematic reviews of the AN treatment outcome literature suggest that, despite practitioners' best efforts, recovery rates are low (Bulik et al., 2007; Steinhausen, 2002). Indeed, based on their review of randomised controlled

trials for AN published between 1980 and September 2005, Bulik et al. (2007) concluded that both the evidence for AN treatment, and the evidence for treatment-related factors associated with efficacy of treatment, was weak. More specifically, outcome studies frequently report that 30-50% of those diagnosed with an ED do not recover and that, instead, they go on to experience long-term biological, psychological and social problems (e.g., Ben-Tovim et al., 2001; Fichter & Quadflieg, 2004; Reas, Williamson, Martin-Corby & Zucker, 2000; Steinhausen, 2002).

Additionally, according to a report written by Matthias Richard (2005) for the European collaboration Co-operation in Science and Technology (COST) Action B6 (a network concerned with the effectiveness of services for ED patients delivered under routine conditions in Europe), psychotherapeutic effectiveness rates across 12 European countries including Great Britain are between 30 and 40% for AN and bulimia nervosa (BN) at the end of psychotherapeutic treatment and at one-year follow-up. Furthermore, the effectiveness figures for the two treatment centres representing Great Britain were 17.7% for AN, 23.3% for BN and 13.8% for eating disorder not otherwise specified (EDNOS) at the end of treatment, and 27.6% for AN and 36.6% for BN at one-year follow-up (there were no follow-up figures for EDNOS).

In conjunction with the low recovery rates described above, AN treatment is also known for its high levels of drop-out (Fassino et al., 2009; Mahon, 2000; Wallier et al., 2009). The drop-out phenomenon is problematic due to its well recognised negative impact on long-term recovery (Fassino et al., 2009; Wallier et al., 2009), and its potential to undermine research results

when the dropping-out occurs in the context of a treatment trial or follow-up study (Mahon, 2000). In their comprehensive literature review of studies published between 1980 and 2009 which analysed the drop-out phenomenon in ED treatment, Fassino et al. (2009) found that drop-out rates ranged from 20% to 51% for inpatient treatment programmes and from 29% to 73% for outpatient programmes. Unfortunately they were unable to identify clear predictors of drop-out due to inconsistencies that arose as a result of methodological flaws and limited sample sizes. Reviews such as Fassino et al.'s (2009) are, however, comparatively rare due to the relative lack of comprehensive outcome research in the ED field generally (Guarda, 2008; Wilson, Grilo & Vitousek, 2007).

The systematic reviews of AN treatment outcome, and meta-analyses of AN treatment drop-out, discussed above suggest that treatment for AN could be enhanced. This conclusion echoes the findings presented by NICE (2004) and their assertion that “the research evidence base to guide decision making [in AN treatment] is very limited” (2004, p.80). It thus appears that there is a need for researchers and practitioners alike to continue seeking new avenues for exploration when it comes to both developing new treatments, and attempting to increase the efficacy of those currently available. To this end, it is proposed here that exploring the ways in which a therapist’s body might be perceived and responded to by their client, and the impact this could have on therapy, is one such avenue for future research. By directly seeking client input, it is also an avenue which recognises the beneficial contribution that service users can make to developing and delivering future treatments (Timulak et al., 2013).

The idea of extending our knowledge of AN by talking to those who have experienced it firsthand, is also at the heart of recent research which has sought to better understand the process of recovery and the elements of treatment that are particularly beneficial.

Client Views on Factors that Facilitate Recovery

Research examining client experiences of recovery from AN has employed both qualitative and quantitative paradigms. Those studies adhering to a quantitative methodology have tended to use limited-answer questionnaire-style measures where participants are asked to tick a box or rate a statement using a Likert-type scale (Likert, 1932). Vanderlinden, Buis, Pieters and Probst (2007), for example, invited both ED patients and therapists to evaluate which elements of the treatment process they considered the most important in the recovery process. In order to do this they developed a 20-item questionnaire based on the main therapeutic elements and tools offered to their patients. Participants had to rate list items such as 'Learning to eat normal portions', 'Improving my self-esteem', and 'Learning to relax myself', using an 11-point Likert scale where 0 meant 'not important at all' and 10 meant 'extremely important'. The three most important items according to patients were 'Improving self-esteem', 'Improving body experience' and 'Learning problem solving skills', whilst for therapists they were 'Improving self-esteem', 'Enhancing motivation to give up the eating disorder' and 'Improving body experience'. It is noteworthy that although there was considerable overlap in the items seen as most important by both the patients and the therapists, their opinions were not in

complete accord – a finding which highlights the fact that patients and therapists may not always view things in the same way.

In a similar vein, Bloks, Van Furth, Callewaert and Hoek (2004) investigated the relationship between coping strategies and recovery over a two and a half year period in 146 patients (72 with a diagnosis of AN, 47 with a diagnosis of BN, and 27 with a diagnosis of EDNOS) who had received intensive day or inpatient treatment for their ED. Also using a self-report questionnaire methodology, they asked participants to rate their use of various coping mechanisms on a 4-point Likert scale and found that recovery was associated with less 'avoiding', less 'passive reacting', more 'active tackling', and more 'seeking of social support'. As a result of being asked to respond to pre-determined list items, respondents in both studies were limited in terms of the information they were able to provide about their experiences (a problem frequently highlighted in relation to such questionnaire-based research e.g., Fine, 1992; Potter & Wetherell, 1987). Thus, whilst providing some insight into the respondents' beliefs about useful elements, tools and coping mechanisms in the treatment process, the studies were unable to shed light on additional factors (i.e., factors not offered as response items in the questionnaire) that the respondents believed to be important.

In contrast, studies utilising a qualitative methodology have tended to explore in more detail the actual experiences of people who have recovered, or are in recovery, from an ED (e.g., Button & Warren, 2001; Colton & Pistrang, 2004; D'Abundo & Chally, 2004; Federici & Kaplan, 2008; Lamoureux & Bottorff, 2005; Maine, 1985; Nilsson & Hägglöf, 2006;

Offord, Turner & Cooper, 2006; Tierney, 2008; Tozzi, Sullivan, Fear, McKenzie & Bulik, 2003). This literature has recently been systematically reviewed by Timulak et al. (2013) who conducted a meta-analysis of qualitative studies investigating helpful and unhelpful aspects of treatment. The 24 studies reviewed by Timulak et al. (2013) involved 1,058 participants with ages ranging from 11 to 50, and were variously conducted in Australia, Canada, Hong Kong, New Zealand, Norway, South Africa, Sweden, the UK and the USA. The six domains (and their meta-categories) identified in the meta-analysis as pertinent to the participants' experience of the helpful aspects of treatment were:

- Broader social support – support from co-patients; sharing with others; support from relatives, close ones and strangers
- Relational support from mental health professionals – trusting and supportive relationships with professionals; feeling understood/being listened to/having the opportunity to talk; being seen as a person; feeling cared for
- Important characteristics of mental health professionals – mental health professionals' (therapists') expertise; mental health professionals providing encouragement and guidance/modelling/validation
- Important general characteristics of treatment – importance of psychological therapy/importance of addressing interpersonal issues; client active in their own treatment/treatment collaboration; structure in the treatment; client soliciting social and professional help; treatment having a focus on symptoms; financial and other

accessibility; treatment focusing on the whole family; importance of follow-up interventions

- Important specific characteristics of treatment – self-monitoring/monitoring; behaviour change/experiments/gaining control; cognitive restructuring; nutritional knowledge/knowledge about detrimental effects of ED and ED itself; emotional expression/emotional awareness; importance of leisure activities/social distraction; therapy providing a 'holding space'; treatment focusing on interpersonal skills
- Important in-treatment changes contributing to the helpfulness of treatment – insight; self-acceptance/self-worth; learning about the self; change in life circumstances/positive life events

While there are clearly overlaps between some of the domain meta-categories listed above, and the findings of quantitative studies such as Vanderlinden et al.'s (2007) and Bloks et al.'s (2004), Timulak et al.'s (2013) meta-analysis demonstrates the breadth of factors that have been identified as beneficial to ED recovery in qualitative studies. This is important as it highlights the need for theoreticians and practitioners alike to think broadly when developing interventions. Additionally, in relation to therapeutic factors in particular, Timulak et al.'s (2013) meta-analysis also highlights the importance of clients' relationships with mental health professionals, and mental health professionals being perceived by clients as experts who can guide, validate and be a model to them. It also emphasises the importance of therapy which focuses on both symptoms and interpersonal issues, and of therapy which allows the client to develop self-worth and self-insight. It is

proposed in this study that one factor which could have an impact on both the client's relationship with their therapist, and the way in which they perceive them, is the therapist's body. For example, if a client is jealous of a 'thin'² therapist's body or distrustful of a 'fat' therapist's ability to model a healthy relationship with food, then therapy could be affected. Similarly, if a client feels inferior to a 'thin' therapist or sees a 'fat' therapist as lacking understanding of their experience, then, once again, therapy could be affected. Thus, if therapy is to meet the needs identified by clients, it seems vital that more be known about the possible impact of the therapist's body on the therapeutic process and relationship.

It is noteworthy that Timulak et al.'s (2013) meta-analysis highlighted clients' belief that therapeutic work should address multiple foci (e.g., symptoms, family dynamics, interpersonal issues) as this echoes the breadth of treatment foci, causal and maintenance factors that have been highlighted by the various theoretical literatures on AN which are now discussed.

Theoretical Accounts of AN

Multiple conceptualisations of AN exist (e.g., Bruch, 1973, 1978; Fairburn, Cooper & Shafran, 2003; Fox & Power, 2009; Goodsitt, 1969, 1983, 1985; Goss & Allan, 2009, 2010, 2012; Lawrence, 1984, 2001; Malson & Burns, 2009; Orbach, 1979, 1986; Zerbe, 2001), each proposing and highlighting different combinations of causal and maintenance factors. One possible way

² Throughout this thesis, when the words 'thin', 'fat', 'normal', 'healthy', 'overweight', 'underweight', 'obese' and 'emaciated' are used in relation to body size, they have been placed in inverted commas. This is to emphasise the fact that they are subjective terms which relate to the perceptual judgements of the person using them. As such, it is noted that a different person may use a different term when viewing the same body stimulus.

of making sense of this diverse group of theories, is to consider them in terms of the degree to which they provide explanations of AN which are individually-, relationally- or socioculturally focused.

Individually-focused accounts of AN. Individually-focused accounts of AN highlight causal and maintenance factors situated within the individual. Included in this group of theories are accounts which see EDs as individual (psycho)pathologies, 'disorders' of biology and/or of thinking patterns. Such theories posit genetic (e.g., Grice et al., 2002; Marx & Berrettini, 2003; Pekar, 2009), biochemical (e.g., Kaye, 2008; Kaye, Fudge & Paulus, 2009) and brain structure variations (e.g., Titova, Hjorth, Schiöth & Brooks, 2013), and neuropsychological impairments such as cognitive biases and deficits (e.g., Kidd & Steinglass, 2012; Lena, Fiocco & Leyenaar, 2004; Polivy & Herman, 2002) as causing and maintaining AN.

According to the cognitive biases literature, individuals' concerns with weight, shape, food and eating are underpinned by elaborate, inaccurate cognitive structures or maladaptive schemata (e.g., Fairburn et al., 2003; Vitousek & Hollon, 1990). These schemata are thought to guide information processing in ways that bias attention, memory and judgment (Williamson, White, York-Crowe & Stewart, 2004). And it has been suggested that repeated use of the schemata may cause weight, shape, food and eating concerns to become automatic and habitual (Williamson, Muller, Reas & Thaw, 1999), thus contributing to the maintenance of the ED. In keeping with this view, numerous treatment protocols (e.g., Fairburn, 2008; Waller et al., 2007) have been developed to 'correct' the so-called maladaptive schemata. Over the years these protocols have become increasingly

sophisticated and their focus has broadened to consider such additional factors as clinical perfectionism and interpersonal problems (Fairburn, 2008).

Although the cognitive deficits literature highlights individual-level factors as key to understanding the causation and maintenance of AN, it simultaneously acknowledges the possible relationship between such deficits (e.g., deficits in executive functioning, in attention, in visual-spatial ability and in memory) and various psychosocial developmental processes (e.g., physical and emotional maturation, interpersonal relationships, sense of autonomy, and healthy self-esteem). Accordingly, in their comprehensive review of the literature relevant to neuropsychological deficits in EDs, Lena et al. (2004) suggested that:

The development of [an] ED in adolescents with cognitive deficits may be viewed as a maladaptive behavior, devised to cope with normal adolescent developments and thereby minimize the stress associated with existing neuropsychological deficits. For example, preexisting deficits in executive functioning domains may diminish the ability to assimilate physical changes, which in turn may render physical and emotional maturation development difficult to attain (p.111).

Empirical evidence for cognitive deficits, automatic thoughts, underlying assumptions, cognitive distortions (focused on food, eating, weight and shape), and negatively and strongly held schemas and core beliefs about the self are well established in both individual studies and reviews (see Cooper, 1997, 2005, and Lena et al., 2004, for reviews). Less well

evidenced, however, are the hypothesised causal links between cognition and behaviour. Indeed, there is either no, or contradictory, evidence in relation to some of the original assumptions made about the links between weight and shape concerns, dieting and binge eating (Cooper, 2012).

Treatment consistent with the cognitive biases and deficits perspective tends to be cognitive-behavioural (e.g., Fairburn, 2008; Waller et al., 2007) in nature and often involves neuropsychological evaluations to help identify an individual's deficit profile (Kidd & Steinglass, 2012). More recently, adjunctive treatments for deficits that are typically associated with EDs have also been developed. For example, Cognitive Remediation Therapy (CRT) was specifically developed to improve thinking processes and enhance cognitive flexibility (Lopez, Davies & Tchanturia, 2012; Tchanturia, Davies & Campbell, 2007; Tchanturia, Lloyd & Lang, 2013).

With regards to treatment, although the NICE guidelines (2004) recommend CBT for BN, its long-term efficacy is limited (Cooper, 2012) and, when used with AN, CBT has not been particularly successful (Cooper, 2012). It has been suggested that this is the result of limitations in current cognitive theories and that it is constraints in our understanding of AN, and perhaps of the strategies needed to deliver therapy, that is curbing treatment outcomes (Cooper, 2012). If this is indeed the case, then it seems important that new theories be developed which pay attention to issues and areas not presently being addressed. To this end, it is noteworthy that the cognitive literature does not talk about the way in which the conjectured cognitive distortions and deficits might be active in therapeutic settings. For example, do they

impact upon the way in which the client sees or interacts with their therapist?

Given that the distortions and deficits are known to be active in relation to food, weight and shape stimuli in particular (see Cooper, 1997, 2005, and Lena et al., 2004, for reviews), it would be beneficial to know if a client's perceptions in the therapy room are affected (e.g., Is the therapist's body being seen or judged in a 'distorted' way? Are assumptions about a therapist's eating behaviours and body management practices being made? Do such perceptions, judgements and assumptions impact upon therapy or the therapeutic relationship?). A better understanding of this may allow for further development of both the cognitive theories and the treatments based upon them. Accordingly, it is suggested that this study could provide information that might be useful in enhancing AN treatment outcomes.

One of the criticisms that has been made of the cognitive models is the fact that they do not fully incorporate emotional states (Cooper, 2012). The importance of emotions in EDs has become increasingly recognised in recent years and a number of theories which focus on their possible roles in the development and maintenance of EDs have been advanced (see Fox & Power, 2009, Fox, Federici & Power, 2012a, and Nowakowski, McFarlane & Cassin, 2013, for reviews). This group of theories is relatively new as, for many years, emotions were relatively neglected by both the theoretical and research ED literatures (Fox et al., 2012a; Treasure, 2012). Emotion-based models of EDs are now, however, being developed in order to explain the triggering role of emotions in ED behaviours, the functions of ED behaviours in managing emotions and the reasons why EDs develop as emotional

coping mechanisms (see Fox & Power, 2009, Fox et al., 2012a, and Fox, Federici & Power, 2012b, for reviews).

Furthermore, there is also research which supports both conceptualisations of EDs that emphasise the role of (poor) emotional functioning in the development and maintenance of EDs (e.g., Bydlowski et al., 2005; Haynos & Fruzzetti, 2011; Svaldi, Griepenstroh, Tuschen-Caffier & Ehring, 2012), and the possible links between emotions and the expression of ED symptoms (e.g., Davies, Swan, Schmidt & Tchanturia, 2012; Harrison, Sullivan, Tchanturia & Treasure, 2009; Wildes, Marcus, Bright & Dapelo, 2012). Although emotion-based accounts are individually-focused in terms of their emphasis on the individual's difficulties in managing their emotions, they do highlight developmental factors beyond the immediate confines of the individual (e.g., family environment and attachment relationships) as important factors in the development of adolescent/adult emotional difficulties (e.g., Fox et al., 2012a).

Treatments consistent with emotion-based accounts include the Schematic Propositional Analogical Associative Representation System (SPAARS) model applied to EDs (SPAARS-ED model; Fox & Power, 2009), Dialectical Behaviour Therapy (DBT; Linehan, 1993) and Emotion Focused Therapy (EFT; Greenberg, 2004; Dolhanty & Greenberg, 2007). Empirical tests of the SPAARS-ED model have yet to be published but guidance regarding assessment, formulation and interventions has been developed (see Fox & Power, 2009, and Fox et al., 2012b, for further details). Evidence for the use of DBT in the treatment of EDs has recently been subjected to systematic review by Bankoff, Karpel, Forbes and Pantalone (2012). Based on their

review of 13 studies which empirically evaluated DBT treatment efficacy across various settings, the authors concluded that although DBT treatments appeared effective in addressing ED behaviours and other forms of psychopathology in the samples, the idea that improvements in emotion regulation capabilities would drive further reductions in ED pathology was not fully supported. The evidence base for EFT currently consists of Dolhanty and Greenberg's (2009) case study of a client who, at 18 months post-treatment, had maintained the weight she gained in hospital and shown improvements on self-report measures of mood and emotional awareness.

Although the evidence base for emotion-focused models of EDs could clearly be further developed (indeed, Fox et al., 2012b, stated that they hoped their review of emotional models would inspire more emotion-centred research in the ED field), the theoretical propositions nonetheless have implications for practitioners. In particular, it seems important that practitioners be aware of the possible ways in which they could provoke or elicit emotional responses in their clients. For example, it may be the case that their body weight or shape – especially if they are particularly 'thin' or 'fat' – might be experienced in a threatening way by their client.

Understanding whether or not, and how, such reactions impact upon the therapy and therapeutic process will potentially be of use to all those who work with emotions and want to better understand the experiences of their clients when in the therapy room.

One model which has suggested a possible role in EDs for threat in particular, is Compassion Focused Therapy for EDs (CFT-E; Goss & Allan, 2009, 2010, 2012). CFT-E is an extension, and specific application, of the

principles of Compassion Focused Therapy (CFT; Gilbert, 2009, 2010). CFT was originally developed to help people with complex, chronic issues surrounding shame and self-criticism, who often came from abusive or neglectful backgrounds (Gilbert, 2010). It was also designed to address the “cognition-emotion problem” wherein clients reported being able to “see the logic of generating alternative thoughts, or engaging in various exposures” (using traditional cognitive behavioural interventions e.g., Socratic questioning, behavioural experiments), without actually feeling any different (Gilbert, 2010, p.98). In relation to EDs in particular, CFT-E argued that if clients did not “feel” that new ways of thinking and behaving were helpful, they would be unlikely to “make the necessary behavioural changes to overcome their ED” (Goss & Allan, 2012, p.304). CFT-E was thus developed to “improve the emotional congruence of the more adaptive thoughts used to challenge eating disorder cognitions” (Goss & Allan, 2012, p.304). It also aims to address causal and maintaining factors such as emotion regulation difficulties (Bydlowski et al., 2005; Harrison et al., 2009; Haynos & Fruzzetti, 2011; Svladi et al., 2012), self-directed hostility (Williams et al., 1993) and issues of shame and pride (Goss & Allan, 2009), and to help clients normalise their eating and weight (Goss & Allan, 2009, 2010, 2012).

CFT-E draws upon the original CFT model which is based on evolutionary and neuroscience findings relating to the existence of specific types of affect regulation systems in the brain (Gilbert, 2009, 2010). In CFT, three specific affect regulation systems are highlighted in relation to the detection and management of threat (Gilbert, 2009, 2010). The first, the “threat-detection

and protection system”, is associated with rapidly activated emotions (e.g., anxiety, disgust and anger), and defensive behaviours such as flight, fight, avoidance and submissiveness. The second, the “drive, vitality and achievement system”, is related to emotions of (anticipated) pleasure and excitement and also to approach and engagement behaviours. And the third, the “soothing and contentment system”, is connected with peaceful well-being, and with affiliation with, and affection from, others which enables people to experience social connectedness and being soothed by others or oneself.

It is further suggested in CFT (Gilbert, 2009, 2010) that many people who have had to cope with difficult or traumatic early life experiences are unable to fully develop their soothing system and that they can consequently become especially sensitive to threat. Moreover, as a result of their sensitivity to threat and their inability to use the soothing system to calm down or seek help from others, it is suggested that they can go on to develop multiple strategies for coping with internal and external threats (Gilbert, 2009, 2010). In the CFT-E conceptualisation of EDs (Goss & Allan, 2009, 2010, 2012), it is argued that ED behaviours (such as calorie counting and body checking) are used “in an attempt to regulate threat via the drive system” (Goss & Allan, 2010, p.148), and that the pride which is felt as a result of behaviours designed to regulate affect (e.g., restricting food intake, losing weight) may also help to regulate threat. At the same time, however, it is suggested that the success of these strategies can prevent healthier, affiliative or self-soothing affect regulation strategies from developing (Goss & Allan, 2009, 2010, 2012).

Additionally, in CFT it is asserted that detection of, and attention to, potential threats (the first elements in developing threat-coping strategies) tends to occur automatically, rapidly and outside of conscious control (Gilbert, 2002). And in anxiety disorders studies it is suggested that attention mechanisms are not only an important initial step in detecting threat but also important factors in the causation and maintenance of the disorders (e.g., Clark, 1999). Accordingly, in CFT-E it is asserted that “increased sensitivity to size-, shape- and food-related information”, and “increased attention to external social cues from others regarding size, shape and weight” are attention mechanisms used as threat detectors (Goss & Allan, 2009, p.307). Furthermore, it is also suggested within CFT-E that people with an ED are likely to compare themselves to others – particularly in domains such as body weight – and that a vicious cycle can develop wherein: “The development of catastrophic imaginal scenarios, linked with anxious arousal, may lead to further rumination, which in turn links to greater sensitivity to threat cues” (Goss & Allan, 2009, p.307).

It is clear from the discussion above that the CFT-E propositions lend support to the idea that the therapist’s body might be an important factor in therapeutic work with clients who have an ED. More specifically, if a client’s attention and threat detection mechanisms are in operation within the therapy room, then a general increase in sensitivity to size-, shape- and food-related information could mean that the therapist’s body and eating become objects of particular attention to their clients. Similarly, if a client has increased attention to external social cues from others regarding size, shape and weight, they might be particularly alert to any verbal and non-

verbal information offered by their therapist in relation to these domains. Furthermore, if clients engage in increased levels of social comparison in general, then it is possible that, when in the therapy room, they will compare their size, shape and weight to that of their therapist. And, if they find themselves wanting in comparison to their therapist, they may start catastrophising and ruminating in ways which make them experience the therapy room itself as a threatening place. Understanding whether or not these behaviours are taking place, and the possible impacts of them on the therapy process (if they are), is thus an important area for exploration.

Although the CFT-E programme is still subject to clinical audit, Goss and Allan (2012) report that data thus far “suggests CFT-E is a promising and potentially effective treatment for EDs, including AN” (p.312). In a study exploring the outcome of introducing CFT into a standard ED treatment programme, Gale, Gilbert, Read and Goss (2012) found (using routinely collected questionnaire data of cognitive and behavioural aspects of EDs and social functioning/well being; n = 99) “significant improvements” on all questionnaire measures. More specifically, they found that 73% of those with BN, 21% of those with AN and 30% of those with atypical EDs were considered to have made clinically reliable and significant improvements at the end of treatment.

In summary, the individually-focused theories described above offer practitioners insights into a number of factors that may be of importance when working with ED clients. At the same time, however, by focusing almost entirely on the individual (albeit with acknowledgement being made – to a greater or lesser degree – of the fact that an individual’s development is

influenced by those around them) they may be missing crucial interpersonal factors (see discussion below about relationally-focused accounts of AN) that cause and or maintain EDs. Furthermore, without prospective population studies it is unclear whether (or to what extent) cognitive biases and deficits (e.g., Kidd & Steinglass, 2012; Lena e al., 2004; Polivy & Herman, 2002), emotions (e.g., Fox & Power, 2009; Fox et al., 2012a; Nowakowski et al., 2013) and suboptimally developed threat regulating systems (Goss & Allan, 2009, 2010, 2012) are causal factors in the development of EDs or outcomes that arise as a result of ED behaviours and thought patterns. That notwithstanding, as discussed above, the individually-focused theories all lend support for the idea that a therapist's body might be important in work with AN clients and that, as such, it is a promising avenue for future research.

Further support for the idea that aspects of a therapist might be therapeutically important can be found in the relationally-focused accounts of AN which suggest that relationships play a crucial role in the development and maintenance of EDs.

Relationally-focused accounts of AN. Psychodynamic theories of EDs focus on the functional role of ED symptoms and the idea that EDs are ways of dealing with relational and emotional difficulties (Winston, 2012). They have evolved alongside developments in psychodynamic theorising in general and have thus been variously influenced by ego psychology (e.g., Erikson, 1965; Freud, 1968, 1973), object relations (e.g., Bion, 1962a, 1962b, 1963, 1967; Balint, 1952, 1959, 1965, 1968; Fairbairn, 1952a, 1952b, 1954, 1963; Greenberg & Mitchell, 1983; Kernberg, 1975, 1976,

1980, 1988; Klein, 1930, 1932, 1946, 1957; Mahler, 1958, 1967, 1972; Winnicott, 1958, 1964, 1971), attachment theory (e.g., Bowlby, 1969, 1973, 1979, 1980) and self psychology (e.g., Kohut, 1971, 1977). For example, as psychodynamic theories about the organisation of the self developed and the importance of the mother-infant relationship on child development became increasingly recognised both in the literature and by clinicians, so aetiological explanations of EDs which drew upon these theories were proposed (e.g., Bruch, 1973, 1978; Lawrence, 1984, 2001).

Influenced by object relations and attachment theories in particular, practitioners such as Bruch (1973, 1978) and Lawrence (1984, 2001) offered formulations of AN which saw symptoms as representative of disturbances in relationships (particularly the early relationship with the mother). Bruch (1973) saw AN as a failure to develop autonomy from parenting figures (especially the mother) which developed around three inter-related ego disturbances: distortions of body image, internal perception, and a sense of ineffectiveness. Accordingly, she suggested that AN represented a “struggle for control, for a sense of identity, competence and effectiveness” (Bruch, 1973, p.24), which is triggered during adolescence when greater independence and assertiveness are required. Furthermore, Bruch proposed that AN offers protection from unwanted emotional intrusion – the taking in of food being confused with the taking in of others’ (especially the mother’s) emotions (Bruch, 1978).

In many ways Bruch’s work in this area can be thought of as a forerunner to the emotion-based theories discussed above. Her approach to treatment differed from more recent emotion theories, however, as she focused not on

developing emotion regulation skills but on enabling patients to uncover their own abilities, resources and capacity to think, judge and feel. Indeed, Bruch rejected traditional psychotherapeutic methods – in particular the use of interpretation and the early formulation of underlying psychodynamic issues. Instead she preferred to focus on developing a client's ability to recognise and make decisions about their own needs, and become more aware of their participation in other areas of life (in particular their relationships to others) so that “the eating function no longer needs to be misused as a pseudo-solution” (1973, p.343).

If a key role of the therapist is to help her client not only uncover skills and resources, but also develop a sense of identity, competence and effectiveness, then it is important that the therapist does not inadvertently make the client feel inadequate or inferior. If the therapist's body or relationship with food is perceived by the client as somehow better than their own (e.g., if the therapist is seen as being 'thin' without having to struggle with her weight, or if she is seen as having a controlled relationship with food which is free from bingeing or purging), then the client might feel self-hating or out of control as a result. Research which explores whether or not such clients have such thoughts or responses to their therapist's body is thus important in understanding whether or not there are hidden – potentially therapy interfering – processes occurring in the therapy room itself.

Also working from an object relations and attachment perspective, Lawrence (2001) conceptualised AN as a fear of intrusion and a way of reinforcing “phantasies” of control of the internal world (including the mother

and father objects). Although Lawrence (2001) advocated psychoanalysis or psychodynamic psychotherapy for AN, she stated that recovery was possible without it – as long as “a relationship on which to depend” was found (p. 26). Furthermore, Lawrence (2001) wrote in detail about the complexities of making a helpful relationship with a client who has an ED and highlighted, in particular, the implications of the client’s fear of intrusion (e.g., the inevitability of the therapist being experienced as intrusive). Although Lawrence does not directly address the issue of the therapist’s body, it is possible to imagine that a ‘fat’ therapist might be perceived as especially intrusive due to the physical space she would take up. How this would be experienced by the client and whether or not it might impact upon – or need to be addressed in – therapy are currently unknown factors. In order to fully optimise therapeutic interventions and establish a relationship upon which a client can depend, it seems important that such issues be explored and better understood.

The importance of interpersonal relationships in the developmental process in general, and in the development of AN in particular, is also emphasised within the self-psychology school (e.g., Kohut, 1971). From this perspective, scholars such as Goodsitt (1969, 1983, 1985) have suggested that AN symptoms represent both a disruption of the self and an adaptive defensive measure against further disruption. Developmental deficits arising from a lack of empathic mirroring and idealisation in maternal responses during childhood are thought to lead to an inability to regulate and maintain self-cohesion and self-esteem (including control of the body). As a result, the growing child is thought to experience a lack of integrity of the self, bodily

helplessness and a sense of being out of control internally, alongside a sense of being overwhelmed by anything that is imposed or provided externally. Once again, adolescence is seen as the triggering period due to emotional and bodily changes being experienced by the individual as threatening as they herald the onset of separation and the need for self-sufficiency as an adult woman. Goodsitt (1983) suggests that the therapist's role is to recognise and actively fill the client's deficits: "We make ourselves available as transitional objects ready to fill the deficits of the patient. When this goes well, our patients tell us: 'When I am feeling better about myself, I no longer obsess about food and weight'" (p.59).

In relation to the idea that the therapist's role is to be available to their client as a transitional object, Goodsitt (1983) uses the example of the therapist making themselves available as an external tension regulator if the client experiences profound tension states. He also suggests that if the client reveals cognitive deficits in organising their assumptions, priorities and goals, the therapist can actively fill these deficits by providing external assistance in organising the client's life coherently. Yet no mention is made of the ways in which a therapist might make their body, or their relationship with their body, available to their client as a transitional object. For example, if a therapist is comfortable in their own body, their client might be able to use this as an external regulator for their own body discomfort. Research which looks at client's thoughts about, and responses to, their therapist's body would consequently help enhance our understanding of whether or not such transitional object processes might be taking place (or able to take place) at a bodily level.

In conclusion, the relationally-focused psychodynamic theories of AN suggest that food restriction and weight management are used by someone with AN to cope with disturbances in relationships (Bruch, 1973, 1978; Lawrence, 1984, 2001), to foster a sense of identity, competence and effectiveness (Bruch, 1973, 1978), to reinforce “phantasies” of control of the internal world (Lawrence, 2001), to protect against unwanted emotional intrusion (Bruch, 1978) and to defend against further disruption of the self (Goodsitt, 1969, 1983, 1985). As discussed above, although none of the theories pay direct attention to the therapist’s body and the way in which it might have an impact on therapy, in each instance it seems possible that the therapeutic process might be affected by the client’s experience of, and responses to, their therapist’s body. Given that such responses could lead to difficulties in the therapeutic relationship, and that relational distress is one of the factors posited by these theories as a causal factor underlying food restriction and weight loss behaviours, it seems important that research exploring the client’s experience of their therapist’s body be undertaken.

In terms of psychodynamic treatments for AN, contemporary practice tends towards an integrative stance that allows practitioners to draw from the various models and increase their overall understanding of the underlying causes of ED symptoms (Zerbe, 2001). Furthermore, efforts have, and are, being made within the field to go beyond the traditional realms of psychodynamic theorising to incorporate, in a more explicit way, findings and observations from biological, cognitive, sociological, feminist and family approaches (e.g., Dare & Crowther, 1995; Tobin & Johnson, 1991).

Evidence for the efficacy of psychodynamic psychotherapy in the treatment

of AN is, however, limited as very few studies have been carried out (Fonagy, Roth & Higgitt, 2005; Winston, 2012). Those that have been conducted (Bachar, Latzer, Krietler & Berry, 1999; Crisp et al., 1991; Dare, Eisler, Russell, Treasure & Dodge, 2001; Hall & Crisp, 1987; Russell, Szmukler, Dare & Eisler, 1987) suggest that psychodynamic psychotherapy is as effective as the treatments it was compared with (which included cognitive analytic, cognitive orientation, behavioural and family therapy) and that it “holds its own” relative to ‘treatment as usual’ (Fonagy et al., 2005). That notwithstanding, like the treatments based on the individually-focused theories of AN, the efficacy of treatments based on the relationally-focused factors described above could still be improved.

One way of doing this might be to design treatment interventions which take into account not only the factors highlighted by the individually- and relationally-focused accounts of AN, but also those emphasised in socioculturally-focused accounts of AN.

Socioculturally-focused accounts of AN. These accounts consider the impact on an individual’s identity, subjectivity and self-development of both the socio-cultural, political and gender-specific contexts within which they reside, and the discourses and discursive practices available to them in those contexts (e.g., Bordo, 2009; Lawrence, 1984; Malson & Burns, 2009; Nasser & Malson, 2009; Orbach, 1979, 1986; Sesan 1994).

The largest body of work in this area is the feminist literature which has, since its earliest days, provided aetiological accounts of EDs based on an exploration of the personal and cultural meanings of disordered eating.

These accounts date back to the 1970s when feminist writers and practitioners began to question and critique the localisation of women's and girls' ED 'pathology' as being within the individual. Works such as Orbach's *Fat Is a Feminist Issue* (1979) and *Hungerstrike* (1986) argued that the extreme body management practices of women and girls with an ED could only really be understood by looking at them within the context of the inequalities in gender-power relations and the oppressive gender ideologies that exist in western patriarchal cultures. Indeed, Orbach (1986) contended that, for women:

An obsessive involvement with food flows out of a cultural insistence that what they eat, how much they eat, and how they cook for others, is their special domain. Food is the medium through which women are addressed; in turn, food has become the language of women's response (p.3).

Similarly, Orbach (1986) proposed that "for women themselves, the body has become a commodity within the marketplace ... the object with which they negotiate the world" (p.16). It is against this backdrop that Orbach (1986) situates AN as: "the excruciating spectacle of women actually *transforming* their bodies in their attempts to deal with the contradictory requirements of their role in late twentieth-century America (sic) and England" (p.4).

As the feminist literature grew and developed, new perspectives emerged and traditional accounts were critiqued both for being grounded in the experiences of white, middle-class, heterosexual women in Western cultures (Bordo, 2009; Nasser & Malson, 2009), and for conceptualising

EDs as forms of either extreme conformity or steadfast resistance to cultural norms (Malson & Burns, 2009). Drawing upon postmodern and post-structuralist theories, critical qualitative methodologies and sociological perspectives (e.g., Hepworth, 1999; MacSween, 1993; Malson, 1998), these newer 'critical' feminist approaches argued that EDs are not inherently conformist or resistant, but rather they are: "discursively constituted and regulated categories of subjectivity" (Malson & Burns, 2009, p.2). These accounts thus problematised both the idea (presented in the early feminist work) that EDs are individual responses to patriarchal cultures, and, more generally, the divide between the 'normal' and the 'pathological' (for everything can be 'normal' and 'pathological' depending upon how it is constituted; Malson & Burns, 2009). Thus these accounts provide a critique of the biomedical and psychiatric models of illness (Eckermann, 2009), and are in conflict with the practice of diagnosis (which depends upon the reification of EDs), with diagnostic criteria such as those in the DSM-5 (2013), and with numerical measures such as the BMI. Indeed, such psychiatric constructs are seen by these accounts as playing a role in the discursive construction of AN (Malson, 1998).

Yet, despite opening up the theoretical arena of EDs beyond that of the individual and their relationships, these newer, critical feminist theories which "allow for multiple and contradictory influences on the individual" (Eckermann, 2009, p.18), have not yet considered the possible influence of the therapist's body. Similarly, no attention is paid in them to the implications of both client and therapist being embedded in – and potentially affected by – the same (or similar) cultural and gendered discursive

practices. As a result, the therapist's body, and its potential impact on the therapeutic relationship and therapy process, remain overlooked and untheorised even within the critical feminist literature. It is thus suggested here that the feminist ED literature may be usefully developed by giving consideration to the potential impact and importance of the therapist's body in work with clients who have AN.

Although feminist theories have produced feminist therapies, there is no singular 'feminist therapy' (Evans, Kincade, Marbley & Seem, 2005; Guilfoyle, 2009). Nonetheless, feminist therapies are united in their valuing of gender as a central organising pillar of an individual's life, and their emphasis on the fact that individuals cannot be separated from their culture (Evans et al., 2005). Feminist ideas can thus be combined with a range of therapies (e.g., object relations, cognitive therapy, systems therapy, narrative therapy; Guilfoyle, 2009) in ways which help clients to explore the inherent contradictions in prescribed social roles, and consider the possibility of changing rather than conforming to the roles available to them (Sesan, 1994). Feminist therapies are also sensitive to the fact that a high percentage of women have experienced victimisation at some time in their life; they also acknowledge the impact of sexism and the oppression of women, and the idealisation of masculine qualities and devaluation of feminine qualities within Western culture; they strive to minimise the power differential between therapist and client; and they reject the idea that psychological distress is internally rooted (Evans et al., 2005; Magnet & Diamond, 2010; Orbach, 1986; Sesan, 1994).

The research base for feminist theories of EDs and for feminist therapies is lacking. This may be because feminism is a political, and not an evidence-based, practice and empirical studies such as randomised controlled trials are at odds with the premises of feminism (Wilkinson, 1997a, 1997b). That notwithstanding, for the purpose of this study, it is important only to note that the author was unable to find any studies which empirically investigated either the putative causal factors highlighted in the feminist theories of EDs, or the efficacy of feminist therapies in the treatment of EDs.

In summary, socially-focused accounts of AN move beyond the individual and their relationships to highlight the possible role played by an individual's context in predisposing them to need and find meaning in ED symptoms. Accordingly, they offer an explanation for why it is that some women use food and their bodies to modulate and resolve the stressors and mixed messages that have arisen as the gender roles and expectations of them have been transformed in the last quarter of a century (Maine & Bunnell, 2008). Even so, although these theories are indeed positing potentially important causal and maintenance factors, they are in fact providing a social level explanation of *why EDs happen*. As a result, they do not aid practitioners in understanding *why particular* women and girls, and men and boys, develop EDs. Nevertheless, the emphasis in these theories on the fact that *all* women are – to a greater or lesser degree – affected by the cultural nexus within which their relationship with their body is constructed, lends support to the idea that a therapist's body may be important in work with client's who have AN. As Orbach (1986) explains: "The multitude of images and meanings that women's bodies represent, forms a part of each

individual woman's relationship with her own and other women's bodies" (p.16). Given that women look at, and are aware of, one another's bodies, it seems likely that clients will look at (and potentially judge, scrutinise and compare their own body to) their therapist's body. Exploring the ways in which this can impact upon the therapy process and therapeutic relationship is thus an important focus for research.

The review above has outlined the key premises, treatment recommendations and, where possible, treatment outcomes for the main individually-, relationally-, and socioculturally-focused accounts of AN. Although the accounts were separated for clarity of exposition, there has been a trend more recently towards integration when thinking about, and working with, people who have AN (e.g., Zerbe, 2008).

Integration in contemporary AN theorising. Having considered, in turn, the individually-, relationally- and socially-focused theories of AN, it is clear that although each of them has explanatory value, none of them fully account for the development and maintenance of AN. This is perhaps unsurprising given that EDs lie: "at the interface between body and mind, emotions and cognition, childhood and adulthood and most of all between the individual, the family and society" (Caparrotta & Ghaffari, 2006, p.191). Similarly, in their comprehensive review of the research literature pertaining to the development of EDs, Polivy and Herman (2002) highlighted the fact that:

The interaction of etiological factors in a complex behavioural syndrome such as EDs is difficult if not impossible to capture. There are so many possible influences that their particular combination in

any given individual becomes almost unique, and thus impractical to generalize to others (p.205).

Indeed, Polivy and Herman (2002) went on to conclude their review with the suggestion that practitioners may have to be satisfied with recognising contributory risk factors and devising therapies, without empirical clarity about what actually causes an ED in any given individual. Many of these sentiments were shared by Strober and Johnson (2012, p.157) who, in their extended clinical forum paper on 'The need for complex ideas in anorexia nervosa', explained that: "It isn't closure around simple models that's needed, but rather efforts that seek connections between once separate lines of enquiry." Furthermore, the idea of seeking connections has also been put forward by Clinton (2006) who has highlighted the importance of integrating perspectives across academic disciplines if our understanding of EDs is to be enhanced.

In line with these views, the stance taken in this thesis is that treatments which draw inspiration and understanding from multiple theoretical approaches might be better at helping clients fully address their unique need for, and use of, AN. It is recognised, however, that while integrative therapeutic practice is commonplace in the UK (Lowndes & Hanley, 2010), tensions exist between some of the individually-, relationally- and socioculturally-focused theories of AN (e.g., as highlighted in the review above, the critical feminist literature directly rejects the psychiatric conceptualisations and diagnostic criteria presented, for example, in the DSM-5, 2013). For some practitioners integration may thus be problematic. Such practitioners may nevertheless be able to broaden the scope of their

work with AN clients by looking at subjects that lend themselves to being explored from the individual, relational and social levels outlined above. It is suggested here that one subject that lends itself to such an approach is that of the therapist's body – or, more specifically, the client's thoughts, feelings, judgements and assumptions about it. Accordingly, it is possible that the therapist's body could be used as a locus for working across theories.

For example, by addressing this subject in the therapy room, a therapist could explore their client's ways of thinking about others' bodies and, if cognitive and perceptual 'distortions' were uncovered in relation to the therapist's body in particular, these could be examined and potentially challenged. Additionally, a client's emotional responses to their therapist's body and their ways of managing them could be explored (e.g., If a client says that they see their therapist as 'thin', the therapist could ask if their client feels jealous or angry about this and, if so, how do they manage these feelings?). The relational implications of a client's thoughts and feelings could also be explored (e.g., the therapist could find out whether or not their client feels resistant to, or untrusting of, them because of their size and shape). And the possible influences on the client of the norms and social discourses that exist in the wider cultural milieu within which both they and their therapist reside (e.g., Bordo, 2009; Lawrence, 1984; Malson & Burns, 2009; Nasser & Malson, 2009; Orbach, 1979, 1986; Sesan 1994) could be addressed.

The subject of the therapist's body thus has the potential to be used as a catalyst for exploring the multiple factors identified in the individually-, relationally- and socially-focused accounts discussed above. It is likely,

however, that therapists would appreciate some information about the possible ways in which their clients might perceive them before they embark upon any of the therapeutic discussion avenues just outlined. Accordingly, it is suggested here that there is a need for research which explores clients' thoughts, feelings, judgements and assumptions about their therapist's body, and provides therapists with the types of information they might find useful when preparing for therapeutic explorations of their body with their client.

In addition to being a subject which might facilitate a multi-level approach to therapy, there is also preliminary (if underdeveloped) empirical evidence to suggest that the therapist's body is important when working with clients who have an ED.

Potential impact of the therapist's body

It is argued by many that a therapist's most valuable instrument in the therapy room is her or his self (e.g., Yalom, 2002). Yet one important and often overlooked element of the therapist's self is that of their body (Lowell & Meader, 2005). The only study (to date) that directly explores female ED clients' preferences in relation to their therapist's body shape/weight is that of Vocks, Legenbauer and Peters (2007). Using the Contour Drawing Rating Scale (CDRS; Thompson & Gray, 1995) with nine silhouette drawings of female bodies of increasing weight, they asked 34 women with an ED (seven with AN, 17 with BN and 10 with EDNOS) and a control group of 30 women with an anxiety disorder: "If you imagine the ideal female therapist for the treatment, which figure would she have?" They also asked the 64 participants to rate on a 5-point Likert scale (where 1 was not at all

important and 5 was very important): “How important to you is the figure of a female therapist who is treating you?” They found that participants in both groups preferred a therapist with an “average” figure (the middle silhouette out of the nine available to choose from), and that the therapist’s figure was significantly more important to the women in the ED group.

Vocks et al. (2007) suggested that because the topics of body weight and shape are addressed in work with ED clients, a female therapist’s credibility and persuasiveness may, as a result, not be independent from her figure. They also speculated that in relation to the women with an ED in particular, the preference for a female therapist with an “average” figure might be linked to the possibility that: “a very slim female therapist could activate feelings of imperfection and shame” (p.420). Vocks et al. (2007) further suggested that a “very slim” therapist might have difficulties reducing fear of weight gain in ED clients and that they might consequently find it hard to convince their client of the necessity to put weight on. Finally, they hypothesised that: “a larger female therapist might trigger further fear of gaining weight in her patients because of the model function that therapists often have for their patients” (p.420). Vocks et al. (2007) concluded their study with the assertion that it provided: “the first hints that a female therapist’s figure seems to be a relevant factor for patients with EDs and should be considered in future research” (p.421). Yet, despite their exhortation for a female therapist’s figure to be considered in future research, their study remains the only empirical examination of clients’ perspectives on the possible importance of a therapist’s body size.

There is also one empirical study which explores this topic from the therapist's perspective. Warren et al. (2009) used quantitative and qualitative methods to canvas 43 professional ED treatment providers (39 women, 4 men) about their experiences of working with ED clients in relation to a number of issues – one of which was their experiences of receiving commentary (direct or indirect) from clients about their appearance. The treatment providers estimated that approximately 25% of their clients commented on their general appearance and 8% made direct comments about their body shape and weight. Furthermore, approximately 83% of the treatment providers felt that their appearance was being “monitored, examined or evaluated” by their clients even when it was not verbalised. Sixty-five percent of those who received comments about their general appearance and 75% of those who received comments about their body shape and weight discussed the comments in session, whilst just 34% of those who sensed their appearance being “monitored, examined or evaluated” voiced their perceptions. Warren et al. (2009) suggest that patients' observational activities might distract them from what the therapist is saying and the process of the therapy, and lead them to make “therapy interfering judgments” (e.g., a client may see an ‘overweight’ or ‘unfashionable’ therapist as incompetent). Although Warren et al. (2009) do not speculate about the potential outcomes of a client making “therapy interfering judgments”, it is conceivable that disconnection from the therapeutic relationship, a loss of trust in the therapist, or termination of therapy could all be possible results.

A small number of theoretical and anecdotal commentaries have also been published in relation to the topic of the possible role, and importance, of the therapist's body in work with ED clients. For example, Orbach (2003, 2004), writing from a feminist, psychodynamic orientation, has explicitly encouraged therapists to consider the idea that their body might have an impact upon their client's body, that their body presence might sanction, confirm, disturb, please or overwhelm the client and that all these factors might affect both the therapeutic relationship and the treatment itself. Similarly, Petrucelli (2008), also writing from a psychodynamic perspective, has challenged therapists to consider the idea that an ED client's habit of comparing and contrasting her appearance with that of others, including with that of her therapist, may be a vehicle for (not only a resistance to) fundamental change. And, Andersen and Corson (2001), in their descriptive and prescriptive summary of the characteristics which are the essential features of an ideal therapist for patients with an ED, stated specifically that: "The initial impression of a naturally thin or naturally above-average-weight therapist may be offputting or stir competitive or negative thoughts and emotions" (p.356).

Finally, a number of therapists have written about their own experiences of working with ED clients. Lowell and Meader (2005), for example, described the mixed feelings and responses they had experienced as self-proclaimed 'thin' therapists:

As thin therapists, while we have sometimes felt proud or grateful about having thin culturally-admired bodies, we have also found that

our bodies are also targets of envy, anger, hatred, all of which can leave us feeling vulnerable and wishing we looked different (p.254). Similarly, Surtees (2009), wrote about her experiences of 'slimness' in her role as a nurse in an inpatient ED unit and her belief that: "The presence of thin bodies is always already troublesome in a medical/psychiatric ED unit, because an objective, inner truth is not visible; hence both eating – and/or not eating – can act as signs of an eating disorder" (p.162). Indeed, when served a "markedly smaller" portion by the hospital kitchen during a supported meal she was eating with the women from the unit, Surtees (2009) described how the women had been: "Catching each other's eyes, directing their gazes on my plate, and then returning the gaze meaningfully towards each other" (pp.163-164).

In contrast to the literature above which demonstrates that some ED therapists are aware of their client's gaze (on both their body and their eating), there is evidence to suggest that other therapists may not have considered the idea that their ED clients might be observing them (Rance, Moller & Douglas, 2010). More specifically, one of the ED therapists interviewed in Rance et al.'s (2010) study said that she did not know what it would be like to consider the way in which a client with AN might look at her as it had not occurred to her to think about it (p.386). This lack of consideration is problematic given the possibility (discussed throughout this literature review) that a therapist's body might have an impact on their client. Consequently, further research into clients' beliefs, perceptions and preferences with regards to their therapist's body, eating and relationship with food, could also help raise the profile of this subject so that therapists

who have not previously thought about the possible impact of their body might be prompted to do so.

In conclusion, despite the existence of preliminary evidence which suggests that the therapist's body might have an impact on the therapeutic relationship and process, it remains the case that very little is actually known about the ways in which clients with AN think about, and respond to, their therapist's body and eating behaviours. One factor which may be important when developing a research project to explore this topic is the possibility that differences might exist between the ways in which female and male clients work with female and male therapists (Costin, 2009; Stockwell & Dolan, 1994; Zunino, Agood & Davis, 1991). This is important because if such differences were to exist (e.g., if female and male therapists were to focus on body-related issues in different ways), it is possible that they could have an impact on the way in which the therapist's body was perceived and responded to by their clients.

Possible gender differences in ED treatment

It has been argued that female and male therapists may work differently with female and male ED clients. Zunino et al. (1991), for example, found that therapist gender could influence the way in which specific gender-related issues (e.g., problems of body experience and sexuality, ambivalence about gender identity, the relationship with mother, and the need for a role model) were approached in therapy for women with bulimia. Similarly, Stockwell and Dolan (1994) proposed that female therapists may empathise more with female clients due to their shared socialisation and developmental experiences. And Costin (2009) argued that:

Male therapists undoubtedly have to deal with the body image issues of their eating-disordered clients, but they are generally not challenged in the same way as female therapists. For the most part, males are not subjected to the same kind of scrutiny and competition from female clients regarding size, shape, and weight ... The dynamics may change with a male client and male therapist (p.180).

Although such gender differences have been highlighted in the literature, there is no evidence to suggest that they confer specific advantages or disadvantages to female or male therapists in particular. Indeed, in their review of the characteristics of an ideal therapist for ED patients, Andersen and Corsen (2001) proposed that although therapist gender may be important in the short run (due to initial perceptions by the client – usually based on past experience or ‘bias’ – that a particular gender of therapist is preferred or required), in the long run it has little role. Additionally, some authors have suggested that factors other than whether a therapist is male or female are more important in determining treatment outcome (e.g., client choice in working with a male/female therapist, appropriate supervision and a therapist’s ability to fully understand their own and their client’s emotional experiences; see Katzman & Waller, 1998, for a fuller discussion). It is important to note that the majority of this theorising has focused on the potential differences between male and female therapists who are working with female clients. Consequently, it is possible that further differences might be found if researchers were to examine how male and female therapists work with male clients.

Although the evidence in this area is clearly limited, it does indeed appear that there might be differences between the ways in which female and male clients work with female and male therapists (Costin, 2009; Stockwell & Dolan, 1994; Zunino et al., 1991). In light of this, the fact that most people with an ED are female (Hoek & van Hoeken, 2003), and the suggestion that there are a greater number of female than male ED therapists (Costin, 2009), it was decided that this study would focus on female clients thoughts about, and responses to, their female therapist's body.

Summary

Although people with an ED are known to observe and assess body related stimuli (Lowell & Meader, 2005), and therapists working with ED clients have reported feeling that their appearance was being “monitored, examined or evaluated” (Warren et al., 2009), it is currently the case that very little is actually known about ED clients' beliefs and preferences regarding a female ED therapist's body size and relationship with food. As highlighted throughout the literature review above, this is problematic for a number of reasons. First, this lack of knowledge makes it difficult to draw conclusions about whether the poor recovery statistics and high drop-out rates from psychological therapy are – at least in part – related to clients not engaging with the process due to their preferences and expectations (in this case in relation to their therapist's body) going unmet (Arnkoff, Glass & Shapiro, 2002).

Second, as detailed above, none of the theoretical accounts of AN directly address the issue of the therapist's body. Consequently, it may be the case that AN treatments based upon these models are underdeveloped. Once

again, this omission may, in part at least, account for the low success rates (Bulik et al., 2007; Berkman et al., 2007; Fichter et al., 2006; Löwe et al., 2001; Steinhausen, 2002), and high drop-out levels (Fassino et al., 2009; Mahon, 2000; Wallier et al., 2009) associated with AN treatment.

Third, the lack of knowledge is problematic in light of the Government's long-standing commitment to both eliciting service user views (e.g., NHS Institute for Innovation and Improvement, 2012; UK Department of Health, 2001, 2006) and improving the experience of care for people using mental health services (NICE, 2011). This is especially pertinent in relation to people with an ED as research suggests that a fundamental part of their intra- and interpersonal experience is that of feeling invisible, unheard and worthless (Reindl, 2001; Shelley, 1997).

Finally, the lack of knowledge about the way in which clients respond to, and perceive, their therapist's body is potentially a missed opportunity. As outlined above, by therapeutically exploring a client's thoughts about, and feelings and reactions towards, their therapist's body, factors highlighted by the individually-, relationally- and socially-focused accounts of AN could all be addressed within the therapy room. In order to facilitate such therapeutic work, however, it is likely that practitioners will need some knowledge about the types of thoughts, feelings and reactions that people receiving counselling for AN might have about a therapist's body. Accordingly, this study has been designed to further develop the preliminary evidence available in this area.

Importance and Relevance of this Research for Counselling Psychology

In order to fully understand the importance and relevance of this research for the field of counselling psychology, it is important to begin by briefly considering the nature and values of counselling psychology itself. This is not a simple task, however, as Kasket and Gil-Rodriguez (2011) explain: “Counselling psychology, reflecting as it does the complexities of life itself, is full of paradoxes and challenges” (p.21). In part these paradoxes and challenges arise from the dual influence within counselling psychology of both the scientist-practitioner (Blair, 2010; Strawbridge & Woolfe, 2010) and reflexive practitioner (Martin, 2010) models of psychology and psychotherapy. This dual influence means that counselling psychology draws upon and aims to develop phenomenological models of practice and enquiry which seek:

1. to engage with subjectivity and intersubjectivity, values and beliefs;
2. to know empathically and to respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing;
3. to be practice led, with a research base grounded in professional practice values as well as professional artistry;

4. 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 (Professional Practice Guidelines of the British Psychological Society (BPS), Division of Counselling Psychology, 2005, p.1-2).

Counselling psychologists are thus required to operate from two different underpinning philosophies (one which prioritises empiricism and scientific method, the other which prioritises subjectivity, reflection and both individual and social levels of understanding). Although these two philosophies can sometimes pull a counselling psychologist in different directions, it is clear that the current lack of knowledge regarding clients' thoughts and feelings about their female therapist's body and relationship with food is problematic to anyone who adheres to either philosophical standpoint. Without knowledge and information about clients' beliefs and perceptions, practitioners lack both an evidence base from which to draw when developing appropriate interventions, and a resource from which they might learn more about the ways in which their clients observe, think, judge and assume.

Unfortunately, EDs in general and AN in particular have been much overlooked by research in the counselling psychology field (Hotelling, 2001). Indeed, with the exception of the Special Issue of *The Counselling Psychologist* (2001, Vol. 29, Issue 5) which focused on EDs, research published in the four main journals in the field (*Counselling Psychology Quarterly*, *Counselling Psychology Review*, *Journal of Counselling*

Psychology, The Counselling Psychologist) have very little to say about AN. Thus, given the poor treatment outcomes and high drop-out rates described above, the growing number of people affected by EDs, and the fact that in the UK counselling psychologists are being increasingly employed in the NHS (where all non-private ED treatment occurs), it seems important for the field of counselling psychology that research explores female ED clients' beliefs and perceptions of their female ED therapist.

Research Aims and Questions

The current study was designed to explore female ED clients' beliefs about a female therapist's body size and shape, and relationship with food. In light of the lack of literature in the area it was anticipated that the findings could begin the process of better understanding the perceptions of these women and give voice to this unexplored element of their experience in the therapy room. It was also hoped that the results might provide clinically relevant information for practitioners regarding the ways in which they are perceived by their clients, the impact (if any) that these perceptions might have upon the therapeutic process and the possibility that a therapist encouraging discussion of their own body in the therapy room could be a useful therapeutic tool.

Research Questions

1. What do women with an ED believe is important about an ED therapist's body weight/shape?
2. What do women with an ED believe is important about an ED therapist's relationship with food?

Methodological Considerations

Design

Rationale for using a qualitative research methodology. As a trainee counselling psychologist I was heavily influenced by the Professional Practice Guidelines of the BPS, Division of Counselling Psychology (2005) when designing this research project. In particular, I kept in mind the fact that:

Counselling psychologists will consider at all times their responsibilities to the wider world. They will be attentive to life experience, modes of inquiry and areas of knowledge beyond the immediate environs of counselling psychology and seek to draw on this knowledge to aid communication or understanding within and outside of their work (p.7).

I also reflected upon the stress placed in these Guidelines on the importance of marrying research models with the values expressed in counselling psychology and of designing and conducting research in a manner that reflects the ways of working emphasised within the field of counselling psychology as a whole. Consequently, I was aware that I needed a research model which would enable me to “engage with subjectivity and intersubjectivity, values and beliefs” and to “know empathically and respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing” (p.1-2).

Furthermore, in his paper entitled 'Human science and counselling psychology: Closing the gap between research and practice', Rennie (1994) explained that:

Like the practice of counselling psychology, human science [or 'qualitative research' as it is now popularly known] focuses on subjectivity and stresses the achievement of an understanding as opposed to the demonstration of truth; it stresses collaboration with participants rather than a subject-object dualism; and it emphasizes holism in contrast with fragmentation (p.235).

Thus, in order to facilitate the aims of the study and remain true to the values of counselling psychology, I decided that a qualitative research methodology would be most appropriate. For, as McLeod (2001) explains: "Qualitative inquiry holds the promise of discovery, of generating new insights into old problems, and producing nuanced accounts that do justice to the experience of all those participating in the research" (p.1).

Furthermore, as I wanted to ensure that both the unique experiences of each participant and the fundamental areas of interest of the research project were explored, I was aware that I would need a flexible data collection method. Given that I was keen to make sure my participants felt respected, heard and free to share their experiences at their own pace, I decided to use semi-structured one-to-one interviews. According to Smith, Flowers and Larkin (2009) one-to-one interviews are: "easily managed, allowing a rapport to be developed and giving participants the space to think, speak and be heard" (p.57). They also allow the interviewer to follow-up on points the interviewee makes, revisit issues that were not perhaps

addressed as fully as might have been useful and move from topic to topic in a way that flows naturally. Thus data collection using semi-structured one-to-one interviews seemed to meet both my research aims and my research values.

Rationale for using thematic analysis. I was guided in my choice of qualitative research method by the fact that a study's theoretical or epistemological position, research question, method of data collection and method of data analysis must fit (Braun & Clarke, 2006, 2013; Willig, 2001). Accordingly, in keeping with my research aims and question, I needed an analytical tool that would enable me to explore my interviewees' thoughts and feelings without imposing any pre-existing theory of what they might be. I also wanted a form of analysis that would allow me to identify both patterns in the data and instances of similarity and dissimilarity both within and between the interviewees' narratives. Furthermore, I wanted to be free to discover unexpected findings, to explore unique responses, to give voice to the interviewees' thoughts and, if appropriate, to interpret their responses in a way which could bring life to their narratives by richly describing the data. With this in mind I chose thematic analysis (TA) as the analytical method to be used in this research project. Described by Braun and Clarke (2006) as: "a method for identifying, analysing and reporting patterns (themes) within data" (p.79), it is a form of analysis that can be used within numerous theoretical frameworks due to the fact that it is wedded to none, and is suitable for a wide range of data collection methods including interviews (Braun & Clarke, 2013). TA can be essentialist (reporting the "experiences, meanings and the reality of participants", p.81), constructionist (examining

the “ways in which events, realities, meanings, experiences and so on are the effects of discourses operating within society”, p.81) or ‘contextualist’ (“a method sitting between the two poles of essentialism and constructionism”, p.81). Additionally, TA can “highlight similarities as well as differences across the data set”, “generate unanticipated insights”, “allow for social as well as psychological interpretations of data”, and produce “qualitative analyses suited to informing policy development” (p.97). These qualities of TA were deemed particularly important as the study was interested in developing an understanding of participants’ thoughts and feelings rather than in testing or developing a particular theory. And in keeping with the interests of the study, a contextualist TA method with an inductive (as opposed to deductive or theoretical) approach was adopted.

Before finally deciding to use TA, I explored the appropriateness of two other analytical methods in particular. The first of these was grounded theory (GT). GT, developed by Barney Glaser and Anselm Strauss in the late 1960s, was originally positioned as: “an explicit method of constructing middle-range sociological theory from data” (Charmaz & Henwood, 2008, p.243). Via the implementation of a systematic set of guidelines for managing and analysing data, it allowed researchers: “to move from data to theory so that new theories could emerge. Such theories would be specific to the context in which they have been developed” (Willig, 2001, p.32). Although the original GT method has been revised and its two founders have each taken it in a different direction, it remains the case that: “the purpose of grounded theory is to develop a theoretical analysis of the data that fits the data and has relevance to the area of study” (Charmaz, 2003,

p.109). Although theory development could have been one of this study's aims, it did not fit with the study's core research questions which had been developed to explore what women with an ED feel is important about an ED therapist's weight/shape, relationship with food and with her own body. Had the research question been "How do women with an ED experience their ED therapist's body", for example, then GT might well have been a more appropriate research method. Similarly, I felt that the emphasis in GT on studying processes (Charmaz, 2003) did not fit with the research questions as they stood at the time of developing the project.

The second analytical method considered for this study was interpretative phenomenological analysis (IPA). IPA, as proposed by Smith et al. (2009), is informed by three key areas of the philosophy of knowledge: phenomenology, hermeneutics and idiography. Accordingly, it is focused on understanding lived experience (phenomenology), it proposes that in order to make sense of the meanings people impose upon their experience a researcher must undertake close interpretative engagement (as informed by hermeneutics) with participants' verbal or written statements, and it is inclined towards exploring particular instances of lived experience (i.e., it is idiographically sensitive). Hence, IPA is fundamentally concerned with understanding people's everyday experience of reality, in great detail, in order to gain an understanding of the phenomenon in question (Smith et al., 2009). In contrast, the aim of this study was not to understand the way in which women with an ED experience their therapist's body, but to understand what women with an ED felt was important about a therapist's weight/shape, relationship with food and with her own body. And although it

was acknowledged that IPA can be used to research people's perceptions and views (Smith et al., 2009), it was ultimately felt that a TA, with a larger sample size than is commonly used in an IPA study (sample size in IPA tends to be smaller as a result of its idiographic focus so analysis of interviews with four to six homogenous participants is typical, Braun & Clarke, 2013), would offer a more suitable method for exploring the primary research concerns of this project.

It was nevertheless acknowledged that, like all analytical methods, TA was not without its own limitations (Braun & Clarke, 2013) and that although steps could be taken throughout the research process to minimise them it would not be possible to overcome them all. Accordingly, the limitations of TA and their possible impact on the study are discussed in the 'Limitations of the Research' section below.

Method

Participants. Ethical approval was received from the faculty research committee and recruitment began in autumn 2010. Inclusion criteria were that participants:

- Be female – this was to reflect the fact that approximately 90% of individuals with an ED are female (Hoek & van Hoeken, 2003)
- Have a formal or 'self-diagnosed' history of AN – only a small percentage of people with an ED actually receive a formal diagnosis ('b-eat', 2009) so allowing for self-diagnosis both increased the number of possible participants and was in keeping with my belief in the importance of respecting first person

accounts as valid in their own terms (BPS, Division of Counselling Psychology, 2005); it is recognised, however, that without evidence of a confirmed diagnosis of AN the participants cannot be referred to as having AN, thus (with the exception of these inclusion criteria) they are referred to as having an ED

- See themselves as recovered or 'on the road to recovery' – given that AN is characterised by disturbed thinking (Freeman, 2002, p.26; Fairburn, 2008, p.12), it was deemed important that participants have some distance from their ED experience; at the same time, however, it was recognised that recovery from AN is a long and ill-defined process (Couturier & Lock, 2006), which cannot be measured in purely objective terms (Jarman & Walsh, 1999) – individuals may therefore feel that they are 'on the road to recovery' some time before they reach the point of self-identifying as fully recovered. Allowing interviewees' to self-define their experiences (in this instance with regards to being recovered or 'on the road to recovery') was also felt to be important in itself and in keeping with the principles of both counselling psychology and qualitative research
- Have received counselling (NHS or private) for their ED from a female therapist – it was assumed that female clients who have had counselling with a female therapist are more likely to have experienced, and be able to talk about their experiences of, issues in the therapy room surrounding bodily comparisons,

identification and/or mirroring because of the shared experience of having female bodies

The study was advertised through 'beat' (the UK's largest national ED association) and, as the research team was based in the South-West of England, through both regional counselling services and support groups, and the University of Bath and the University of the West of England Psychology Departments' participant pools (see Appendix 1, p.211, for recruitment flier). In order to enable the identification, analysis and reporting of patterns (themes), similarities and differences within the data, whilst simultaneously being able to give voice to each interviewee, Braun and Clarke's (2013) recommendations for sample size were followed and 12 women were recruited. Their demographic details and brief ED history are shown in Table 1 overleaf. Their ages ranged from 18 to 50 years (mean 31.5), and the duration of their EDs ranged from two to 28 (mean 13.3). When asked to rate how recovered they saw themselves on a scale from 0 to 100% the participants' responses ranged from 40 to 100%. All 12 participants had received counselling from at least one female therapist.

Table 1 Age, ED history, food-related ED behaviours and therapist history details for interviewees

Pseudonym	Age (years)	Age at onset of ED (years)	Duration of ED (years)	Self-reported % recovered (%)	Food-related ED behaviours	Therapist history
Katie	26	11	15	No data	Food restriction, binge-purging	Four female therapists; Three female community psychiatric nurses (CPNs); Two female psychologists; Female nurses and therapists on inpatient ward; One male therapist
Sarah	32	16	16	<50	Food restriction, binge-purging	Three female therapists; One female psychologist; One male therapist; One male psychologist
Susie	23	16	7	40-50	Food restriction, purging	Three female therapists
Alice	50	22	28	60	Food restriction, binge-purging	Three female therapists; Female nurses and therapists on inpatient ward; One male psychiatrist
Megan	41	14	27	60	Food restriction only	Female therapists and CPNs running contemplation programme; One male therapist; One male psychiatrist
Sophie	19	13	6	60	Food restriction, binge-purging	Four female therapists; One female CPN; One male psychiatrist

Pseudonym	Age (years)	Age at onset of ED (years)	Duration of ED (years)	Self-reported % recovered (%)	Food-related ED behaviours	Therapist history
Claire	33	12	21	50-80	Food restriction, binge-purging	Female nurses and therapists on outpatient day-programme; One male therapist
Nina	34	30	4	70	Food restriction only	Female nurses and therapists on inpatient ward; One female consultant; One female therapist; One female support worker
Sam	18	12.5	5.5	95	Food restriction, binge-purging	Female nurses and therapists on outpatient day-programme; Two female therapists
Amy	42	19	16	95	Food restriction only	Nurses (one male, others female) and therapists on inpatient ward; Four female therapists; One male therapist
Hayley	25	10	12	100	Food restriction, binge-purging	One female support worker; Female nurses and therapists on inpatient ward; Female therapist
Lucy	25	16	2	100	Food restriction, purging	Three female counsellors

Data Collection. All prospective participants who expressed an interest in taking part in the research were provided with a participant information sheet (see Appendix 2, p.212) detailing the purpose of the study, their role in it and the fact that they were free to withdraw at any time. They were encouraged to ask questions if they were unclear about anything and, if happy with all that they had read and heard, were asked to suggest a place for the interview to take place – four chose their own home, five chose the counselling service where I work, two chose the university where I am a student and one chose her local library. Upon arrival at the interview site, all participants were encouraged once again to ask any questions they might have and they were reminded that they could withdraw at any time. They were then asked to sign a consent form (Appendix 3, p.214) and, after the interview, were reminded of the sources of support listed on the participant information sheet (if they no longer had their sheet they were offered another) and given the opportunity to share their feelings about having taken part in the study.

The interview schedule was designed in accordance with Braun and Clarke's (2013) guidelines. In particular, attention was paid to developing questions that were open-ended and sequenced in a logical order that showed respect to issues of sensitivity (i.e. more personal or potentially emotive questions were asked later in the interview when the interviewee was more likely to be feeling relaxed and comfortable with the interviewer). The initial question schedule was developed through a combination of brainstorming, discussions with my supervisors, insights acquired through the literature, and consideration of knowledge gained from my own clinical

practice and experiences of receiving therapy for an ED. The schedule was not, however, fixed and additional questions were added when the interview process began and the interviewees' narratives revealed additional areas to enquire about in future interviews. See Appendix 4, p.215, for the final interview schedule. I tried at all times to give interviewees sufficient space and time to respond in as much detail as they wished and I saw my role as one of facilitating and guiding (using probes where necessary to encourage richer, fuller answers – Smith et al., 2009) rather than leading and directing.

All interviews were tape-recorded and 'orthographic' transcripts (Braun & Clarke, 2006, p.88) were produced to provide the level of detail appropriate for the analytical method used. For example, words that were emphasised by interviewees were underlined. Additionally, in relation to the extracts presented in the analytical write-up, commas were added to aid readability and important contextualising information or words that increased understanding were added in square parentheses. The transcripts were checked against the original audio recordings for precision (Braun & Clarke, 2006) and the researcher used both the transcription and checking processes as a means of beginning the process of 'immersion' in the data (Morrow, 2005, p.256).

Data Analysis. As discussed above, the data analysis was based upon Braun and Clarke's (2006) six-phase approach to thematic analysis. Phase one ("familiarizing yourself with your data") began when I transcribed and checked the transcripts (to ensure that they were 'accurate') and continued as I read and re-read the transcripts multiple times thereafter. As I read I contemplated the meanings conveyed by the interviewees and made

notes of ideas for coding. In phase two (“generating initial codes”) I began to identify features of the data (‘codes’) that would eventually allow for the identification of repeated patterns within and across the interviews. I coded at both the semantic and the latent level – namely, I coded both descriptively (e.g., “untrusting of ‘overweight’ therapist”) and interpretatively (e.g., “ashamed of bingeing”). I also coded broadly (i.e., I coded for as many potential themes/patterns as possible), inclusively (i.e., I retained contextualising data surrounding the coded data extract when appropriate) and exhaustively (i.e., I did not limit the number of codes a data extract could have and used more than one if appropriate). I collated these codes and their associated data extracts in an Excel Spreadsheet. See Appendix 5, p.217, for a coded section of transcript, and Appendix 6, p.219, for three codes with illustrative data extracts from across the transcripts. In phase three (“searching for themes”), I sorted the identified codes into potential themes. As there were multiple ways in which the codes could be combined into overarching themes, I spent time considering alternative groupings and tried to be flexible and creative in my thinking.

In phase four (“reviewing themes”) I repeatedly refined the candidate themes – rejecting some and modifying or collapsing others into one another. Furthermore, I used thematic maps throughout to help myself understand the relationship between codes and themes (see Appendix 7, p.221, for the final overarching thematic map which depicts all three themes and their subthemes). And I checked the validity of the candidate themes repeatedly at both the level of the individual coded data extracts (i.e., I looked to see if the meanings reflected in the themes were evident in the

individual data extracts they represented) and the level of the data set as a whole (i.e., I looked to see if the meanings reflected in the themes were evident throughout the data set as a whole). In phase five (“defining and naming themes”), I sought to identify the essence of the themes. The aim of this phase was to ensure that there was clarity about what each theme was, and what it was not. See Appendix 8, p.222, for an example of the definitions and labels for a theme. In the final phase, phase six (“producing the report”), I attempted to provide a “concise, coherent, logical, non-repetitive and interesting account of the story” (Braun & Clarke, 2006, p. 93) being told by the data. This is presented in the ‘Analysis’ section below.

My supervisors read all transcripts and met with me on a regular basis throughout the data analysis process. As highlighted above, in addition to discussing the emerging patterns, codes and themes, they also encouraged me to reflect upon my relationship with the data and the possible influence of my preconceptions, my own ED history and my desire to challenge the views commonly held about people with an ED. As such, they helped me to maintain the quality and rigour of the analysis and to develop an account of the data that was meaningful and informative.

Ensuring Quality and Rigour. Morrow’s (2005) guidelines for enhancing trustworthiness in qualitative research, and Morrow’s (2005) and Matthews’ (2005) recommendations for crafting qualitative research articles influenced both this research project as a whole and the production of the journal article (presented on pp.192-209) in particular. For example, in order to manage and minimise the potential for researcher ‘bias’, I kept a reflective research journal, consulted my supervisors and made explicit my

assumptions and presuppositions (Morrow, 2005; see the 'Reflexivity' section below for further details of my engagement with the possible impact of my ED history and my status as an 'insider'). Additionally, Braun and Clarke's (2006) 15-point checklist of criteria for good thematic analysis (see Table 2 overleaf) was used to ensure the quality and rigour of the analysis described above.

Table 2 Braun and Clarke's (2006) 15-point checklist of criteria for good thematic analysis

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the recording for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
	Analysis	7
8		Analysis and data match each other – the extracts illustrate the analytic claims.
9		Analysis tells a convincing and well-organised story about the data and topic.
10		A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as <i>active</i> in the research process: themes do not just 'emerge'.

Reflexivity

Qualitative research paradigms view research as a subjective process and accept the influence of the researcher, the research participants, and the research tools and process (Braun & Clarke, 2013). Indeed, qualitative research paradigms actually view subjectivity as an “opportunity” and a possible research tool in itself (Finlay, 1998). At the same time, however, these paradigms acknowledge that in order for subjectivity to be beneficial, it must be engaged with. One method for doing this is that of “reflexivity,” an activity described by Banister, Burman, Parker, Taylor and Tindall (1994, p.151) as: “acknowledging the central position of the researcher in the construction of knowledge.” As Finlay (1998) explains: “Through constantly reflecting on, questioning and evaluating the research process, the researcher attempts to distinguish how subjective and inter-subjective elements have impinged on (and possibly transformed) both the data collection and the analysis” (p.453).

The need for such reflexivity is even greater when the researcher is an ‘insider’ – namely: “An individual who possesses intimate knowledge of the community and its members due to previous and ongoing association with that community and its members” (Labaree, 2002, p.100). At first I saw my ‘insider’ status as being due to the fact that I was a female who had received counselling for an ED from a number of female therapists. As I explored the idea further, however, and as I considered Deutsch’s (1981) assertion that “we are all multiple insiders and outsiders” (p.174), I realised that, as someone who had recovered from an ED, I was in fact an ‘outsider’ to the community of people with a *current* ED – and thus to the interviewees

who were 'on the road to recovery' rather than recovered. Furthermore, as everyone's ED experience is unique, I knew that I would also be an 'outsider' to the specific experiences, thoughts and behaviours of my interviewees. Indeed, although I had restricted and engaged in a lot of exercise during my ED, I had never purged or experienced myself as 'fat' – the latter being a phenomenon that many of my participants described. I soon realised therefore that I needed to be very clear with myself (and any readers of my research) about my positionality – hence my in-depth reflection process and this extensive 'Reflexivity' section.

Additionally, as I continued to explore the issue of 'insiderness', I became aware that although it conveyed many benefits (e.g., the value of shared experiences, of trust, and of deeper understanding and clarity for the researcher; Labaree, 2002), it also had potential costs (e.g., the risk of failing to notice the familiar or unique, being 'biased', feeling responsible to one's own community; Labaree, 2002). As Haniff (1985) explains: "An insider or native must take this status seriously. Its methodological implications are profound, for it is this group who can either do the most harm or the most good" (pp.112-113). My personal and professional ethical commitment to avoid doing harm (as encapsulated in the BPS Code of Ethics and Conduct, 2009), my desire to do good (for both people with an ED and those who wish to help them), and my commitment to counselling psychology's reflexive practitioner model (Martin, 2010; which I see as applying not only to my clinical practice but also to my research practice), meant that reflexivity (and the idea of using it and my 'insider' status to enhance this project) was an important element of the research process.

I began my reflexivity as soon as I had decided upon the research topic as I wanted to monitor and reflect upon my initial beliefs, assumptions and expectations, and the potential impact of my own ED history. In order to do this I kept a reflective research journal (Braun & Clarke, 2013) and engaged in conversations about my project with those around me (e.g., my thesis supervisors, fellow students, counselling colleagues). I continued with both activities throughout the research project and encouraged my thesis supervisors in particular to challenge me regarding the possible influences of my 'insider' and 'outsider' statuses on the way in which I was collecting, viewing and interpreting the data. Furthermore, as discussed in detail below, I used my increasing self-awareness to try and "bracket off" (Husserl, 1931) my beliefs, assumptions and expectations during the interviews and the analysis in order to focus on my interviewees' views and voices (Finlay, 1998). Given that the elimination of a researcher's subjective responses is neither possible nor desirable within qualitative paradigms (Finlay, 1998; Braun & Clarke, 2013), I also wanted to share my reflections with the reader in order that they too might have a clearer idea of my location within the project and, ultimately, within the analysis presented below. In particular I felt it was important to make explicit my personal history and motivation for undertaking this research project, my assumptions and presuppositions in relation to people with an ED and the ED treatment system in particular, and the potential influence of three specific factors.

Personal history and motivation for undertaking the research project

Prior to my own ED experience I was relatively naive about both mental health in general and EDs in particular. This all changed during my first year

at university when, approximately five months after I began restricting my calorie intake and overexercising, I was diagnosed with AN. Interestingly, I was aware of my 'thinness' throughout my ED experience and my aversion to weight-gain came not from a fear of becoming 'fat' but from my belief that eating more would be an undeserved indulgence. During my recovery journey I saw a number of (predominantly female) therapists in both NHS and private settings, and I read various autobiographical accounts, texts and journal articles about EDs in general and AN in particular. Consequently, I discovered much about myself, about EDs (especially AN) and about the treatment approaches available. Therefore, when I came to decide upon a research topic for my second year counselling psychology doctorate project, I knew that I wanted it to be located within the ED field – thus, like many counselling and psychotherapy doctoral students, I was choosing a topic that had personal meaning (Etherington, 2004).

As I started to think about possible research areas and questions I remembered a paper that one of our course tutors had asked us to read in my first year on the course: Vocks et al's (2007) "Does shape matter? Preferences for a female therapist's figure among patients with eating disorders." It had interested me from the outset as I had often wondered about the issue of an ED therapist's body – the ways in which it might be perceived and the possibility that it might have an influence on the therapeutic process. Although at that point I had not worked with any ED clients (I wanted to be sure in myself as a practitioner before starting to work in a field that I knew would challenge me personally), I had often felt conscious of my own body in the therapy room and wondered how it might

have been perceived by my clients. I had also thought about how a client with an ED might see me if I were to work with them and whether or not my body might have an impact on them. Indeed, I had sometimes wondered if a therapist's body might actually influence therapy itself – for example, might a 'thin' therapist be seen as a competitor or hypocritical and thus invoke resistance to treatment? As none of these theories had been explored in the literature it seemed an area that merited research.

As a neophyte researcher, however, I was unsure about the wisdom of exploring a topic that overlapped so much with both my history as an ED client and my current status as a counselling practitioner. Accordingly, I decided to look at the topic from the ED therapist's (rather than the ED client's) perspective and conducted an IPA study focused on the way in which counsellors working with ED clients experience their own bodies and food. After submitting the write-up of this research as my second year counselling psychology doctorate project, I submitted it for publication (Rance et al., 2010). From start to finish, the project was both a professional and personal learning process as I developed and gained confidence in my research skills, engaged with the ED literature and ED world in a new way, and reflected upon my own recovery journey and motivations for working in the ED field. At the end of the process I felt that I wanted, and was ready, to look at the same research area from the 'other side of the couch'.

Consequently, I decided that for my doctoral research project I would interview people who had received therapy for their ED about their beliefs in relation to a female therapist's weight/shape and relationship with food.

Assumptions and presuppositions in relation to people with an ED and the ED treatment system

I was aware from the outset that this project would be a very different endeavour from my previous one as speaking to others who have experienced an ED always reminds me of my own ED, of the difficulties I faced, of the things that used to frustrate me and, thankfully, of how far I have come since then. Additionally, conversations with anyone who has had an ED invariably include reflections on treatment – reflections which can often be highly emotive. My own experiences of treatment (both NHS and private) were certainly mixed and at times I felt that I was not only given little choice regarding my treatment options, but also that I was seen as a problem because I struggled to gain weight at the required rate or found it hard to challenge and change my eating behaviours. Furthermore, over the years I have heard numerous accounts from both my clients (I began seeing clients with an ED in my third year of the course) and others with an ED about waiting lists that mean months can pass before treatment commences, and practitioners who are well intentioned yet poorly informed.

Given the emotive nature of such accounts, the memories of my own experiences and my passion to make a difference in the ED field, I was aware that my emotional involvement with the topic of study could “interfere with a fair collection and interpretation of data” (Morrow, 2005, p.254).

Consequently, I recognised the need to identify and be aware of my implicit assumptions and presuppositions about people with an ED and the ED treatment system in order to set them aside and minimise their impact on my research. My identified assumptions and presuppositions were that:

1. The NHS treatment system is underfunded which means that provision of care can be limited and potentially mediated by physical markers such as an individual's BMI rather than their psychological need;
2. Treatment contexts (NHS and private) sometimes overlook both the pervasiveness of the "thin ideal" throughout society (Brown & Slaughter, 2011) and the promotion and glamorisation of weight loss (and even of anorexia) by the media (Owen & Laurel-Seller, 2000) which can make 'underweight' clients' struggles to gain weight (in a cultural context where weight loss is admired and weight gain condemned; Vartanian, Herman & Polivy, 2005) harder to recognise and acknowledge;
3. Treatment can enhance rather than diminish an individual's focus on food and weight (Gremilion, 2002) and it can even consolidate their use of the ED as a coping mechanism (Eivors, Button, Warner & Turner, 2003);
4. Despite clients being the 'experts' on their own experience and having a sense of what will/will not be helpful in aiding their recovery, their knowledge is sometimes ignored;
5. People with an ED are sometimes stigmatised, discriminated against (Rich, 2006; Stewart, Schiavo, Herzog & Franko, 2008) and even seen as being "to blame" (Crisp, 2005, p.148).

In addition to both identifying and endeavouring to bracket off my assumptions and presuppositions, I also worked hard to ensure that the analytic process and the writing up of my findings were honest reflections of

the interviewees' narratives rather than vehicles for substantiating my own pre-existing stance. In particular, in the Appendices I have provided evidence of my coding (see Appendix 5, p.217, for an example of coded transcript, and Appendix 6, p.219, for an example of codes with illustrative data extracts) and theme development (see Appendix 7, p.221, for a thematic map and Appendix 8, p.222, for author notes, definitions and labels for a theme), and in the Analysis itself I sought to "exemplify a balance" between my analytic interpretations and supporting quotations from participants (Morrow, 2005, p.256).

The potential impact of three specific factors

As a result of my reflective research journaling and reflexive discussions with my supervisors, I became aware of three further potential influences on my engagement in the project which I feel should be mentioned here.

Firstly, throughout much of my ED I felt that the only people who really understood me were others with an ED or an ED history. Furthermore, at times during my ED experience I felt as if I was living in a 'them' (people without an ED) and 'us' (people with an ED) world where I was somehow separated from my family and friends. I was thus aware that my particular 'insiderness' might lead me to assume I knew what an interviewee was saying or that I had some kind of privileged understanding of their experience. Although I felt I was mindful of this at the time of the interviews, I realised as I transcribed them and talked with my supervisors that there were some instances when I had failed to follow up on, or seek clarification about, a remark. For example, when one of the interviewees spoke about her desire to help others once she had recovered, I did not ask her for

details about how or why she might do this as I remembered feeling the same way myself. While an 'outsider' might also have decided not to follow this comment up – after all, it did not relate to the key focus of the research project – my recollection of having had a similar experience may have additionally influenced my own decision not to probe or ask for clarification. As such, it is possible that I may have missed an opportunity to elicit information that could have given added meaning to the interviewee's own experience.

Secondly, as I engaged with the possible meaning and impact of my 'insider' status (both to myself and to my participants), I spent time thinking about whether or not I would disclose my ED history to any interviewees who enquired about my interest in the research topic and/or motivation to train as a counselling psychologist. Although there are no formal ethical guidelines regarding such disclosures, some researchers (especially those with a feminist background) have recommended that disclosure be made (Oakley, 1981; Reinharz, 1992). I thus spent time reflecting, in both my research journal and discussions with my supervisors, on my feelings about my ED history, my sense of what it might be like to disclose it, and the ways in which doing (or not doing) so might impact upon the interview process. As part of this process I contemplated the option of disclosing my history to all participants at the start of the interview as I was aware that if they knew we had a shared experience it could help "form the basis for building trust and forging a strong relationship" (Labaree, 2002), and facilitate my efforts to create a rapport free from tension – something that might, in turn, contribute to my legitimacy in their eyes (Haniff, 1985). I was worried, however, that if

my participants had explicit awareness of my 'insiderness' they might credit me with knowledge or understanding I did not have, give me less detailed descriptions of their beliefs or (inadvertently) encourage me to slip into the role of peer rather than interviewer.

Ultimately, I decided to disclose my ED history if an enquiry was made (as I wanted to be honest and congruent with my interviewees), but say nothing if it was not (as I felt that my training as a counselling psychologist meant my communication skills and ability to form relationships were strong enough to compensate for any benefits I might miss out on by not disclosing). In the event approximately half of the participants made enquiries – all bar one of these were made after the interview had ended, the exception being one which was made before we actually began. There is, of course, the possibility that I covertly disclosed my history through my use of language and non-verbal cues during the interviews and it may even have been such implicit 'outing' that led some of the women to ask me directly about my interest in the research topic and my reasons for training as a counselling psychologist.

Thirdly, the focus of the research project necessarily caused me to reflect upon my own (recovered) (therapist's) body. I am still 'thin' and very much aware of it – although my family are all naturally tall and 'thin', when I'm around people in the ED field or people who know something of my past, I often feel I should justify or explain my body shape in order to prevent them from speculating about my current relationship with food. Furthermore, given the known propensity of ED clients to observe and assess body related stimuli (Lowell & Meader, 2005), I was especially aware of my body

during the interview process and purposefully spent time thinking about the way in which it might be perceived, how I would present myself when conducting the interviews and how my own body shape and weight might influence the interviewees and the dynamics of the interviews themselves. I found Maree Burns' (2003, 2006) work on interviewing as embodied communication particularly helpful when thinking about these issues and wondered, like her, if my body might be used "as a resource for participants' sense-making around women's bodies generally and around their own in particular" (2006, p.11). Also, like Burns (2006, p.12), I found myself trying to hide my body by wearing looser clothes. This was in part due to a slight guilt that "I/my body somehow signified an embodied complicity with the slender imperative" (Burns, 2006, p.12) and "thin ideal" so pervasive throughout society (Brown & Slaughter, 2011), and in part because I wanted to minimise the degree to which it 'spoke' to my interviewees as I did not want to distract them from, or influence, their thoughts about their own therapists.

Despite my efforts, it appeared that in at least one instance my body did talk – as Claire remarked at the end of our interview: "It's interesting, I felt quite aware of your body and perhaps your motivations and your interests while we've been talking." As this felt like an implicit enquiry about whether or not I had an ED history, I briefly disclosed that I had experienced an ED many years earlier and explained a little about my motivations for undertaking the project. Although I had spent time thinking about the ways in which my body might be seen by my interviewees, this incident made me feel especially self-conscious and caused me to question the assumptions that might have

been made by the women about my weight and relationship with food. It also made me wonder if I was being ascribed an ED history and viewed as an 'insider' without my knowing it. Without asking the participants what they thought of my body it is impossible to know how they felt about it but I am aware that I kept thinking about their possible interpretations as I conducted the analysis and that I wondered if I too was being subjected to the same process that is described in the 'Analysis' section below.

In addition to engaging with the reflexive activities described above both before and during this research project, I have also been engaging with them during this final stage of the project – namely, the writing up of the report. As a result, I would like to end this 'Reflexivity' section by describing the changes I have noticed in my engagement with ED clients and the ED field in general as a result of the data collection, data analysis and report writing phases of this project:

1. I have become more aware of my 'insider' status and the way in which it might influence my client work as well as any future research I do in the ED field;
2. I have been reminded of just how different each individual's ED experience is and how people can view the same phenomenon (e.g., a therapist having an ED history) in dramatically different ways;
3. I am far more aware of my body and of my clients' (and possible future interviewees') gaze upon it – essentially, I now realise that my body is always 'talking';

4. I have also discovered that fully engaging with reflexivity is hard, yet worthwhile, as it fosters a far greater level of immersion in the research process.

Analysis

Analysis of the interview transcripts revealed three themes in the women's discussions of a therapist's³ weight/shape and relationship with food: "Wearing eating disorder glasses", "You're making all sorts of assumptions as a client" and 'Appearance matters'. Although each theme stands alone, the three can also be conceptualised as a process (as depicted in Figure 1) where the assumptions made by the women in response to what they observe about the therapist can have the power to impact upon the therapy itself.

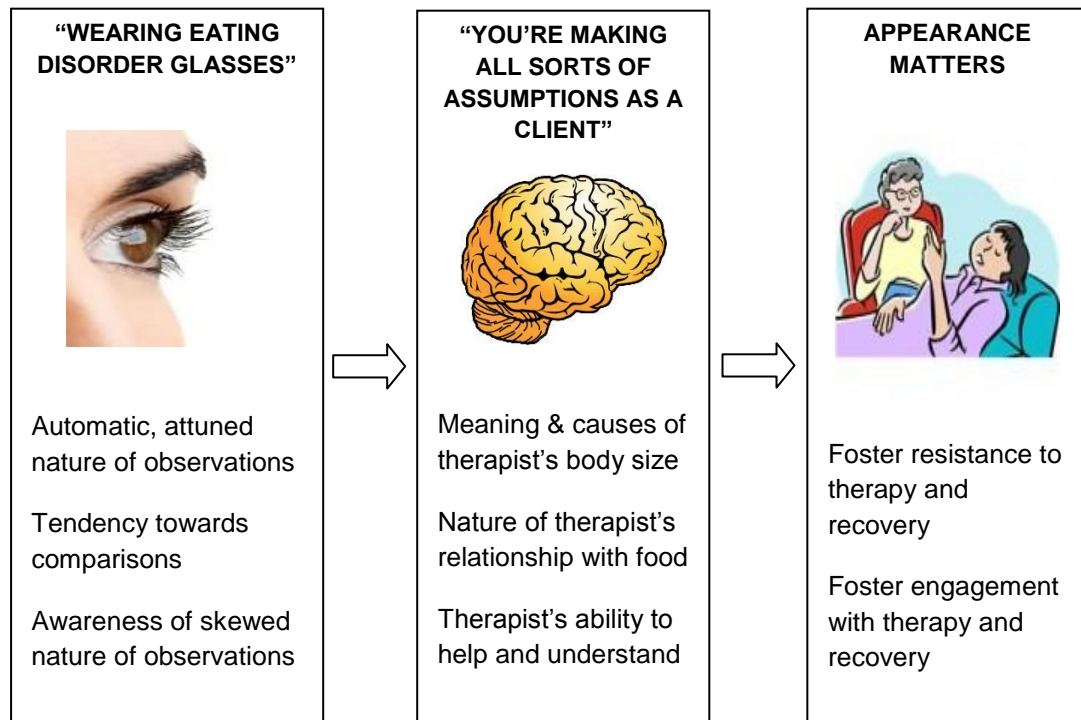


Figure 1 Links between the themes "Wearing eating disorder glasses", "You're making all sorts of assumptions as a client" and 'Appearance matters'

³ Although the study was primarily designed to explore ED clients' beliefs about an ED therapist's body and relationship with food, the interviewees also spoke about their beliefs in relation to other ED health professionals (e.g., psychiatrists, CPNs, dieticians, inpatient nursing staff). Consequently, the term 'therapist' is used both in reference to therapists in particular, and when reference is being made at a more general level to the phenomenon identified during the analytical process – when an interviewee is speaking about a health professional other than a therapist the precise term (e.g., dietician) is used.

Extracts from the interview transcripts are used to demonstrate the interpretative adequacy of the analysis and give voice to the interviewees.

“Wearing Eating Disorder Glasses”

The theme “*Wearing eating disorder glasses*”, with its sub-themes ‘*Automatic, attuned nature of observations*’, ‘*Tendency towards comparisons*’ and ‘*Awareness of skewed nature of observations*’, describes the characteristics of the women’s apparent predisposition to observe body- and food-related stimuli. Although the analysis below focuses primarily on their observations in the therapy room, in order to provide context and a fuller picture of the way in which they were acutely aware of body- and food-related stimuli throughout their day-to-day lives, reference is also made (when appropriate) to the women’s descriptions of their observations and observational tendencies outside the therapy room.

Automatic, attuned nature of observations. Whether they were conscious of it or not, each of the women appeared highly attuned to body- and food-related visual stimuli. For most of the women this was something they seemed to be aware of. As Lucy put it: “You kind of sort of size somebody up,” and as Sophie described it: “If I see somebody therapist or anything, I’ll immediately sort of scope them out.” For Katie though, this did not appear to be the case. When asked what she felt was important about a therapist’s weight or shape Katie said: “I’m never bothered by a person’s appearance, I never ever really take it in.” Yet, when talking about her past therapists, she was able to describe their appearance in great detail and, when asked if she ever speculated about a therapist’s body

shape and weight before seeing them for the first time, Katie said: “It is the biggest thing that we all talk about.”

The women seemed to accept their observational tendencies as a normal part of their daily routine and spoke with freedom and ease about what they saw – whether it related to their therapist’s body weight or shape in general, or to a specific part of their body in particular: “I noticed she’s [therapist] got a slightly rounded stomach when she sits down” (Claire). While Claire spoke about the way in which she found her therapist’s rounded stomach “reassuring”, Megan spoke about her distaste for such “wibbly bits”:

So many teenage girls have them, [I’m] so obsessed by this, this, I mean again I know that a woman’s stomach is supposed to be rounded, I personally can’t stand that, but there’s a difference between rounded and sticking out there which so many of them have.

Megan’s use of the quantifying term “which so many of them have” adds authority to her assertion and is indicative of the scale of her observational activities. She was not only aware of others’ size, shape, dress and style to a degree unmatched by the other interviewees, but also, it appeared, tortured by what she saw in a way that the other women never referred to: “I have to be in the right frame of mind to go to shops because, quite frankly, there are a lot of thin teenage girls there and sometimes it does my head in.”

Furthermore, Megan seemed at times to be almost out of control of her behavioural responses to her observations:

I followed somebody the other day I saw this lady and I followed her she looked so awful I followed her oh my God I can't believe I'm turning into a stalker she was very overweight, she was very short, and she was wearing a skin-tight dress, did her absolutely no favours whatsoever, it was too young a style, wasn't the right size, wasn't the right style, it was bad, I was fascinated.

Although Megan seemed more critical of others' appearance than any of the other women, "I do look at what they're wearing, does it suit them, does it fit them, does it flatter them, I do look at how they sit," she was not alone in observing (and making judgements about) a therapist's clothing. Sophie, for example, was particularly attuned to whether or not a therapist made an effort to look after herself and felt that she "clicked better" with Sandra, her therapist who "Was sort of fashionable and kind of gave off the impression that she looked after herself," than she did with three other therapists and community psychiatric nurses who wore: "Just like baggy T-shirts and jeans and stuff like that and I just kind of thought 'mmm', don't know, it's like they didn't really sort of make the effort sort of thing." From woolly cardigans that were perceived as "reassuring" (Nina), to "dreadlocks flowery things and weird sandals" being seen as "eccentric, bleurgh" (Amy), the women both noted and felt a reaction to the clothes their therapist wore.

The women's acute observational tendencies were also evidenced in their awareness of others' food consumption and eating behaviours. Communal meals with members of staff on inpatient wards and trips to hospital canteens for day-patients were spoken about in particular by the interviewees. Nina, for example spoke about the way in which: "S-ome of

the staff sort of in the eating disorders unit would, they wouldn't talk about diets, obviously, but you'd notice, 'Oh they're eating diet food'." Indeed, as the extract below from Claire demonstrates, the women noticed all kinds of things about staff eating habits:

I'm finding it fascinating, well kind of fascinating I'm finding it reassuring and helpful eating lunch because we always have at least one or two members of staff eating with us it's interesting to see how much they choose to eat and what they eat every day, and sometimes you know they'll have fruit and yoghurt, and sometimes one of them will have crisps instead or [a] bar of chocolate even and the this kind of thing as if it was completely, as if it was completely normal.

Claire's reference to the fact that the staff would sometimes eat crisps and chocolate "as if it was completely normal" highlights the way in which her own relationship with, and beliefs about, food have reshaped her world and her norms to a point where she cannot quite understand that eating crisps and chocolate is indeed "normal" for many people. Thus Claire's words create the image of an outsider looking in on the activities of a group they do not belong to – the staff members being positioned not as lunch companions but as people who belong to the non-ED world.

The reshaping of the women's worlds was also evident in the attention they gave to objects or events that might well go unobserved or unacknowledged by someone without an ED. Sam, for example, described how she would "Look for the like scarred knuckles or, you know, that type of thing" to see if her therapist: "Engaged in some, some of the bad habits [of

an ED].” And Nina spoke about the way in which she had noticed and been “upset” by her consultant’s “rumbling” stomach. Indeed Hayley, who saw herself as fully recovered and thus able to reflect upon her ED experiences and behaviours from that place of recovery, explicitly spoke about this very phenomenon when she remarked that while she had noted her psychiatrist’s desk drawer full of oranges: “Somebody without an eating disorder probably wouldn’t even have acknowledged the drawer of oranges.” Thus the women appeared alert to multiple aspects of their therapist’s body – its size and shape, what was worn on it, what went into it and clues as to whether or not it might once have been subject to an ED were all noted to a greater or lesser extent by each of the women. These observational tendencies did not, however, end with a simple noting of what was seen as the women frequently made comparisons between what they saw and themselves.

Tendency towards comparisons. It was clear from the way in which the women spoke about their tendency to make comparisons that it was as automatic as their tendency to take in the body- and food-related stimuli in the first place. As such it seemed that they were almost unable to control what they were doing, it just overcame them:

I probably, without meaning to, every street I walk down, every person that I pass I do a kind of split second assessment, ‘Am I bigger than them? Am I smaller than them?’ and I can’t stop, I can’t help from doing it. (Claire)

This sense of being unable to control their comparison-making tendency was encapsulated by Hayley who actually presented it as a normative part

of having an ED – so natural in fact that she felt it was “obvious” that a client with an ED would compare themselves to their therapist: “That’s what you do when you’ve got an eating disorder, compare yourself to everybody like obviously you’re going to compare yourself to the person who’s trying to help you.” The women’s belief in the inevitability of comparison-making either went unquestioned or, in Sophie’s case, was attributed to her neural networks: “It’s such a huge feature in my life and it’s kind of how my brain operates, is what that person looks like and then sort of comparing yourself.”

Although the women appeared fully aware of their body-related comparisons, it appeared at times that they were less aware of the extent to which they made food and eating comparisons. Alice, for example, spoke about the fact that she would “slightly” watch what people ordered when she went out with a crowd. Yet, when she described a recent lunch with a group of friends, Alice was able to compare in detail her own choices and consumption with that of the friend sat next to her, and was aware of the fact that her friend had been the only one on the “whole” table to order dessert:

We ordered the same thing yes, except that I didn’t have the mashed potato and she did but I did have the calves’ liver which I literally never have and ate the whole lot as well and she had a pudding, I didn’t but she, you know, she was the only one on the whole table who had a pudding.

Alice’s description is informative not only because it highlights the level of detail in her observations and comparisons but also because it

demonstrates the way in which she justifies (to herself or perhaps to me as her audience) what might be perceived as her own minimal eating (calves' liver without the mashed potato which normally accompanies it). By emphasising the rarity of having allowed herself something she would never normally eat and focusing on the fact that she was not alone in declining a dessert, she effectively diverts attention away from the issue of whether or not what she ate was 'normal' or sufficient. Similarly, Katie (who sometimes ate lunch with her therapist) seemed deeply upset that she was having to eat more than her therapist who was on a weight loss diet, despite the fact that she was only eating a regular amount herself: "She had Ryvita and cottage cheese for lunch and I'd say to her 'But it's not fair that I have to have a full brown bread sandwich with tuna and salad cream and a banana'." Once again the comparison is presented with both detailed description and attention-directing emphasis which seem to work, in this instance, to convey how unjust Katie felt it was that she should have to eat so much – thus a tuna sandwich and banana becomes a "*full* brown bread sandwich *with* tuna *and* salad cream *and* a banana." Yet in both instances it appears that the comparison being made is without context – in Alice's case it is her own under eating which is missed and in Katie's it is the fact that a tuna sandwich and banana is not – to someone without an ED – a large quantity of food. In contrast, the women's narratives suggested that when it came to body size as opposed to portion size, they were aware of the lack of accuracy of their perceptions.

Awareness of skewed nature of observations. The women were clearly aware that their perceptions of body size could be skewed or

distorted and again they seemed to accept it as a normative part of an ED. Thus Sarah described the way in which: “People with eating disorders don’t see size, they see themselves as bigger and everyone else as thinner, so they don’t actually see what’s really there.” And Sam stated that: “Images are distorted anyway so they [therapist] might be [a] normal [size] but you see I’d see it differently.” As one of the women who saw herself as fully recovered, Sam was also able to reflect upon her past perceptions from outside the ED experience. Consequently, when trying to decide whether or not the therapist she had worked with while in hospital really had been thinner than her, she said: “I can’t picture her now as she was then because I probably saw her as thinner than she was and myself larger than I was.” Although Sarah and Sam spoke of their perceptual inaccuracies with acceptance, Claire seemed annoyed and somewhat bemused by her own. In particular she described the way in which her therapist had encouraged her to compare their thighs in order to challenge the mismatch between her cognitive awareness of being ‘underweight’ and her felt sense of being ‘fat’:

She [therapist] said ‘Well when you look at me what do you see, do you would you say my thighs are too fat?’ and I was like ‘Well no, not at all’ and she said ‘Well would you say they were bigger than yours?’ [and] I was like ‘Well yes, I would say they were bigger than mine but I still think mine are too fat’.

Claire’s annoyance seemed to be compounded by her awareness of the instability of her perceptual inaccuracies and the fact that although she often felt her thighs were “too fat”, there were times when in fact she thought they

were “fine”. This instability was referred to by Megan as well as she explained how she both saw and judged things differently to others:

I look in the mirror and I don't, I know I don't see what everybody else sees but I can, I can see sometimes you're more bones sticking out or stuff like that so I ca-, I can judge my judging standards are [just] different to everybody else's.

Hence it was evident that while the women were indeed aware of their skewed perceptions of body stimuli, their distortions – and their attitude towards them – were multiple, unique and variable.

Although there was a general acceptance and awareness of the skewed nature of body-related observations, when it came to food and eating only Hayley made reference to how perceptions could be inaccurate. Speaking about the way in which she had gradually started eating in order to avoid being sectioned as a result of further weight loss, she said:

So I started eating [what I would see as] very very minimally now but I thought it was like huge back then because I'd only been eating something like once every nine days and so I was basically eating like a bowl of vegetables type thing a day.

Hayley's reflection, made from a place of recovery, contrasts with Alice and Katie's food-related statements discussed above and highlights the way in which the skewed nature of the women's perceptions was very much a part of being 'in' an ED.

In summary, it was clear from the women's narratives that they lived in a world that was visually focused on bodies and eating – not just their own but also that of those around them. Furthermore, it appeared that this focus

was supported and shaped by their automatic, attuned observations, their comparison-making tendencies and the skewed, unstable nature of their perceptions. Yet, according to Hayley and Sam's reflections, although this focus could be all-consuming, it is left behind once recovery is achieved. The next theme describes the ways in which the women seemed to make assumptions and speculations based upon the information they gathered through their observations.

“You’re Making All Sorts of Assumptions as a Client”

The theme *“You’re making all sorts of assumptions as a client”* with its subthemes *‘Meaning and causes of therapist’s body size’*, *‘Nature of therapist’s relationship with food’* and *‘Therapist’s ability to help and understand’* encapsulates the women’s tendency to speculate and make assumptions about their therapist based on the (sometimes distorted) observations they had made. It also highlights the ways in which the women’s assumptions and speculations seemed to be influenced by both their own experiences of living with an ED, and by a number of cognitive distortions. The automatic, unquestioning nature of the women’s tendency to speculate and make assumptions can be seen in Hayley’s assertion that: “You’re making all sorts of assumptions as a client about what’s going on in terms of a-any-thing that’s physically obvious.” And in Sophie’s belief that: “First impressions and what they look like would sort of form a lot of your sort of preconceptions about them and your opinion of them.” It is noteworthy here that Sophie uses the words “form a lot of” when describing the contribution of visual appearance to her preconceptions and opinions of someone – the way they look does not merely ‘contribute to’ or ‘inform’ her

thoughts, instead it dominates and “forms” them. In particular, this was true of the assumptions and speculations the women made about the underlying reasons for a therapist’s body size and the likelihood of her having, or having had, an ED herself.

Meaning and causes of therapist’s body size. It was clear from the women’s narratives that they made assumptions about therapists’ bodies of all shapes and sizes and that, in doing so, they were drawing upon particular understandings of the meanings and causes of both ‘fatness’ and ‘thinness’. Without question, therapists who were perceived to be ‘fat’ (the women generally defined this as being larger than a UK dress size 14) were assumed to eat too much, to have “lost control” (Nina) and to have an unhealthy “perception” of food (Hayley). Sam, for example, spoke about the way in which derogatory comments such as “Where have all the doughnuts gone?” were made about ‘fat’ therapists by inpatients on the ED ward she had been a resident on. In addition to invoking an overeating, out of control explanation for a ‘fat’ therapist’s size, the women also held beliefs about the actions such therapists should take to reduce their size. Accordingly, Megan asserted that a therapist with a dress size of 16 or above should “Go on a diet” and Sarah stated that: “It’s easy, how can you get overweight? You just throw your food up.” Implicit in their narratives were thus the ideas that being ‘fat’ is an unnatural, intolerable state that should be remedied, and that engaging in disordered eating behaviours such as throwing up is better than being ‘fat’. Indeed Megan felt quite sure that you could never be truly comfortable as an ‘overweight’ person:

I think people may think, have convinced themselves, that they're happy with their style and their size and they're saying to themselves 'Well I don't want to be one of those really skinny people who stress about things', yeah but if somebody gave you a magic pill and said 'This will help you lose a stone', would you take it? [Megan starts nodding] mm-hmm.... so, you know, there was lack of them being less than honest with themselves.

'Thinness' was thus seen and presented by the women as a universally desirable state, one which – in their minds – *everyone* would like.

In contrast to their singular belief that 'fatness' was the result of excessive eating, the women saw 'thinness' as either a "natural" or "biological" state, or as something that could be achieved by "forcing" or "maintaining" your body through diet. Interestingly, although they agreed about the existence of these two – competing – explanations for 'thinness', they were at odds regarding whether or not you "could tell" which explanation was true. Amy, for example, said: "I think you know intuitively whether it's skinny because it's biologically or whether it's skinny because we are forcing our bodies into a skinny size". Somewhat less certain about discriminating between the two causes of 'thinness' was Susie who felt that: "Sometimes it can be quite hard to tell if it's entirely natural or not, but, you kn-, you can to a certain extent based on their just general colouring." And, convinced that you could not be sure about the reasons for someone's 'thinness', Claire stated that: "You wouldn't know whether that person was just naturally that build or whether they were doing something to, to maintain it."

It appeared that the women's thoughts about a therapist's 'thinness' could be swayed by the presence of additional visual information. Race was one such factor mentioned by Nina when discussing her ED consultant: "She's Asian so in my head I know that well that's just her make-up I probably weigh more than her and that hasn't bothered me because I've just thought 'well that's just obviously how she is'." Although there may indeed be links between 'race' and morphology (Saldanha, 2011; Sesardic, 2010), Hayley's assertion that her therapist's 'thinness' was probably related to the fact that she was "very tall" is perhaps as unfounded as Alice's assumption that her therapist would not bother about her own weight because she looked "very masculine."

When additional visual information that could explain a therapist's 'thinness' was absent, the women instantly considered the possibility that their therapist might have an ED history – especially when she worked in an ED service (as opposed to in private practice or within a school or university counselling service). Sam, for example, recalled a fellow inpatient telling her that the ED therapists had chosen to work there because: "They've all got their own issues with food." Although Sam's fellow inpatient was unusually adamant in her assertion that "all" ED therapists have issues themselves, many of the interviewees' questioned why someone would want to work in the ED field and wondered if it was because the therapist had had an ED themselves. Katie, for example, said:

I always wonder 'have they gone into it because they've had issues themselves?' and [I] wonder whether they're now recovered and want to do something to help and kind of give back what, the help

they had, or whether it's stayed an interest for them, not an obsession but an interest, or whether they are still a bit ill and they're doing it because it is such an obsessive addictive kind of hobby almost.

Katie's description of EDs as "an obsessive addictive kind of hobby" is somewhat contradictory as it both accentuates ("obsessive addictive") and minimises ("hobby") the severity of EDs – a contradiction which is perhaps indicative of Katie's own experience of having an ED. Furthermore, it is noticeable that Katie fails to offer an explanation for an ED therapist's motivation to work in the ED field that is not related to them having had an ED history. Indeed, it appeared from the women's narratives in general that their natural inclination was to see EDs and restriction wherever they looked – especially when they were looking at a 'thin' therapist.

Nature of therapist's relationship with food. The women seemed to use a therapist's size and character to make deductions about their diet and relationship with food. Claire, for example, remarked that: "The dietician, she looked like somebody who was very rigid and controlling about what she ate, she looked like she would not allow her body to devel-, you know, to gain an ounce of fat." Similarly, when speaking about her therapist, Lucy said:

It came across that she was quite a reserved person and I think that she probably had that kind of relationship with food as well, sort of like, 'No I'm not going to have a McDonalds today', you know, sort of very strict with herself, very controlled person.

Claire and Lucy not only make unquestioning assumptions about the parallels between their respective therapists' characters and their relationships with food but also they seem to project onto them the type of relationship that they themselves have with food. Thus Lucy spoke the words "No I'm not going to have a McDonalds today" with a steely determination that was perhaps indicative of the way in which she had spoken to herself when she had been restricting and controlling her own intake. And Claire's reference to her dietician looking like she would not allow her body "to gain an ounce of fat" was said with a disgust which mirrored the contempt that was evident when she spoke about gaining weight herself. As such, the women's descriptions of their therapists revealed as much about their own relationships with food and their bodies as they did about their tendency to make assumptions based on what appeared to be very limited information.

Although on many occasions the women seemed unaware of their tendency to "project" particular relationships with food onto their therapist, there were times when this was not the case. Indeed, just as the women had sometimes been aware of the ways in which their perceptions could be distorted, so it seemed that there were also times when they were aware of their projections. For example, when discussing her former belief that her psychiatrist had issues because she had a drawer full of oranges, Hayley said that: "I think you project that people that are thin or appear to be the low end or underweight don't eat very much." Similarly, although the women frequently assumed that a 'healthy'-sized therapist (this was generally defined by the women to be someone with a UK dress size 12–14) had "a

good relationship with food” (Lucy), Nina said that she had probably assumed her therapist had no problems with food because: “That was what I needed to see in her whether that was true or not.” Thus Nina was not only aware of her projection but also of her need, and reason, for it.

As will become apparent below, the women’s assumptions and speculations about their therapist’s body size and relationship with food clearly influenced their beliefs about the therapist’s ability to help them.

Therapist’s ability to help and understand. It was clear from the women’s narratives that their perceptions of a therapist’s size, ED history and body confidence status had the potential to foster or diminish their belief in the therapist’s ability to help and understand them. Interestingly, conclusions about a therapist’s ability to help and understand were also drawn from the therapist’s gender and beliefs about their age.

‘Fat’ and ‘thin’ therapists. Although very few of the women had actually worked with a therapist they considered to be ‘fat’, it was evident from the way in which they spoke about the possibility of doing so that they had doubts about such a therapist’s ability to understand them. Lucy, for example, described how she would think: “Well you don’t actually know where I’m coming from because you don’t kind of get it,” while Alice said that she would think: “If you’re overweight how would you know what I felt like?” In addition to believing that ‘fat’ therapists would be unable to understand them, the women also seemed to believe that ‘fat’ therapists were personally lacking – that they were, as Amy put it, “somehow inferior.” As Megan explained: “I see it [eating more than you have to] as a weakness

and I probably, totally honestly, would look down on them slightly thinking ‘Just control yourself.’” Hence ‘fat’ therapists were positioned as both lacking in understanding and as morally deficient in some way. In contrast, the women did not tend to link a therapist being ‘thin’ with an inability to understand or empathise. The only exception to this was Hayley (who felt her ED had been a delayed reaction to childhood trauma and a desire for a gender neutral, rather than a ‘thin’, body) who said she would worry that a therapist: “Who was naturally very thin wouldn’t understand and they’d just assume it was about trying to be very thin.” Similarly, no connections were made between ‘thin’ therapists and a moral deficiency or lack of control, although Nina felt that: “If they’re in that role of helping you and they’re underweight there’s something about them you can’t trust.”

Thus while the women saw ‘fat’ therapists as unlikely to understand and empathise with an ED, and as lacking in control and even morally deficient, they questioned a ‘thin’ therapist’s relationship with food, made speculations about her having an ED history and wondered about her trustworthiness. Hence it was clear that the women made multiple, often contradictory and idiosyncratic, negative assumptions about both ‘fat’ and ‘thin’ therapists based on their perceptions of the therapist’s size – assumptions that related not only to the therapist’s ability to understand and help them but also to aspects of the therapist’s character.

Therapists with(out) an ED history. The women’s tendency to speculate about a ‘thin’ therapist having an ED history was important because it was apparent from their narratives that they held an array of ideas about how an ED history might influence a therapist’s ability to help. In

particular, therapists with an ED history were believed to be “better equipped to deal with it” (Sophie) and as having an “innate understanding” (Amy) which would enable them to “see through the lies” (Sam) and: “Know not to take you at face value and they know the kind of tricks you play on yourself, things that you say they would know what questions to ask better as well” (Claire). Furthermore they were also seen as knowing first-hand “about the way it can usurp onto the mindset” (Susie), as being “easier to talk to” (Lucy) and as offering “comfort” because you would know that: “They get you when you say you’re you feel too big to walk through a door” (Katie). In addition to seeing advantages in a therapist having an ED history, the women also saw disadvantages. In particular they were concerned that a therapist with an ED history might “lead the client to think certain things” (Sophie), not realise that “just because they experienced [it] like that it’s not how everyone experiences [it]” (Sarah) or that: “There’d be too much weight carried on their experience to sort of be an example of what, you know, of a sort of almost mass equation of how I should stop [my] cognitive thinking, or whatever” (Susie).

In contrast, although therapists without an ED history were believed to have less understanding, this was sometimes seen as a benefit: “Something that was really helpful for me was actually to see somebody who didn’t assume they already knew exactly what it was like” (Claire), and as enabling the therapist: “To come into it quite open-mindedly and also be quite optimistic and helpful in terms of what it’s like to have a healthy relationship with food” (Katie). Thus although most of the women preferred the idea of seeing a therapist with an ED history, this preference was not unanimous.

Therapist's (body) confidence. One particular aspect of a therapist's character referred to by the women was that of their 'confidence'. In particular the women spoke about the way in which they could gauge a therapist's confidence by both their body language and their self-presentation. Furthermore, it was clear from the women's narratives that their deductions had the power to influence their beliefs about the therapist's ability to help them. Megan, for example, said that:

If somebody seemed uncomfortable I would put that down to how they felt about themselves and if they seemed uncomfortable then obviously I'd then feel uncomfortable because I'd be thinking, 'Well do they know what they're doing? Are they competent in this setting? Am I wasting my time?'

And Nina too felt that: "If you pick up that they've got a sort of doubt about themselves then that makes you think they can't help you." Hence the women seemed to make a direct link between a therapist's apparent self-confidence, her skills as a therapist, and her associated ability to help them. For Sophie though it was not just her therapist's self-confidence but her apparent confidence in her body that was important because it enabled Sophie to feel that her therapist was:

Equipped to make you feel that way if they respect, they seem to respect themselves, I think it's easier for you to respect them as, not somebody with authority but somebody with the skills kind of the upper hand in a way, that they are capable of sort of helping you.

Sophie's words emphasise the somewhat tenuous links that were sometimes made by the women between visual aspects of their therapist

and their ability to help – therapist self-confidence and liking their own body are not empirically supported predictors of treatment success. Similarly, although there is no evidence to support the idea that a therapist's gender or age can impact upon treatment success, the women nonetheless saw both factors as potentially indicative of a therapist's ability to help.

Accordingly, the women seemed to link their belief that men tend not to worry about their bodies as much as women, to the idea that a male therapist would not be able understand them. Likewise the women seemed to think that a young therapist would be unable to help them due to a lack of either life or professional experience.

In conclusion, this theme has outlined the multiple ways in which the women made assumptions and speculated about their therapist's body size and relationship with food based on their observations of them. Furthermore, it has highlighted how these speculations and assumptions shaped the women's perceptions of the therapist's ability to help. The third and final theme describes how the women's assumptions and speculations had the potential to influence their willingness to engage in therapy.

Appearance Matters

The theme '*Appearance matters*' with its subthemes '*Foster resistance to therapy and recovery*' and '*Foster engagement with therapy and recovery*' describes how the women's observation-based assumptions had potentially far-reaching implications for their attitude towards the therapeutic endeavour. In particular, it illustrates how a therapist being 'thin', 'fat', having (or being perceived to have) an ED history or eating in a session

could reduce the women's willingness to engage in therapy while a therapist being a 'healthy' size could enhance it.

Foster resistance to therapy and recovery.

'Thin' therapists. Working (or the idea of having to work) with a 'thin' therapist was repeatedly presented as problematic by the women. As Sam, who had worked with a therapist she considered to be "really" 'thin', explained: "It wasn't helpful at all when that was my only intention, was to be like them." The idea that a 'thin' therapist's body could be something to aspire to or a source of envy was also evident in Megan's description of the response she would have to such a therapist: "[I would be thinking] 'Am I jealous of you because you're just born that way, you cow, or am I jealous of you because you're doing a better job of this than I am?', you know, 'Your eating disorder's probably better than mine'." Inherent in Megan's words is the idea that an ED – like a job – can be done with varying degrees of success and that any two people with an ED can be compared with one another in terms of how well they are doing their ED. In contrast, rather than feeling jealous or being inspired by a 'thin' therapist, some of the women said that they would begin to question whether or not they actually needed help. Susie, for example, said that if her therapist was 'thin' her first thought would be: "“Oh my problems aren't really a big deal' if they're quite clearly pretty much the same size as me, then, you know, 'What are we both doing here?'” In all three quotations it is apparent that the women are making comparisons between their own body and that of their therapist – comparisons which have an impact on the way they feel about their own ED and thus, potentially, on their engagement with therapy. Indeed, when it

came to weight-gain in particular, it was clear that the women would find themselves struggling if their therapist was 'thin'. Amy, for example, spoke about the fact that:

If I was with somebody skinny and I was having to put on weight I would have found that quite unfair you know, 'How come they can stay so skinny? How come I've got to put this weight on? That seems like wrong' and I would have battled with that.

The idea that it would be "unfair" to have to put weight on if your 'thin' therapist did not have to was common amongst the women. Hayley, for example, described the difficulties she had experienced while working with a 'thin' therapist: "At that point my dietician was like 'Can you eat more fats in your diet?' and I was like 'But if she [thin therapist] doesn't do it why do I have to do it?'" Indeed, Hayley actually felt that her therapist's 'thinness' endorsed her own undereating: "My perception was that she was eating less and that it was okay to eat less if she was eating less." Hence it was clear from the women's narratives that in addition to any ambivalence they might already be bringing to therapy, they could find additional fuel for not engaging if their therapist was 'thin' and appeared not to be trying to gain weight herself.

Furthermore, working with a 'thin' therapist also seemed to engender in the women a range of negative feelings and concerns about themselves and the way in which their therapist might perceive them. For Claire, this was particularly difficult in a one-off session she had with a 'thin' dietician:

I just felt like I, it was so shameful to admit that you know the, the, the a- the problem is that you eat too much 'You're just a greedy fat pig'

and to admit that to somebody who looks too thin or even just thin you'd think they would be just as condemning of my greed as I am or even more so.

Although Claire reported no evidence of actually being condemned for her “greed” by someone who was ‘thin’, her certainty that the dietician was indeed condemning her meant she felt so bad about herself that she never went back. Similarly, Lucy spoke of the intense negative feelings she had experienced as a result of believing that her “reserved”-looking therapist had a strict, controlled relationship with food:

You kind of compare yourself to them and think do you, you know, ‘Actually I’m a really bad person compared to you who, who can maintain this, this good like figure and not go under but not go over. [There’s a] very very controlled person that’s sat in front of me and I’m just sat here and I’m completely out of control and I don’t know what’s going on in my life and my life’s a mess and I’m feeling a little bit inferior to you right now’.

Claire’s and Lucy’s words highlight once again just how negative the women’s self-perceptions could be. Claire’s description of herself as a “greedy fat pig” in particular highlights the self-hatred she felt towards herself – self-hatred that was common in many of the women’s narratives. Furthermore, Claire’s words also reflect once again the way in which the women appeared to project their own ways of thinking onto their therapists – in this instance Claire assumed that her therapist would see her as the same “greedy fat pig” that she saw herself as.

Thus it was clear that the women experienced a broad range of potentially therapy-interfering feelings when working with a 'thin' therapist – from jealousy, envy and unfairness, to shame, condemnation and inferiority.

'Fat' therapists. It appeared from the women's narratives that they were particularly concerned that if they worked with a 'fat' therapist they would end up bigger themselves. As Sophie explained: "If somebody sits opposite me and is telling me that 'Oh you need to increase your intake and you need to do this' and they're overweight I'm gonna be thinking, 'If I do it I'm gonna end up bigger'." Nina voiced the same concerns as she described how she would feel that: "They've lost control so they're not gonna tell me when it's time to stop putting on weight". Hence it appeared that the women's assumptions about 'fat' therapists (as described in the previous theme) meant that they were unable to trust in a 'fat' therapist's professional abilities and consequently felt that they should not listen to her. For Amy, her belief that a 'fat' therapist could not help was so strong that she said: "If she [the therapist] opened the door, if she'd been, you know, obese I think I would have just got back in the car and driven off, I would have managed one session but I wouldn't have gone back."

Megan raised a further issue in relation to 'fat' therapists, namely that of being totally distracted by their size. Talking about a psychiatric nurse who had co-run a group she was a member of, Megan explained how:

I considered her overweight and yet she seemed really comfortable with it, but it really got in the way for me because I spent so much time thinking, 'Are you really comfortable with it?', and I started wondering about, you know, 'What do they do, do they, do they all go

into their staff room and, and, at lunchtime, and get out really unhealthy packed lunches?’ or, you know, ‘What do eating disorder therapists eat for lunch?’

Megan went on to say that she had become “really hung up on the whole thing” and that it had “got in the way” for her. Thus it appeared that there were also multiple reasons why the women struggle to fully engage with a therapist who was ‘fat’.

Therapists with an ED history. Another situation which seemed to hold the potential for problems in the therapeutic setting was that of the client working with a therapist who had an ED history (be it a disclosed one or a speculated one). Two scenarios in particular were spoken of by the women. The first, described below by Claire, was that knowledge or speculation about the therapist having an ED history could lead the client to feel they had to: “Get even worse, just in case the therapist had been at death's door and was sitting there pretending to be concerned while actually thinking ‘That's nothing compared to what I went through’.” The idea that a client might feel the need to get worse was supported by Sarah who offered an alternative explanation for why such a drive might arise: “Even if I don’t know how ill they got I would probably feel that I would need to be iller than them, because it [an ED] is competitive.” Although Claire and Sarah are suggesting different causes for a client feeling that they had to lose more weight, both are demonstrating the women’s general tendency to make exaggerated deductions based on little (or no) factual information – indeed Sarah even acknowledges the fact that she would feel the need to make herself worse despite not knowing how ill the therapist had been.

Furthermore, Claire's words highlight once again the women's tendency to view themselves negatively and to feel bad about themselves or inadequate in comparison to their therapist.

The second scenario spoken about by the women was that of a client feeling they had to protect the therapist if they knew they had an ED history. As Sam explained: "I'd spend quite a lot of time just worrying about them, hoping that they're alright, that type of thing I'd be very conscious about what I said just in case that umm, triggered anything for them." Hayley too was concerned that by speaking about her own problems she might "make them [the therapist] worse" and Sarah wondered: "Working with people with other eating disorders couldn't that trigger them [the therapist] or bring it all back for them." Implicit in the women's concerns seems to be the idea that recovery is precarious and that relapse could easily be triggered. Indeed, for Claire, a therapist being female (let alone having an ED history) was enough for her to feel uneasy: "I still feel uncomfortable a little bit, talking with, with women, especially women in a kind of helping role who, about my struggles with eating because I'm thinking 'Well how is this making you feel?'" Claire's general discomfort about talking to women about her struggles with food, in conjunction with her specific worry about unknowingly working with a therapist who had an ED history, were so great that she avoided female therapists altogether saying: "I know men have eating disorders too [but] It's much more likely that a man will have just quite a normal healthy relationship with food and with his body."

In addition to the two scenarios described above, Amy mentioned one further scenario which struck her as particularly problematic, namely that of an 'overweight' therapist disclosing that they had recovered from AN:

If they were really overweight then I would think 'Oh my God, they've had anorexia and now they're like sixteen stone, shit,' that, that would to me feel like 'I don't, if that's what it's going to be like, if that's what recovery is, yeuck.'

Amy's deduction (that if one woman who has recovered from AN is sixteen stone then she too would be sixteen stone if she were to recover) epitomises the women's tendency to overgeneralise based on a single case, while simultaneously failing to seek, or take into account, contradictory evidence.

Hence it appeared that for multiple reasons, knowledge of, or speculation about, a therapist having an ED history could elicit in the client a sense of needing to make themselves worse, a worry about triggering the therapist into a relapse and a fear of becoming 'fat' if therapy and recovery is engaged with.

Therapist eating in session. A further factor that seemed to have a negative impact on the women was that of a therapist eating *during* a therapy session. For both Nina and Amy it was an experience that had made them quite angry. Although Nina began by describing her consultant's in-session eating as "inappropriate", she went on to excuse it as: "Maybe necessary because she probably doesn't get to eat otherwise". Upon further discussion though, it became apparent that while she might be trying to see

it as “necessary” and thus perhaps as not a problem, it had actually been quite a significant issue for her. As Nina explained:

I just felt that she wasn’t concentrating and it wasn’t necessarily that she was eating it, and part of it was a bit of jealousy as well a bit of ‘well how can she just sit there and eat like it doesn’t mean anything, you know, it’s not, it’s not a big thing to her’ and that made me quite angry so I suppose in that way it probably did influence the appointment.

Inherent in Nina’s words are two conflicting positions. On the one hand she is claiming that because her consultant is eating she is not concentrating on the appointment and on Nina – a statement that reflects Nina’s own experience of being unable even to eat with her husband and son when she first left hospital because she needed to: “Sit on my own and focus on what I’m meant to be doing.” Yet on the other hand Nina is saying that she is jealous of her consultant because eating does not appear to be a “big thing” for her – in which case doing it in an appointment should not necessarily be a distraction from her client or the things they are discussing. Ultimately though, while this contradiction is insightful in terms of the information it provides about Nina’s own thinking and the fact that she does not reconcile the difference between the two positions she presents, what is especially important in terms of therapeutic process is the fact that Nina felt the consultant’s eating had made her “quite angry” and influenced (though Nina did not explain how) the appointment.

Amy also reported feeling angry in response to her therapist’s eating though her reasoning was very different to Nina’s. As Amy explained:

I remember her distinctly eating a banana once during our session and sort of being slightly horrified that she was eating during a session, and w- and then thinking 'She's just doing this t-, just test me out', and and thinking 'Does she think I'm just not aware of this?', and then not knowing this whole 'Is she testing me or is she eating a banana?', and this whole like 'Oh for f**k's sake, I just can't be doing with this.'

Amy's account illustrates not only her anger but also the degree to which she was distracted by her therapist's eating. Furthermore, her final remark "I just can't be doing with this" demonstrates how a therapist's behaviour could in fact lead a client to disengage from the therapy process completely. It is also interesting to note that neither Amy nor Nina reported being invited to discuss their therapist's in-session eating.

Foster engagement with therapy and recovery. In contrast to the wealth of observations and assumptions about a therapist's body size and relationship with food which seemed to have a negative impact on the women's willingness to engage in therapy, there were very few which seemed to have a notably positive impact. In relation to a therapist's appearance, however, it did seem that a therapist being a 'healthy' size could help make the prospect of weight-gain and eating 'normal' foods more palatable. Nina, for example, spoke positively about her experiences of being weighed by her size 14 support worker: "I'm glad that she is [a size 14] cos I look at her and think 'Oh she's happy, and she's that size' I sort of feel with her I suppose happier with putting on weight than I would with somebody who was slim." The women also seemed able to use a

'normal' or 'healthy'-sized therapist as a kind of benchmark against which they could assess certain kinds of eating behaviours. Hayley, for example, spoke about the way in which her 'normal', 'healthy'-sized therapist's disclosure that she ate take-out once a week helped her feel okay about the idea of eating take-out:

I remember her saying something about her having like a take-out every Friday night and I was like 'Oh, okay' and like 'She's normal and she's healthy and she eats a take-out on a Friday night, okay, that's fine.'

The idea of a 'normal' or 'healthy' therapist acting as a role model was expressed by a number of the women who saw such a therapist as offering them something that they too could (in time) have for themselves. Claire, for example, felt this was: "Not about learning from somebody else but you want to be able to take on a bit of what they have or instil a kind of sense of trust and a norma-, a sense of normality about food and eating." The idea of being able to "take on" what the therapist had was also evident in the women's belief that by witnessing someone else appearing confident about her own body they could be permitted to feel positive about their own body. As Sophie put it: "If somebody's sitting opposite you who's trying to help you, is the complete opposite of that [self-hating], it kind of tells you okay, it is possible [to like yourself]." Thus it appeared that one of the main ways in which a therapist could help a client engage with therapy and with recovery was by appearing to have a 'normal', 'healthy' body which they liked.

Final comments

As the analysis above has demonstrated, the women were keen observers of therapist body- and food-related cues in the therapeutic environment. Furthermore, it appeared that they made a number of assumptions – especially in relation to a therapist’s competence as a practitioner – based upon the visual information they gathered, and that these assumptions could have an impact on their resistance towards, or engagement with, therapy and recovery. Ultimately, when it came to a therapist’s appearance it seemed that Alice spoke for most of the women when she said: “Whilst it shouldn’t matter it probably does matter, because whilst I’m still having some sort of counselling I’m still vulnerable.” Vulnerable and primed to observe, to make assumptions and to be influenced by them – quite often in an automatic, unquestioned way.

Discussion

The analysis presented above offers preliminary evidence of a potentially important process taking place in the therapy room⁴; namely, ED clients' tendency to both observe their therapist's⁵ body and eating behaviours, and make assumptions and judgements based on what they have seen. The analysis also suggests that ED clients' assumptions and judgements may influence both their beliefs about their therapist's ability to help them, and their willingness to engage in the therapeutic endeavour. The links between these results and the ED research literature, the implications for the ED field and for Counselling Psychology in particular, and the limitations of the study and possible areas for future research are discussed below.

Overview of Findings

The importance of the therapist's body. The analysis clearly demonstrates the importance of the therapist's body in ED treatment. Accordingly, it offers support for the assertion at the end of Vocks et al.'s (2007) empirical study that a therapist's body size and shape might be a relevant factor for patients with an ED. Similarly, it provides evidence for the suggestion made by Warren et al. (2009) in the conclusion of their study

⁴ The term 'therapy room' is used here as the focus of the study was on the client-therapist relationship in particular – as mentioned above, however, the phenomenon being described appeared to take place between ED clients and ED health professionals (e.g., psychiatrists, CPNs, dieticians, inpatient nursing staff) in general so the findings are potentially relevant to therapy contexts other than the therapy room itself (e.g., inpatient dining rooms, group therapy spaces, psychiatrists' and dieticians' consultation rooms).

⁵ The term 'therapist' is used here as the focus of the study was on the client-therapist relationship in particular – as the analysis demonstrated, however, the phenomenon being described appeared to take place between ED clients and a range of ED health professionals (e.g., psychiatrists, CPNs, dieticians, inpatient nursing staff) in general.

analysing ED practitioners' experiences, that patients' observational activities might lead them to make 'therapy interfering judgments' (e.g., a client may see an 'overweight' therapist as incompetent) and distract them from what the therapist is saying and the process of therapy. More specifically, the analysis indicated that ED clients can have potentially therapy-interfering emotional and cognitive responses to both 'thin' and 'fat' therapists.

It was apparent from the women's narratives that working with, or the prospect of working with, a 'thin' therapist could evoke strong negative feelings – envy, jealousy, unfairness, shame, condemnation and inferiority in particular. Furthermore, the analysis showed that as well as feeling jealous and envious of a 'thin' therapist – feelings that self-proclaimed 'thin' therapists Lowell and Meader (2005) said they have been aware of evoking in ED clients – the women also tended to feel correspondingly more negative about themselves. This negativity seemed to stem from either the belief that a 'thin' therapist would view them with contempt and condemn them for their "greed", or the assumption that the 'thin' therapist had a rigid, controlled relationship with food – an assumption which left them feeling bad in comparison as they believed their own eating was chaotic or prone to binges.

Additionally, it appeared that working with a 'thin' therapist could, in itself, elicit resistance to treatment. This resistance seemed to occur when the women made one of two assumptions. The first assumption was that it is unfair for a client to have to gain weight if their 'thin' therapist does not have to. Underlying this assumption was an apparent fusion between the client's

perceptions of their own AN 'thinness', and their perceptions of their therapist's 'thinness', such that the two were seen as equivalent – hence the belief that if one of them should have to gain weight, so should the other. The second assumption sometimes made by the women was that the 'thin' therapist had had an ED herself and that it had been far “worse” than the client's own. Attached to this assumption seemed to be the belief that such a therapist would necessarily look down on her client or minimise the severity of her client's problems because her own ED had been so much “worse”. Thus these two assumptions (and their associated beliefs) appeared to lead the women to a (logical – to them) reluctance to engage in treatment. Additionally, there seemed to be an element of competitiveness in the women's desires to be at least as ill as they presumed their therapist had been – a finding which adds to the results of previous studies that have described ED competitiveness in peer relationships on inpatient wards and online communities (Colton & Pistrang, 2004; Rich, 2006).

It is possible that the women's emotional and cognitive responses to 'thin' therapists were in part a result of the way in which they appeared to construe 'thinness' as a desirable state which was either “natural” or “forced”. Accordingly, when a therapist's 'thinness' was perceived as “natural”, her 'thin' body elicited jealousy as the women wished that they too were naturally 'thin' and did not have to work so hard to control their own body. And when a therapist's 'thinness' was perceived as “forced”, she was viewed with suspicion as the women felt she might be controlling her size yet avoiding treatment. Thus the women's experiences of having to “work” at being 'thin' seemed to provide them with a norm against which 'thin'

therapists had to prove themselves an exception in order to be accepted as naturally 'thin' and thus above suspicion.

Although the prospect⁶ of working with a 'fat' therapist seemed to elicit fewer negative emotions in the women, the one negative emotion it did have the potential to elicit was fear. Furthermore, it appeared that this fear could be powerful enough to increase a client's resistance to therapy. Once again, this resistance seemed to occur when the women made one of two assumptions. The first assumption was that they would become 'fat' if they took a 'fat' therapist's advice, and the second was that a 'fat' therapist would not tell them when to stop gaining weight. These assumptions, like those related to the resistance that 'thin' therapists seemed able to elicit, also appeared underpinned by implicit beliefs about the therapist and her size. In the case of 'fat' therapists, the women seemed to believe that their therapist's 'fatness' was almost contagious and that, by her acts of verbal commission or omission respectively, they would also become 'fat'.

Additionally, 'fat' therapists also tended to be viewed as out of control of their eating and morally inferior. Once again, the women's emotional and cognitive responses seemed to be the result of the way in which they construed body size. In contrast to 'thinness' which was construed as desirable and either "natural" or "forced", 'fatness' was always seen as unnatural and the result of overeating. Associated with this were the beliefs that action (e.g., dieting and vomiting) should be taken to lose weight if you

⁶ As noted in the 'Analysis' section, very few of the women had actually worked with a 'fat' therapist. As a result, most of their thoughts and beliefs about doing so were based upon the idea – rather than the experience – of working with a 'fat' therapist.

are 'fat', that you cannot be comfortable with yourself if you are 'fat', and that being 'fat' is unbearable and to be avoided at all costs.

The finding that 'fat' therapists were viewed negatively is in accord with the findings of weight 'bias' research which has repeatedly shown that 'overweight' and 'obese' individuals are vulnerable to stigmatising attitudes in numerous domains (see Puhl & Heuer, 2009, for a comprehensive review). In their study of weight 'bias' against women from various weight categories, Swami, Pietschnig, Stieger, Tovée and Voracek (2010a) found that greater weight 'bias' was associated with individuals who had greater dislike of 'fat' people, greater concern about becoming 'fat', greater belief that being 'overweight' is a matter of personal control, greater 'fat' phobia, and more negative attitudes towards 'obese' people. Given that people with AN have high levels of concern about becoming 'fat' and high levels of 'fat' phobia (as emphasised in the DSM-5 (2013) criteria for diagnosing AN), and that (as demonstrated in the analysis above) they tend to hold the belief that being 'overweight' is a matter of personal control, it is likely that they will have high levels of weight 'bias' and thus make potentially negative judgements about a 'fat' therapist.

The analysis also highlighted the way in which therapists who were perceived to be a 'healthy' size (this was generally seen as a UK dress size 12 – 14 by the women) were consistently portrayed in a positive way.

Interestingly, there were parallels between the women's perceptions of the benefits of working with a 'healthy'-sized therapist and some of the benefits that have been spoken of in relation to therapists disclosing an ED history (Bloomgarden, Gerstein & Moss, 2003; Costin & Johnson, 2002). In

particular, the women saw 'healthy'-sized therapists as role models – not, in this instance, as role models of the possibility of recovery but instead as role models of 'normality' and the possibility of having a good relationship with food and one's own body. It was further noteworthy that therapists with a 'healthy'-sized body were generally not criticised in any way. For example, although they were usually assumed not to have an ED history, none of the women saw 'healthy'-sized therapists as possessing the disadvantages that were often associated with the lack of an ED history. Thus 'healthy'-sized therapists seemed to be viewed with an almost universal degree of approval.

The nature of “eating disorder glasses”. Details about the characteristics of the women's “eating disorder glasses,” and their relationship with these glasses, were also provided in the analysis. More specifically, the automatic nature of the women's observations of body- and food-related stimuli was illustrated, and the potential for these observations to be 'distorted' was demonstrated. The analysis also showed that, at times, the women were both aware and accepting of the impact that the “glasses” had upon their perceptions. Finally, the frustration and helplessness the women sometimes experienced as a result of the variability and incomprehensibility of some of their perceptions (e.g., seeing themselves as “too big” one moment and “okay the next”; simultaneously seeing their own thighs as “too fat” and their therapist's thighs as not 'fat', despite knowing that their own thighs are smaller than their therapist's thighs) was highlighted.

The automatic nature of the women's observational behaviours and the centrality of these behaviours within their lives thus appeared comparable to the presence and influence of the "anorexic voice" described by Tierney and Fox (2010). Both the "anorexic voice" and the observational tendencies described above seem to have the ability to dominate the attention of the person with the ED and to influence their thoughts and behaviours. The fact that the women presented their observational tendencies as beyond their control and a normative part of having an ED was especially problematic as it suggests that they might feel a sense of helplessness regarding their behaviours which could, in turn, influence their perceptions of their ability to recover. Indeed, people with AN are known to experience themselves as ineffective (Bers & Quinlan, 1992; Bruch, 1973, 1978) and to see recovery as "difficult, distant and unimaginable" (Malson et al., 2011, p.29). In conjunction with the high levels of ambivalence towards recovery that have been shown in people with AN (Cockell, Geller & Linden, 2003; Williams & Reid, 2010), feelings of powerlessness and low self-efficacy are obviously problematic.

The use of body-related information. A further phenomenon highlighted in the analysis was the women's tendency to place great emphasis on body-related visual information when forming their opinions of, and beliefs about, a therapist. It was noteworthy that the visual information they used was both relatively limited and prone, as discussed above, to being interpreted according to the women's own experiences of body size and eating management practices. There are a number of explanations that could be proposed for the women's tendency to use this visual information

as the basis for their assumptions and judgements. One possible explanation is that people with an ED are so used to using external markers such as body size information as a globalised measure of their own worth (Fairburn, 2008; Goss, Allan, Galsworthy-Francis & Dave, 2012), that they generalise this tendency and use body size information as a means of assessing other people's worth as well.

A second explanation, in line with the propositions of CFT-E (Goss & Allan, 2010; see pp.30-33 in the 'Literature Review' section of this thesis for further details), is that the women's pre-occupation with food and body weight/shape and their observational tendencies – both in general and in relation to their therapists in particular – are part of an attention mechanism that is used to detect threat. Given that therapy invites clients to confront their difficulties and challenge their ED behaviours, one could imagine that the therapy room itself might be experienced as a potentially threatening place. Thus it would make sense for these attention mechanisms to be in a heightened state of operation. If this is indeed the case then therapists need to be aware that their clients are not only highly attuned to body- and food-related stimuli in the therapy room, but also that they might be monitoring them for signs of (perceived) threat.

A third conceivable explanation for the women's use of visual information as the basis for their assumptions and judgements about a therapist may be linked to the low levels of self-esteem (Peck & Lightsey Jr, 2008; Polivy & Herman, 2002; Slade, 1982), and the sense of ineffectiveness (Bers & Quinlan, 1992; Bruch, 1973, 1978) that are common in people with an ED. From this perspective it is possible to imagine that external sources of

information might appear more reliable or trustworthy than one's own judgement and that such information might consequently be sought and used as a basis for decision making. If this is true then it would make sense that the type of information turned to by people with an ED would be food- and body-related as these are the very things that, as the analysis above has suggested, seem to shape and define their world. The fact that such alternative sources of information might be influencing the women's beliefs about a therapist's ability to help them is important as expectancy has been shown to account for approximately 15% of client progress (Lambert & Barley, 2002) and one element of expectancy may well be a client's belief in their therapist's ability to help.

Fourthly, it is also possible that the women's apparent alertness to their therapist's appearance might be associated with the ambivalence towards recovery known to exist in clients with AN (Cockell et al., 2003; Williams & Reid, 2010). Accordingly, clients might quite literally 'look for' distractions and potential problems in the therapy room in order to avoid addressing their own issues. This explanation was in fact offered by at least one of the women and would certainly account for the level of detail in the women's descriptions of the therapists they had worked with. It would also make sense of the preponderance of negative impacts described by the women in relation to the way a therapist looked. Thus it may be the case that therapy, and recovery in particular, is viewed by the client as so difficult (Malson et al., 2011; Nordbø et al., 2012) that avoidance feels safer or, in the moment, preferable.

The possible impact of clients assuming their therapist has an ED history. The analysis also provided information pertinent to the on-going debate about the “fitness to practise” (Johnston, Smethurst & Gowers, 2005) and pros and cons of ED therapists with an ED history (Bloomgarden et al., 2003; Costin & Johnson, 2002; Johnston et al., 2005). As discussed above (in relation to the problems that could arise when the women assumed a ‘thin’ therapist had experienced an ED herself) the study findings suggest three key ways in which knowledge (or the assumption) that a therapist had an ED history could be problematic. Firstly, it could evoke competitiveness (as the client seeks to be at least as ill as they assume their therapist was); secondly, it could lead a client to monitor what they said in order to avoid triggering a relapse in their therapist; and thirdly, if the recovered therapist was perceived to be ‘fat’, fear of becoming equally ‘fat’ if recovery were engaged with could be elicited. Although practitioners working in the ED field have previously highlighted and discussed the issue of relapse in relation to ED therapists with an ED history (e.g., Costin & Johnson, 2002; Johnston et al., 2005), they have not mentioned the possibility that clients might see such therapists as a source of competition. This finding is thus both new and problematic given the women’s apparent tendency not only to assume an ED history when a therapist was ‘thin’, but also to make extreme assumptions about the severity of that history. This latter assumption, in conjunction with the women’s sense of needing to be more ill than their therapist had been, seemed to have the potential to motivate them towards further weight loss and increased engagement in ED behaviours.

Although the ED research literature has begun to explore a number of the questions that have been raised in relation to ED therapists with an ED history (e.g., ‘What constitutes a “recovered enough” therapist?’, Bloomgarden et al., 2003; ‘How do clinicians use their own ED recovery in ED treatment?’, Costin & Johnson, 2002; ‘What impact does an ED history have on therapists who work with ED clients?’, Rance et al., 2010), there is still much that remains unknown (Bowlby, Anderson, Hall & Willingham, 2012; Bloomgarden et al., 2003; Rance et al, 2010). In particular, the analysis above suggests that one issue which might merit further attention is that of the clinical implications of clients assuming that their therapist has (or does not have) an ED history. Additionally, given that the women seemed to assume that a therapist they perceived as ‘thin’ had an ED history, and a therapist they perceived as ‘fat’ was out of control of her eating, the analysis highlights the need for therapists of all sizes to be alert to the fact that the perceptions made of their body size may lead to assumptions and judgements being made about their past and present relationship with food.

When thinking about the findings presented in the analysis it is important to remember that, as discussed in the ‘Literature Review’, it is not only women with an ED who are critical of their own bodies, observe the bodies of those around them, engage in body comparisons, and believe that their body will determine the way in which they are perceived by others (e.g., Franzoi et al., 2012; Strahan, Wilson, Cressman & Buote, 2006; Swami et al., 2010b). Indeed, it has been argued that:

Compulsive eating and its corollary 'going on a diet' are so common that they are experienced as normal by all, including those of us in the mental health professions. In fact, these experiences are so much a part of ordinary daily life, a lived ideology, that it is hard to imagine a world in which people did not worry constantly about their size and appetite (Bloom, Gitter, Gutwill, Kogel & Zaphiropoulos, 1994, p.xi).

While it is important that the women's observational tendencies be considered against this back drop, it is the centrality and extreme nature of their tendencies, and the potentially significant impact of their assumptions and speculations on the therapeutic process and relationship, that make the findings of this study important.

In summary, the analysis provided evidence of ED clients' tendency to both observe their therapist's body and eating behaviours, and make assumptions and judgements based on what they have seen. In doing so it emphasised the potential importance of the therapist's body in ED therapy; provided details of the way in which ED clients' "eating disorder glasses" seem to influence what they see; gave examples of the ways in which visual information sometimes shapes client's opinions and beliefs about their therapist; and highlighted the possible impact of client assumptions about their therapist having an ED history.

Implications for ED Theory

The analysis presented above has a number of implications for the literature relating to EDs. First, it provides evidence from the everyday lives and treatment experiences of women with an ED for both the attentional biases and cognitive distortions previously highlighted in empirical studies and theoretical accounts of AN (e.g., Cooper, 1997, 2005; Fairburn, 2008; Kidd & Steinglass, 2012), and for ED practitioners' reports of being observed and monitored by their ED clients (Surtees, 2009; Warren et al., 2009). More specifically, the findings support the body- and food-related attentional biases in people with an ED that have been identified using laboratory style tests such as the modified Stroop task (Johansson, Ghaderi & Andersson, 2005), the dot-probe task (Shafran, Lee, Cooper, Palmer & Fairburn, 2007) and distracter tasks (Dickson et al., 2008).

Similarly, the often tenuous basis upon which the women appeared to make deductions about both their therapist's eating (e.g., that because they looked controlled they also had a controlled relationship with food) and what might happen if they followed their therapist's dietary advice (e.g., that they would end up 'fat' if they listened to a 'fat' therapist telling them to eat more), provide possible evidence of cognitive distortions (Leahy, 1996; Leahy & Holland, 2000) taking place in the therapy room itself. For example, in relation to the women's apparent concern about a 'fat' ED therapist revealing a history of AN, it seemed that a combination of overgeneralising and failing to use disconfirming evidence (Leahy, 2003) contributed to their fear of becoming as 'fat' as the therapist if they too

recovered. The fear being provoked here is perhaps similar to that discussed by Burka (2001) in relation to 'thin' ED clients being frightened when in the presence of an 'overweight' therapist, because they are reminded of the way they could end up looking if they are not careful.

Additionally, the analysis supports the perceptions of the ED treatment providers canvassed in Warren et al.'s (2009) study – 83% of whom said that they felt their appearance was being 'monitored, examined or evaluated' by their clients. And it is also in accord with Surtees' (2009) descriptions of the way in which her eating was watched by the patients she sat with during supervised meals (p.163).

Second, the findings highlight the fact that a client's feelings about, and responses to, their therapist's body can have an impact on the therapeutic relationship. This is particularly important given that the therapeutic relationship is acknowledged as a core component of therapeutic change across theoretical orientations (e.g., Gilbert & Leahy, 2007; Jacobs, 2004; Jordan, 2010; Norcross, 2002). It is also important in light of the psychodynamic theoretical suggestion that early attachment experiences and relationship difficulties play a role in the very development of EDs (see pp.35-40 in the 'Literature Review' section of this thesis for further details). Indeed, as Lawrence (2001) explains:

In eating disorders, many relationships will have broken down and the patient is more or less terrified of getting close to anyone. And yet this is precisely what she needs to do if she is to understand what has happened to her and begin to find a way forward in her development (p.25).

The possibility that a client's feelings about, and responses to, their therapist's body could have an impact on, or place a strain on, the therapeutic relationship is thus an important finding for those thinking about ways in which the relationship might be used to aid change and recovery.

Third, the findings are important in relation to the literature highlighting the difficulties people with an ED have in experiencing, expressing and processing emotions (see pp.28-29 in the 'Literature Review' section of this thesis for further details), and their need for a safe therapeutic space (Zerbe, 2001). As Zerbe (2001) explains:

Because these patients' emotional pain is often experienced as difficult to bear, the defense mechanisms of denial, splitting, dissociation, projective identification, and repression are adaptively used by the mind to (temporarily) sidestep internal anguish. The first step of treatment, therefore, must be the creation of a safe haven where these patients gradually grow more comfortable in sharing aspects of the self that have stymied personal growth (p.306).

Zerbe's (2001) assertion is problematic in light of the finding that many of the interviewees had actually experienced the therapy room (as a result of their therapist's body in particular) as quite an unsafe place. Indeed, the findings suggested that a client's negative feelings towards both herself and her therapist, alongside any concerns she might have about her therapist's ability to help, could increase her likelihood of disengaging with, or growing in resistance to, therapy. It is also possible that such feelings and concerns could foster a sense of threat which might, in turn, exacerbate the clients felt need for her ED symptoms.

The fact that a client might feel threatened when in the therapy room is also problematic given the suggestion in CFT-E that the attention mechanisms associated with EDs (e.g., increased sensitivity to size-, shape- and food-related information, and increased attention to external social cues from others regarding size, shape and weight) might be forms of threat detectors (Goss & Allan, 2010; see pp.30-33 in the 'Literature Review' section of this thesis for further details). If they are, then a client who experiences the therapy room as threatening might be expected to become increasingly reliant upon such threat detectors which could, in turn, lead to a heightening in their ED-related observational behaviours and their tendency to make judgements and assumptions based on what they have seen. If such a cycle were to develop it could end up perpetuating the very behaviours that therapy was meant to be addressing.

In conclusion, the analysis adds to the ED literature relating to both the presence of attentional biases and cognitive distortions in people with EDs, and ED practitioners' perceptions of being observed by their clients. It also extends the ED literature by both highlighting the possibility that a client's feelings about, and responses to, their therapist's body could have an impact on the therapeutic relationship, and suggesting that some clients might find the therapy room an unsafe, or even threatening, place to be.

Implications for ED Practitioners

The analysis also has a number of implications for practitioners. First, it highlights some possible avenues for therapeutic intervention. For example, given that the findings suggested that clients often compare themselves to their therapist, therapists could directly address this behaviour in sessions. By doing so they could afford their client both the opportunity to explore the behaviour in a *live* situation, and the opportunity to talk about their feelings towards the therapist's body. As comparison-making is a form of body checking that is believed to "actively maintain concerns about shape" (Fairburn, 2008, p.110), this could be a particularly useful topic to discuss with clients as it might help them better understand why they do it and, if possible, find ways to do it less. It would also be useful as people with an ED are known to compare themselves less favourably to others than controls (Troop, Allan, Treasure & Katzman, 2003), so it is likely that they will be making negative comparisons between themselves and their therapist – especially, this study suggests, if they perceive their therapist to be 'thin'.

By encouraging their clients to share any assumptions and judgements they might have made about their therapist's body, and any emotional responses they are having to their therapist's body, therapists might also help clients uncover possible cognitive distortions. Such an exploration could then be used to help moderate or negate any resistance to therapy that might be arising in response to the therapist's body. Additionally, the therapeutic

relationship might be strengthened and energised through the use of such here-and-now exploration (Yalom, 2002).

Second, the findings pertaining to the nature and characteristics of the women's observational behaviours provide useful insight regarding the potential variability in a client's perceptual experiences and the ways in which a client's outlook can change from session to session. They also provide information about the feelings of frustration, helplessness and low self-efficacy that people with an ED may be living with both in and outside of the therapy room. A greater awareness of these factors may help to further increase practitioners' empathy for their clients' experiences, and act as an antidote to the feelings of hostility, anger, helplessness and suspicion (e.g., Kaplan & Garfinkel, 1999; King & Turner, 2000; Shipton, 2004) that can be experienced by ED practitioners due to working with a client group known to have high levels of co-morbidity, potential medical complications and higher than average risk of suicide (Franko & Rolfe, 1996).

Third, the analysis also has implications for ED training. In particular, it appeared from the women's narratives that none of them had been encouraged to talk about their perceptions of, or feelings towards, their therapist's body or relationship with food. While it is possible that such conversations did take place and that the women simply did not mention them, it seems unlikely that this was the case given the nature and scope of the interviews. In light of the potential impact of the women's unchecked assumptions and judgements, it seems important that training courses encourage practitioners to think about the possible merits of finding ways to address their physical presence so that their clients have the opportunity to

share their thoughts and feelings about them. Only then will it be possible for therapists to find out if any body- and food-related therapy-hindering processes are taking place.

It is likely, however, that in order for a therapist to feel comfortable talking about her own body and be prepared for the responses she might receive, she would need to spend time thinking about how her body might be perceived, the assumptions that could be made about it by her clients, and the possible impact that it (and any feelings it engenders) might have on the therapeutic relationship and process. It also seems important that therapists be encouraged to reflect upon their own feelings towards their body and relationship with food. This might involve personal journaling, talking to a supervisor or peers, or reading books that will help them engage with their thoughts about their own physicality and any frustrations or struggles they may have with the way they look and their interactions with food. For example, practitioners might like to explore the literatures examining researchers' body disclosures in research interactions (e.g., Burns, 2003, 2006; Finlay, 2006), and the importance of dress and appearance in communicating identity (e.g., De La Haye & Wilson, 1999; Roach-Higgins, Eicher & Johnson, 1995; Wilson, 2003). Both of which highlight the fact that the way we look (from the size and shape of our body, to the ways in which we adorn it) always communicates meaning.

Fourth, it also seems important that therapists both think about whether or not they would want to disclose an ED history (or lack of one), and that they reflect upon whether, and how, they might address any significant changes in their appearance (e.g., pregnancy, sudden weight loss/gain) or their own

physical signs of hunger (e.g., a rumbling stomach). A therapist's theoretical orientation may well influence their thinking about these issues. For example, although therapists working within the cognitive behavioural (Goldfried, Burckell & Eubanks-Carter, 2003), existential (Geller, 2003) and psychodynamic (Jacobs, 2004) traditions have mixed views on the issue of self-disclosure, relational (Tantillo, 2004), feminist (Mahalik, VanOrmer & Simi, 2000), humanistic (Robitschek & McCarthy, 1991) and multicultural therapists (Jenkins, 1990; Sue & Sue, 1999) see self-disclosure as a critical part of the therapeutic process. Ultimately though, it would appear that, irrespective of theoretical orientation, all practitioners in this area need to be aware that the way they look and the way in which they are seen (or believed) to relate to food is observed, judged and, potentially, interpreted in ways that might impact upon the therapeutic process and relationship.

Finally, practitioners might also want to consider the finding that a number of the women had strong reactions to their therapist eating in session. From feelings of anger and jealousy, to thoughts of being tested by the therapist and the belief that the therapist was not concentrating, it appeared from the women's narratives that a therapist eating in session had the potential to elicit a negative reaction in the client. Although it appeared that much of this negativity was linked to the assumptions and judgements the women made in the given situation, it nevertheless provided evidence of a therapist behaviour that had the potential to impede the therapeutic process.

In summary, the analysis highlights a number of factors that might be useful for practitioners. In particular, it identifies the potential benefits of a therapist inviting her (or his) clients to talk about their feelings towards her (or his)

body; and it provides information about clients' "eating disorder glasses" that might help increase therapists understanding of ED clients' perceptual experiences and their empathy towards people with EDs. The analysis also highlights potential roles for both training and personal reflection in enabling practitioners to think about the possible impact of their body, their feelings towards talking about their bodies and, if relevant and appropriate, the option of disclosing whether or not they have an ED history. Finally, the analysis drew attention to the possible negative impacts of a therapist eating in sessions.

Implications for Counselling Psychology and for Myself as a Trainee Counselling Psychologist

The study findings have a number of implications for the discipline of counselling psychology. In particular, the analysis suggested that part of clients' phenomenological experience in the therapy room – namely, their experience of their therapist's body – is, in some cases at least, not being fully engaged with. As a result, it is possible that for some ED clients, elements of their perceptions, ways of experiencing, feeling, valuing and knowing are not being fully heard. This is both a problem and an opportunity for counselling psychology given its commitment (see pp.58-59 of this thesis for further details) to developing models of practice and research which seek to empathically engage with clients' subjective and intersubjective experiences, values and beliefs (BPS, Division of Counselling Psychology, 2005, p.1-2). Further exploring the topic and contributing to the future development of ED theory and practice is thus something that counselling psychology is both well placed and perhaps also obligated (in light the commitment stated above) to do.

The apparent lack of knowledge about the potential impact of the therapist's body on both the therapeutic relationship and process is also both a problem and an opportunity for counselling psychology in light of the emphasis within the discipline on the importance of the scientist-practitioner model and the need for practitioners to evaluate practice and engage with research (Strawbridge & Woolfe, 2003). Although it is difficult to know how many counselling psychologists specialise in ED treatment, the increasing

number of ED clients coming to therapy suggests that it is a topic counselling psychologists could benefit from understanding. The lack of ED research in counselling psychology journals (see pp.59-60 of this thesis for further details) suggests, however, that it is, as yet, an under-researched topic for the discipline. Yet, it could be argued that because counselling psychologists value subjectivity, phenomenology and client's perceptions and world views, they are well placed to undertake research in the ED field and to examine the phenomenological experiences of ED clients when they are in the therapy room (or other treatment setting).

Additionally, it has been argued that counselling psychology differs from medical and other psychological approaches because its therapeutic focus is shifted away from what a therapist does *to* a client (via the application of specific treatment techniques) towards how they are *with* a client (Strawbridge & Woolfe, 2003). As Strawbridge and Woolfe (2003) explain, the self of the helper must consequently be acknowledged as an active ingredient in the helping process which means:

Understanding therapy as a shared exploration, a process of mutual discovery into which the helper brings his or her own personal emotional history and baggage Like our clients we are people with issues and difficulties in our lives, and understanding how these impact upon relationships with clients demands a willingness to explore our own histories, attitudes and emotional defences (p.12).

Given that a therapist's body is not only a part of their self in the therapy room but also a part that can impact upon their relationship with a client, it would appear that Strawbridge and Woolfe's (2003) statement might

usefully benefit from being broadened so that therapists begin to explore the possible repercussions of their appearance and physical presence in the room. This is not to say that ED therapists must conform to the women's 'ideal' (UK dress size 12-14), simply that they must be aware of, and to have thought about, the fact that their body is speaking to their clients and that their clients are interpreting what they see in ways that can have an impact upon both the therapeutic relationship and process. Such awareness and reflection is also paramount in light of the emphasis within counselling psychology on the importance of being a reflective practitioner (Hammersley, 2003; Martin, 2010).

The findings of the study also have implications for me as a counselling psychology trainee. In particular, they have made me more aware of my own presence in the therapy room – in terms of the way I look, the way in which I respond to client comments about my body, and my willingness to raise the subject of my body without being prompted to do so by my clients. I have found that when I initiate a conversation about my body my clients have welcomed the opportunity to discuss their thoughts and feelings towards it. My 'thinness' is often raised during such discussions and questions about the types of food I eat are also sometimes asked. In most of these interactions my client seems to start off a little shy or even embarrassed – something they put down to feeling uncomfortable about their interest in my body. As we continue talking, however, they often seem to relax and at the end of the conversation they tend to say how relieved they feel as a result of being able to share their thoughts and feelings about the way I look.

Furthermore, the process of conducting the study (from inception to the writing of this thesis), has enhanced my sense of myself as a counselling psychologist who is committed to both the scientist-practitioner (Blair, 2010; Strawbridge & Woolfe, 2010) and reflexive practitioner (Hammersley, 2003; Martin, 2010) models. I believe this change to be the result of having to engage, over a prolonged period, with the ED literature, with my beliefs and thoughts about EDs, with my own ED therapy practice, with the rigours of academic research and writing, and with the process of doing all the above reflexively. Additionally, presenting preliminary findings of my research at conference (Rance, 2012, July) helped me gain a sense of myself as a practitioner whose work might not only be taken seriously by my peers, but also be of value to the field of counselling psychology and beyond.

Limitations of the Research

Some limitations should be noted when interpreting the findings presented in the analysis. From a methodological perspective, the choice of TA might be seen as a limitation due to its potential weaknesses. In particular, it has been noted that TA lacks concrete guidance for higher level, more interpretative analysis (Braun & Clarke, 2006, 2013) and that, in practice, analyses are often simple descriptions of participants' concerns (Braun & Clarke, 2006, 2013). In order to address these possible issues I had regular meetings with my supervisors who encouraged me to look deeper in the data so as to move beyond the level of description to that of interpretation by focusing on articulating the meaning of the women's experiences.

Additionally, Braun and Clarke (2013) have highlighted the fact that TA may fail to provide a sense of continuity and contradictions within individual accounts due to its focus on patterns across datasets hence potentially losing the 'voices' of participants – particularly when larger datasets are being used. I endeavoured to minimise the chances of this happening by purposefully trying to convey a sense of continuity as I analysed the data and wrote up my findings and by trying to highlight contradictions within individual accounts when they appeared. Similarly, I paid attention to honouring the individual 'voices' of the participants in order that their unique perspectives might be communicated alongside the presentation of patterns across the dataset as a whole. Indeed, as discussed in the 'Methodology' section (see p.69 of this thesis for further details), the decision to have a

sample size of 12 was influenced by my commitment to doing this as it facilitated a more idiographic approach.

Finally, it is also the case that TA cannot make claims about the effects of language use in ways that discourse analysis, discursive psychology and conversation analysis can (Braun & Clarke, 2013). That notwithstanding, efforts were made – during both the analysis and the writing up of the results – to explore the interviewees’ use of language and the ways in which they structured and framed their observations and beliefs (though it is acknowledged that this in no way makes the analysis akin to that of a discourse analysis, Potter & Wetherell, 1995).

A further potential methodological limitation relates to the fact that the women found it hard to discuss and describe their preferences for a therapist’s body weight and shape using words alone. Although UK dress size was used as a proxy, it is acknowledged that this is a subjective measure and one that fails to differentiate between “real” and “perceived” size. It is also the case that people of the same weight can look very different in size depending upon whether they are toned and muscular, or untoned and fleshy. Thus it is not possible to know precisely what body size and shape the women had in mind when they referred to a given dress size.

From a participant perspective, it should be noted that none of the women had actually received therapy from a ‘fat’ therapist, consequently their feelings about what it would be like to do so were conjectural rather than grounded in firsthand experience. Also, it is important to highlight the fact that there was a high level of demographic homogeneity amongst the

participants as they were all white, British, well educated women.

Furthermore, they all appeared middle class and eight spoke of a husband or boyfriend (three did not comment on their sexual orientation and one self-identified as lesbian). As a result it is possible that they had introjected similar cultural norms regarding female body shape and size (e.g., the “thin ideal” – Brown & Slaughter, 2010; Owen & Laurel-Seller, 2000; Thompson & Stice, 2001), and that these norms had influenced their perceptions and responses. If the participants had come from different demographic groups the findings may thus have been different too.

Additionally, as it was not a key focus of the study, potential areas of difference between the participants’ life histories were not overtly explored. For example, the analysis did not track such things as the relative importance of body weight/shape within each participants’ family of origin or the extent to which they had been exposed to environments which emphasised or encouraged being slim (e.g., ballet schools, athletics clubs). It was therefore not possible to compare participants’ responses to the research questions with this in mind.

Similarly, as the main focus of the study was clients’ thoughts and feelings about their therapist’s body, the analysis did not closely track the treatment approach of the therapists being talked about or the participants’ commitment to therapy (e.g., Were they in therapy because they wanted to make changes or because they had been encouraged to get help by someone else?). It is acknowledged, however, that both are important factors that could potentially have influenced the interviewees’ feelings and perceptions at the time of their therapy.

Finally, from a researcher perspective, it is important to note that I am tall and 'thin'. Although I was interviewing the women rather than counselling them, it is nevertheless possible that they had emotional reactions to my own body and that any such reactions might have influenced them in some way or, for example, made them more attuned to their feelings about 'thin' people. Indeed, as discussed previously (see pp.88 in the 'Reflexivity' section of this thesis for further details), at the end of my interview with Claire, she said that she had been quite aware of my body during the interview and that she had wondered about my motivations and interests for working in the ED field.

Moreover, as discussed earlier (see pp.78-80 in the 'Reflexivity' section of this thesis for further details), qualitative research paradigms accept the influence of the researcher (Braun & Clarke, 2013) and encourage activities such as "reflexivity" to maximise the potential benefits and minimise the potential risks (Banister et al., 1994; Finlay, 1998). Although I engaged in good practice and endeavoured to address the possible drawbacks of my 'insider status' and make the most of the potential benefits (see pp.78-90 in the 'Reflexivity' section of this thesis for further details), it is nevertheless possible that my 'insiderness' influenced the analysis in ways that might be seen as a limiting as well as potentially beneficial.

Suggestions for Future Research

Given that the findings of this study shed light upon a hitherto unexplored process taking place in the therapy room, there are numerous avenues that future research might explore in order to develop a more complete picture of this process, its consequences and ways in which any negative effects of it might be mitigated. As discussed earlier, it was apparent from the women's narratives that none of them had been encouraged to discuss their feelings about, or observations of, their therapist's body. It would therefore be helpful to know if being invited to do so can mitigate any of the negative sequelae described in the third theme. Similarly, it would be beneficial to know whether clients find it helpful to talk about their observation and assumption-making tendencies in general, as it might prove therapeutic for them to have the opportunity to consider their behaviours in a supportive environment where they can explore their impacts and possible inaccuracies.

Additionally, as none of the women in this study had actually received therapy from a 'fat' therapist, it would be useful if research could explore the experiences of those who have in order to ascertain whether or not they are in accord with the conjectures made by the participants in this study.

In light of the high level of demographic homogeneity amongst the participants, future research could usefully examine the perceptions of individuals with AN who come from more diverse demographic groups. For example, the views of non-heterosexual women with AN could be explored as it has been suggested that lesbians have higher levels of body esteem and are less concerned with dieting and 'thinness' than heterosexual

women (e.g., Share & Mintz, 2002; Wagenbach, 2004). Thus it might be the case that they are less concerned about how their therapist looks and less likely to make comparisons with them. Also, the views of men with AN could be explored as it has been suggested that men face different issues in relation to EDs and that all-male treatment environments can be beneficial (e.g., Strother, Lemberg, Stanford & Turberville, 2012; Weltzin et al., 2012). While it is also the case that all of the participants were white, British women, there is, as yet, little evidence (Polivy & Herman, 2002; Striegel-Moore & Bulik, 2007) to suggest that race is a risk factor for AN so at this point it might make more sense to explore the perceptions of demographic groups where current evidence suggests differences might exist.

Furthermore, given that individuals' experience of, and relationship with, various elements of their AN can change over its course (e.g., the "anorexic voice" is viewed more positively during the early stages of AN, Tierney & Fox, 2010; AN is seen as increasing feelings of control during the early stages, but becomes increasingly out of control as it continues, Patching & Lawler, 2009), it might be helpful if future research were to explore the perceptions and experiences of people at different stages in the recovery process. For example, the women who responded to the recruitment adverts for this study all self-defined as "recovered or 'on the road to recovery'", so it would be useful to see if the perceptions of women who do not see themselves as 'on the road to recovery' view their therapists differently. Similarly, the women in this study self-rated themselves as between 40 and 100% recovered – given the breadth of this range it might be helpful to see if perceptions vary in smaller percentage intervals (e.g., do

people who see themselves as 90% recovered view their therapist differently to those who see themselves as 50% recovered). If it transpired that there were indeed differences in perceptions at different stages in the recovery process, this would be useful for clinicians in relation to both treatment planning (e.g., there is evidence to suggest that the Stages of Change Model (Prochaska & DiClemente, 1992) is relevant for the treatment of EDs (Hasler, Delsignore, Milos, Buddeberg & Schnyder, 2004)) and their understanding of the phenomenological experience of having AN.

As mentioned in the analysis, it appeared that the bodies of male therapists were less problematic than those of female therapists and that it might be more acceptable for someone of, for example, “Asian” origin to be particularly slender. As there is currently no research that can be drawn upon to understand why this might be the case, it would be useful if this finding could be further explored by examining ED clients’ experiences with different therapists. For example, such research might determine whether or not some therapists’ bodies are seen as less threatening, as less suitable for comparison or as unnecessary to compete with. Such understanding may, once again, help practitioners to better understand the phenomenological experience of people with AN.

Similarly, it would be helpful to know if clients who come from families where body size and shape is a focus of attention are more sensitive to their therapist’s body. Polivy and Herman (2002), for example, have discussed the multiple ways in which families might influence the development and maintenance of EDs, including the transmission of eating concerns, mother’s comments on a child’s body, modelling of weight and shape

concerns, and praise for self-control, slenderness and discipline. It is thus possible that some clients are primed to pay more attention to the bodies of those around them – including that of their therapist. If this were to be the case then therapists could potentially gauge their client's likelihood of being sensitive to their body by establishing the way in which bodies were viewed and related to within their client's family of origin.

Given the drawbacks discussed above in relation to the use of UK dress size as a proxy for body size and shape (when trying to establish what size therapist participants were talking about), future research might benefit from using more visual forms of methodology (Reavey, 2011). For example, the Contour Drawing Rating Scale (CDRS; Thompson & Gray, 1995) used by Vocks et al. (2007) in their study of female ED clients' preferences in relation to therapist's body shape/weight (see pp.49-50 in the 'Literature Review' section of this thesis for further details), might be a useful tool for eliciting and discussing a client's views about a therapist's body. In addition to using the CDRS to help participants describe the size of the therapist they are talking about, researchers could also use it to find out what body shapes and sizes participants perceived as 'thin', 'fat' and 'normal'. Such information could be useful in helping therapists to have some idea of how their clients might perceive their body size, and, accordingly, the types of related assumptions their clients might be making about them.

As discussed in the 'Limitations of the Research' section, a different analytical approach might have produced different results. Accordingly, this study could be repeated using different research methods in order to expand the literature in this area and extend the results of this study. In

particular, approaches such as discourse analysis, discursive psychology and conversation analysis (see Braun & Clarke, 2013, for further methodological details) could be used in order to explore participants' constructions of terms such as 'thin', 'fat' and 'normal'. Similarly, the participants in this study might have responded differently to a different researcher (e.g., one who was neither 'thin' nor an 'insider'). Thus, the literature base in this area could also be extended by researchers with different backgrounds and physical appearance conducting the interviews. Finally, once a body of evidence had been developed, it could be subjected to a meta-analysis (of the type conducted by Tiumlak et al., 2013 – see pp.21-23 in the 'Literature Review' section of this thesis for further details) to establish the common themes and areas of overlap between the studies.

Final Conclusions

The analysis presented in the three themes 'Client's observations in the therapy room', 'Client's assumptions and speculations about what they see' and 'Potential impact of client's assumptions on therapy', described the characteristics and implications of the interviewees' body- and food-related observational tendencies. More specifically, the results highlight the complex ways in which the women's willingness to engage in therapy seemed to be influenced by the assumptions they made about a therapist based upon both their observations of the therapist's body size and their observations and speculations about the therapist's eating behaviours. In particular, body size and eating behaviour seemed to elicit judgements about a therapist's ability to help and their trustworthiness. As such, the analysis sheds light upon some of the implicit, unacknowledged processes that take place when ED clients and ED professionals meet.

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Journal Article

“If I See Somebody Therapist or Anything, I’ll Immediately Sort of Scope Them Out”: Anorexia Nervosa Clients’ Perceptions of Their Therapist’s

Body

Nicola M. Rance, Victoria Clarke and Naomi P. Moller

The University of the West of England

Author Note

Nicola M. Rance, Victoria Clarke and Naomi P. Moller, Department of Psychology, The University of the West of England

Correspondence concerning this article should be addressed to Dr. Victoria Clarke, The University of the West of England, Department of Psychology, Faculty of Life Sciences, Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY, Britain. E-mail: victoria.clarke@uwe.ac.uk.

Abstract

Although people with an eating disorder are known to observe and assess body related stimuli, research has yet to explore these behaviors in the therapy room. Consequently, practitioners do not know if their body is having an impact on their client or the therapy process – a lack of knowledge which is problematic given the poor recovery rates and high levels of drop out in eating disorder treatment. Using semi-structured interviews this study investigated the beliefs and experiences of 12 women with a formal or 'self-diagnosis' of either anorexia nervosa or bulimia nervosa with restricting, who had received counseling from a female therapist. Results derived from a thematic analysis suggested that the women not only observed, speculated and made assumptions about their therapist's body but also that their assumptions and speculations had the potential to influence both their beliefs about the therapist's ability to help them, and their willingness to engage in therapy.

Keywords: eating disorders, information processing, qualitative, therapist appearance, therapist eating, treatment resistance

“If I See Somebody Therapist or Anything, I’ll Immediately Sort of Scope Them Out”: Anorexia Nervosa Clients’ Perceptions of Their Therapist’s Body

When a body meets a body, no formal introductions are made ... As therapists, we focus on words but our bodies also speak Yet most accounts of therapeutic process mention very little of what the bodies mean to each other (Petrucci, 2008, p.237).

Although people with an eating disorder (ED) are known to observe and assess body related stimuli (Lowell & Meader, 2005), and some therapists working with ED clients have reported feeling that their appearance was being “monitored, examined or evaluated” (Warren, Crowley, Olivardia & Schoen, 2009), very little is actually known about ED clients’ thoughts regarding a female therapist’s body size and relationship with food. This is problematic for two reasons. Firstly, the limited empirical and theoretical evidence that is available suggests that a therapist’s body may be an important factor in work with ED clients (Orbach, 2003, 2004; Petrucci, 2008; Vocks, Legenbauer & Peters, 2007; Warren et al., 2009). Secondly, practitioners currently have little guidance regarding the ways in which their body might be perceived by their clients and the possible impact their clients’ perceptions might have upon the therapy process.

This lack of knowledge is also troublesome in light of evidence suggesting that client expectations and preferences might influence their willingness to engage in, and be influenced by, their therapist and the therapy process (Arnkoff, Glass & Shapiro, 2002). Without knowing what clients actually think, it is difficult to know if the poor ED recovery rates

(Berkman, Lohr & Bulik, 2007; Fichter, Quadflieg & Hedlund, 2006; Löwe et al., 2001; Steinhausen, 2002, 2009) are related in any way to clients' preferences and expectations regarding their therapist's body going unmet.

Given that a fundamental part of ED sufferers' intra- and interpersonal experience is that of feeling invisible, unheard and worthless (Reindl, 2001; Shelley, 1997), it feels important to give voice to their views. Consequently, the current study was designed to redress the lack of research and knowledge in this crucial area by exploring female ED clients' beliefs about a female therapist's body size and relationship with food.

Method

Participants

Participants were 12 women from the UK with a formal or 'self-diagnosis' of either anorexia nervosa (AN) or bulimia nervosa (BN) with restricting, who saw themselves as either recovered or 'on the road to recovery' and had received counseling for their ED from a female therapist. Participants ranged in age from 18 to 50 years (mean 31.5 years) and the duration of their ED ranged from 2 to 28 years (mean 13.3 years). When asked how recovered they saw themselves on a scale from 0 to 100% their responses ranged from 40 to 100% (see Table 1). All interviewees had received some form of treatment for their ED from the United Kingdom (UK) National Health Service (NHS) and all had at least one experience of working with a female therapist. The study was advertised through 'beat' (a UK nationwide charity providing information, help and support for those affected by EDs), and through regional counseling services and support groups in the South-West of England. Ethical approval was received from

the University of the West of England (UWE) Health and Life Sciences
Faculty Research Ethics Committee.

[Insert Table 1 about here]

Data Collection

A semi-structured interview format was utilized and interview questions focused on female therapists' body weight and shape, and relationship with food. Interviews were audio-recorded and lasted between 59 and 103 minutes. The first author conducted all interviews and transcribed them for analysis.

Data Analysis

A thematic analysis utilizing Braun and Clarke's (2006) six-phase approach was conducted. In short this involved: familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report. The first author led the analysis and the second and third authors reviewed each phase of the analysis with the first author in order to finalize the developing codes and themes. Accordingly, the three authors worked together to maintain the quality and rigor (Morrow, 2005) of the analysis, and to develop the final three overarching themes.

Results

The three themes were: "Wearing eating disorder glasses," "You're making all sorts of assumptions as a client," and 'Appearance matters.' Taken together, the three themes highlight not only the women's tendency to observe, speculate and make assumptions about a therapist's body and relationship with food, but also the fact that their assumptions and

speculations had the potential to influence both their beliefs about the therapist's ability to help them, and their willingness to engage in the therapeutic endeavor. Extracts from the interview transcripts are used to demonstrate the interpretative adequacy of the analysis and give voice to the interviewees; words that have been added to clarify a quote are in square parentheses and words that were stressed by interviews have been underlined. Although the study was primarily designed to explore ED clients' beliefs about an ED therapist's body and relationship with food, the interviewees also spoke about their beliefs in relation to other ED health professionals (e.g., psychiatrists, CPNs, dieticians, inpatient nursing staff). Consequently, the term 'therapist' is used for both ED therapists in particular, and when reference is being made to ED health professionals in general; when an interviewee referred to a specific health professional other than a therapist the precise title they gave for that person's role is used (e.g., dietician).

“Wearing Eating Disorder Glasses”

This theme describes the way in which the women's observational tendencies seemed to be shaped by what Megan described as “eating disorder glasses.” In particular, these glasses seemed to prime the women to automatically notice body-related stimuli – something that, in general, they seemed to be both aware, and accepting, of. As Sophie explained: “If I see somebody therapist or anything, I'll immediately sort of scope them out.” Indeed Katie described the way in which speculating about a therapist's body shape and weight before seeing them for the first time was a big thing she and her friends (with an ED) talked about. The women's

narratives suggested that they observed not only their therapist's weight and shape in general, but also specific parts of their therapist's body (e.g., her stomach and thighs). As Claire said: "I noticed she's [therapist] got a slightly rounded stomach when she sits down."

The women's narratives also suggested that they were aware of having an almost uncontrollable tendency to compare their bodies with the bodies of those around them:

It's such a huge feature in my life and it's kind of how my brain operates, is what that person looks like and then sort of comparing yourself. (Sophie)

Without meaning to, every street I walk down, every person that I pass I do a kind of split second assessment, 'Am I bigger than them? Am I smaller than them?' and I can't stop, I can't help from doing it. (Claire)

Indeed Hayley actually presented it as a normative part of having an ED – so natural that she felt it was "obvious" that a client with an ED would compare themselves to their therapist.

Similarly, the women also seemed to be aware that their perceptions of body size could be skewed or distorted and they seemed to accept this as a normative part of an ED. Sarah, for example, described how: "People with eating disorders don't see size, they see themselves as bigger and everyone else as thinner, so they don't actually see what's really there." In addition to being aware that their perceptions could be skewed, the women were also aware that their perceptions were not fixed – thus they spoke

about the fact that they could switch from seeing themselves (or a part of their body) as “too fat” one day, to seeing it as “fine” the next.

“You’re Making All Sorts of Assumptions as a Client”

This theme illustrates the women’s tendency to speculate and make assumptions about their therapist based on the (sometimes distorted) observations they made of her. The essence of the theme is encapsulated by Hayley’s assertion that: “You’re making all sorts of assumptions as a client about what’s going on in terms of a-any-thing that’s physically obvious [about your therapist].”

The women’s assumptions about a therapist’s body size clearly drew upon their understandings of the meanings and causes of both fatness and thinness. In particular, therapists who were perceived to be fat (this was generally seen as anything above a UK dress size 14) were assumed to eat too much and to have “lost control” (Nina). The women also seemed to feel that fatness was intolerable and that fat therapists should “go on a diet”; as Sarah stated: “It’s easy, how can you get overweight? You just throw your food up.”

In contrast to the singular belief that fatness was both bad and the result of excessive eating, thinness was seen as positive and either “natural” and “biological”, or as something that was achieved through food restriction. Although the women agreed about the existence of these two – competing – explanations for thinness, they disagreed about whether or not you “could tell” which explanation was true for any one therapist. While Amy felt that you “know intuitively” whether thinness is natural, others believed it could be “quite hard to tell” (Susie) or that “you wouldn’t know” (Claire). The

women's thoughts about the naturalness of a therapist's thinness were influenced at times by the presence of additional visual information such as race. As Nina explained in relation to her consultant psychiatrist: "She's Asian so in my head I know that well that's just her make-up I probably weigh more than her and that hasn't bothered me because I've just thought 'well that's just obviously how she is'."

In addition to using their observations of a therapist to make assumptions about the causes of her thinness or fatness, the women also made deductions about her relationship with food. Thus they often assumed that a therapist working in a specialist ED setting would have an ED history. Sam, for example, recalled a fellow inpatient telling her that the ED therapists had chosen to work there because: "They've all got their own issues with food." Additionally, the women seemed to correlate body size with particular personality characteristics and relationships with food. Claire, for example, spoke about her thin dietician looking like "somebody who was very rigid and controlling about what she ate"; while Lucy decided that her "reserved" therapist had a similarly reserved relationship with food which meant she was "very strict with herself, [a] very controlled person" when she ate.

Similarly, "healthy"-sized therapists (generally defined by the women as someone with a UK dress size 12–14), who appeared happy with themselves, were generally seen as having "a good relationship with food" (Lucy). Although neither Claire nor Lucy questioned their assumptions about the parallels between their respective therapists' size, personality characteristics and their relationships with food, Hayley – who saw herself

as fully recovered – did. Reflecting on the way that, during treatment, she had believed her psychiatrist had issues because she had a drawer full of oranges, Hayley said: “You project that people that are thin or appear to be the low end or underweight don’t eat very much.” Similarly, Nina said her assumption about her therapist having no problems with food was: “What I needed to see in her, whether that was true or not.”

The women’s perceptions of their therapist’s size also seemed to influence their beliefs about her ability to help and understand them. Despite very few of the women actually having worked with a therapist they viewed as fat, it was clear that they were all concerned about such a therapist’s ability to understand them. Furthermore, the women also seemed to view fat therapists as personally lacking, “somehow inferior” (Amy) and, for Megan, over-eating was: “A weakness and I probably, totally honestly, would look down on them slightly thinking ‘just control yourself’.” In contrast, although therapists who were viewed as thin were generally not seen as unable to understand or empathize, Hayley worried that a therapist: “Who was naturally very thin wouldn’t understand and they’d just assume it [an ED] was about trying to be very thin.”

A further factor which seemed to influence the women’s beliefs about a therapist’s ability to help them was their perceptions of the therapist’s body confidence – something they gauged from her body language and self-presentation. As Nina explained: “If you pick up that they’ve got a sort of doubt about themselves then that makes you think they can’t help you.” In contrast, when a therapist was seen as being confident in her own body,

the women felt she was then “equipped to make you feel that way [too]” (Sophie).

Appearance Matters

This theme describes how the women’s assumptions and speculations had the potential to foster both resistance to, and engagement with, therapy and recovery. More specifically, resistance to therapy and recovery seemed to be increased by a therapist being thin or fat. A thin therapist’s body was variously seen as something to aspire to, a source of envy and jealousy, and as endorsing undereating. Additionally, the women said that if a thin therapist asked them to gain weight it would feel “unfair” and “wrong” (Amy) due to the double standard of the therapist being “allowed” to stay thin. Furthermore, it appeared that working with a thin therapist made the women view themselves more negatively, and it seemed that the women assumed a thin therapist would view them negatively too. Claire, for example, said that she would feel “ashamed” if she disclosed her bingeing to her thin dietician as she assumed she would be: “Just as condemning of my greed as I am or even more so.” And Lucy spoke of feeling “inferior” when talking to her thin therapist who she believed had a strict, controlled relationship with food. Thus it was clear that the women experienced a broad range of potentially therapy-interfering feelings when working with a thin therapist – from jealousy, envy and unfairness, to shame, condemnation and inferiority.

By contrast, the women were worried that if they worked with a fat therapist they would end up bigger themselves because fat therapists have: “Lost control so they’re not gonna tell me when it’s time to stop putting

on weight” (Nina). Indeed, Amy’s concerns were so strong that she felt her response to discovering that a therapist was fat would be to manage the first session but never go back. A further issue raised in relation to fat therapists was that of their body being distracting. Megan, for example, said she had been so “hung up” by a fat psychiatric nurse who had co-run an ED group she was a member of that it had “got in the way” for her and prevented her from focusing.

In relation to a therapist’s size, it appeared that the women saw the prospect of being asked to gain weight and eat ‘normal’ foods as more palatable if it came from a “healthy” sized therapist. They also seemed able to use a “normal” or “healthy” sized therapist as a kind of benchmark against which they could assess certain kinds of eating behaviors. Hayley, for example, felt that her “normal”, “healthy” sized therapist’s disclosure about eating take-out once a week helped her to feel “okay” about the idea of eating take-out herself. “Normal” or “healthy” sized therapists who appeared comfortable with their own body were also seen by the women as modelling the way they could be if they recovered. An idea described by Claire as: “Not about learning from somebody else but you want to be able to take on a bit of what they have or instil a kind of sense of trust and a norma-, a sense of normality about food and eating.”

Discussion

The results of this study describe a hitherto unexplored feature of ED treatment; namely, ED clients’ tendency to observe and make assumptions about their therapist’s body. The findings also highlight the possible impact of ED clients’ observations and assumptions on their beliefs about their

therapist's ability to help them, and their willingness to engage in therapy. The fact that a therapist's body could have a negative impact upon a client's willingness to engage in therapy is noteworthy given the poor recovery statistics (Berkman et al., 2007; Fichter et al., 2006; Löwe et al., 2001; Steinhausen, 2002, 2009) and high drop-out rates from psychological therapy (Mahon, 2000; Wallier et al., 2009) in the ED field, and the ambivalence towards recovery (Williams & Reid, 2010) of people with AN in particular.

Consequently, it seems important that therapists working with ED clients think about how their body might be perceived, what messages it might be sending and the ways in which their clients might be interpreting their body size and speculating about their relationship with food. In doing so, practitioners will need to reflect on their own feelings about their bodies.

The main limitation that should be noted when interpreting the results of this study is the fact that very few of the women had actually worked with a fat therapist. Consequently, their responses were based on their ideas about how they would feel if they were to do so and not on their experiences of having done so. A further limitation of the study was the relatively limited sample size which precludes generalization. In order to address these limitations future research could look at larger sample sizes and investigate the beliefs and experiences of clients who have actually worked with a fat therapist. Future research could also explore the beliefs and experiences of other samples: for example, male clients, clients with AN or BN only, and clients who see themselves as having an active ED rather than being recovered or 'on the road to recovery'.

Ultimately, it appears that appearance really does matter when working with ED clients. Accordingly, it seems important that practitioners in the field be both aware of this and reflect on the ways in which their bodies might be perceived and interpreted by their clients.

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Table 1

Age, ED and Recovery Details for Interviewees

Name	Age (yrs)	Age at onset of ED (years)	Duration of ED (years)	Self-reported recovery (%)
Katie	26	11	15	no data
Sarah	32	16	16	<50
Susie	23	16	7	40-50
Alice	50	22	28	60
Megan	41	14	27	60
Sophie	19	13	6	60
Claire	33	12	21	50-80
Nina	34	30	4	70
Sam	18	12.5	5.5	95
Amy	42	19	16	95
Hayley	25	10	12	100
Lucy	25	16	2	100

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Appendix 1: Recruitment Advert



Interviewees wanted for a study on preferences regarding a counsellor's weight/shape

- **Are you female?**
- **Do you have a formal or self-diagnosed history of anorexia?**
- **Do you see yourself as recovered or on the road to recovery?**
- **Have you received (or are you receiving) counselling for your eating issues from a female therapist?**

My name is Nicola Rance and I am completing a Professional Doctorate in Counselling Psychology at the University of the West of England, Bristol. Little is known about women's preferences regarding their counsellor's own weight/shape, relationship with food and past experiences (if any) of eating issues so I am exploring these topics as part of my doctoral research programme.

If you would be happy to talk about your beliefs and experiences in this area, if you have any questions about doing so, or if you are unsure about whether or not your experiences fit the criteria above please contact me:
nicola2.rance@live.uwe.ac.uk

If you have any questions about this research, please contact my supervisor: Victoria.Clarke@uwe.ac.uk
Dr Victoria Clarke, Department of Psychology, Faculty of Life and Health Sciences, Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY.

This research has been approved by the School of Life Sciences Ethics Committee, University of the West of England.

THANK YOU!

Appendix 2: Participant Information Sheet



What is important to clients about their therapist's weight/shape, their relationship with food and their thoughts and feelings about their own body?

Who is the researcher and what is the research about?

My name is Nicola Rance, I am a trainee counselling psychologist at the University of the West of England, Bristol and I am undertaking this research as part of my Doctoral thesis. My project is being supervised by Dr Victoria Clarke, Reader in Sexuality Studies and Dr Naomi Moller, Principal Lecturer in Counselling Psychology.

It has been found that people seeking counselling have certain preferences and expectations in relation to their counsellor. In the field of eating disorders, such preferences and expectations may relate to a counsellor's weight/shape, their relationship with food and their thoughts and feelings about their own body. This project has therefore been designed to find out what (if anything) is important to clients about their therapist's weight/shape, relationship with food and their own body, and how (if at all) they would like these aspects of the therapist to be a part of the therapy process.

What does participation involve?

Participation will involve being interviewed by me in a mutually agreed location for approximately 1 - 2 hours (there is, however, no maximum or minimum interview length so you will be free to say as much or as little as you like). The interview will be audio recorded and will explore your views about a therapist's weight/shape, their relationship with food and their own body, and how (if at all) you would like these aspects of the therapist to be a part of the therapy process. There are no right or wrong answers to the questions you will be asked, all that matters is *what you think* and *why you think* it.

How will the data be used?

All information collected for the study will be anonymised (i.e. any information that could identify you will be removed) and will remain confidential (i.e. data stored on paper will be held in a locked filing cabinet and data stored on computer will be password protected). The audio recording of the interview will be typed up and analysed, and the findings will then be written-up and submitted as part of my Doctoral thesis. The findings might also be included in academic presentations, reports or papers for publication in academic journals. The information you provide will be treated confidentially and personally identifiable details will be kept

separately from the data. Agreeing to take part in this research (*by signing the consent form*) means that you agree to this use of the information you provide.

How do I agree to take part?

In order to take part you will need to complete a consent form confirming that you have read this information sheet and are happy with the procedures that will be followed and the ways in which your data will be used.

What happens if I decide to withdraw from the research?

Participation in this research is entirely voluntary and all information provided is anonymous. If you decide you want to withdraw from the research after the interview has taken place please contact me *quoting your participant code* (which can be found at the top of the first page of this Information Sheet). Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when my Doctoral thesis has been submitted or journal articles reporting the analysis of the data have been published. It is therefore strongly advisable that you contact me *within a month* of participation if you wish to withdraw your data.

What are the benefits/risks of taking part?

It is not anticipated that there will be any particular risks with participating in this research – indeed, it is hoped that you will find taking part in the interview an interesting experience. There is, however, always the potential for research participation to unexpectedly raise uncomfortable or distressing issues. If this is the case, then the following resources may be of help to you:

- **Eating Disorders Association** (*beat*) www.b-eat.co.uk
Telephone helpline: 0845 6341414 (Monday to Friday, 10.30am to 8.30pm; Saturdays, 1pm to 4.30pm)
Support by e-mail: help@b-eat.co.uk
- **Anorexia and Bulimia Care** www.anorexiabulimiare.co.uk
Telephone helpline: 01934 710679 (Monday to Friday, 9am to 5pm)
Support by e-mail: suffererssupport@anorexiabulimiare.co.uk
- **Caraline** www.caraline.com
Telephone helpline: 01582 457474 (Monday to Friday, 10am to 3pm)
- **Mind** www.mind.org.uk
Mindinfoline: 0845 766 0163 (Monday to Friday, 9am to 5pm)
Support by e-mail: info@mind.org.uk

If you have any questions about this research please contact me:
Nicola2.Rance@live.uwe.ac.uk

Or my supervisor:

Victoria.Clarke@uwe.ac.uk

0117 3282176

Dr Victoria Clarke, Department of Psychology, Faculty of Life and Health Sciences, Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY.

This research has been approved by the School of Life Sciences Ethics Committee, University of the West of England.

Appendix 4: Interview Schedule



University of the
West of England

Background info re. ED and therapy

- Can you tell me a bit about your eating disorder history?
(Possible prompts: *When do you think your eating disorder began? Why do you think you developed an eating disorder? How long did your eating disorder last? How do you see yourself now?*)
- When and how did you access help?
- Why did you decide to access help?
- What sort of help did you access?
(Possible prompts: *Did you see a counsellor/psychotherapist/psychologist/psychiatrist? Did they work in the NHS/private practice/voluntary organisation? Did you specifically ask for a female counsellor or was it coincidental?*)
- Can you tell me a bit about your experiences of therapy/counselling?
(Possible prompts: *Do you think it helped you? If so, in what ways?*)

What is important about a therapist's weight/shape, relationship with food and their own body

- What, if anything, do you feel is important about an eating disorder therapist's own weight/shape?
(Possible prompt: *What, if any, place would you like a therapist's own weight/shape to have in the therapy process?*)
- What, if anything, do you feel is important about an eating disorder therapist's own relationship with food?
(Possible prompt: *What, if any, place would you like a therapist's own relationship with food to have in the therapy process?*)
- What, if anything, do you feel is important about an eating disorder therapist's relationship with their own body?
(Possible prompt: *What, if any, place would you like a therapist's relationship with their own body to have in the therapy process?*)

Speculations about a therapist's weight/shape, relationship with food and their own body

- To what extent, if any, do you think clients speculate about their therapist's body shape/weight before they see them for the first time?
(Possible prompt: *To what extent, if any, did you speculate about your therapist's body shape/weight before seeing them for the first time?*)
- To what extent, if any, do you think clients speculate about their therapist's relationship with food?
(Possible prompt: *To what extent, if any, have you speculated about your therapist's relationship with food?*)
- To what extent, if any, do you think clients speculate about their therapist's relationship with their own body?
(Possible prompt: *To what extent, if any, have you speculated about your therapist's relationship with their own body?*)

Experiences and thoughts re. a counsellor's ED history

- What, if anything, do you think would be different about working with a therapist who'd had an eating disorder themselves and working with one who had not?
(Possible prompts: *What do you feel would be the possible strengths of each? What do you feel would be the possible weaknesses of each?*)
- Have you ever known your therapist's eating disorder history (whether it be that they have, or have not, had one)?
(Possible prompt: *Would you like to know?; Do you think it would be helpful to know?; Do you think a therapist should be obliged to disclose whether or not they have an eating disorder history?*)
- What, if any, place do you feel a therapist's eating disorder history should have in the therapy process?
(Possible prompt: *In your experience, what place has your therapist's eating disorder history actually had in the therapy process?; could you please give me an example (or examples) of when your therapist's history was important in the therapy process?*)
- To what extent, if any, do think a therapist's weight/shape influences the way in which their client's view them?
(Possible prompt: *To what extent, if any, do you think your therapist's weight/shape might have influenced the way in which you viewed them?*)

And finally.....

- Before we finish, is there anything you were expecting or hoping to be asked about that you would like to add?

**Appendix 5: Extract of a Coded Transcript
(Megan’s Transcript, p.23, lines 857- 878)**

Transcript	Codes
<p>Megan: I am more critical of women, erm, when I did the contemplation group [in an NHS outpatient setting] they had a <u>few</u> erm they had I think they had they had a psychologist and a couple of umm psychtiac-psychiatric nurses, <u>in</u> the room so there were always</p>	<p>More critical of women’s appearances Gender differences in judgements</p>
<p>Int: Mmm.</p>	
<p>Megan: because it was quite a big group so there were always about three of them there I guess in case anybody got a knife out and started running amok erm and one of those was quite a young lady and I considered her overweight and yet she seemed really comfortable with it <u>but</u> it really got in the way for me because I spent so much time thinking “are you <u>really</u> comfortable with it is it?” and I started wondering about you know “what do they do do they do they all <u>go into their</u> staff room and and at lunchtime and get out really unhealthy packed lunche-s?” or you know</p>	<p>Social norms re. ill people being dangerous Views of people with EDs Judging practitioner’s body size Judging practitioner’s comfort with own body Struggling to understand how someone can be happy ‘overweight’ Distracted by ‘overweight’ practitioner’s apparent comfort with own body Wondering what ED practitioners eat</p>

<p>“what <u>do</u> eating disorder therapists <u>eat</u> for lunch?” so and <u>it was all</u> like this “do they have cakes on a Friday?”</p>	<p>Social norms around eating Do ED practitioners follow social norms</p>
<p>Int: (laughs)</p>	
<p>Megan: I just I got <u>really</u> hung up on the whole thing particularly err with this one lady I genuinely think she was really happy or she'd come to terms I don't know I don't know <u>but</u> it does get in the way for me.</p>	<p>Distracted by 'overweight' practitioner Judging practitioner's relationship with own body Comfort with being 'overweight' requires 'coming to terms' with size 'Overweight' practitioners distract from therapy</p>

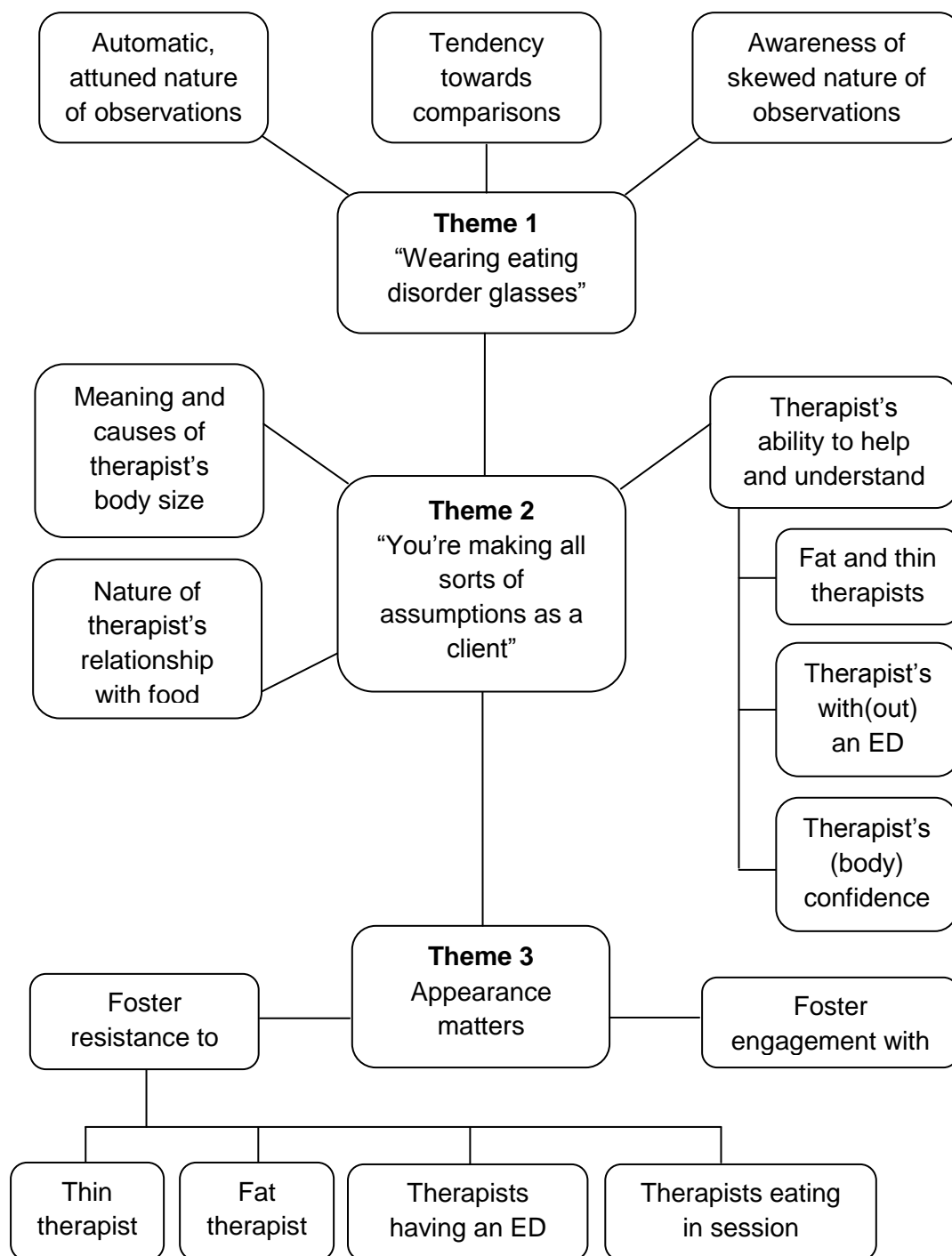
Appendix 6: Examples of Codes with Illustrative Data Extracts

Code: Thin practitioners	Code: Practitioners’ clothing	Code: Ideal weight for an ED practitioner
<p>Data Extracts:</p> <p>One of them [therapists in the ED unit] was <u>really</u> thin, and I was like eughh, okay this isn’t, it wasn’t helpful at all (Sam)</p> <p>If somebody’s [therapist] <u>too</u> thin then you’re thinking “Well how can you, you know, how can you be, you know, talking to me about <u>weight</u> if you’re too thin?” (Alice)</p> <p>If they’re [therapist] an eight or a six or what have you I start getting jealous so I don’t want them to be that thin (Megan)</p> <p>Who are you [thin therapist] to say that I need to be putting on weight, how about take a look at yourself (Lucy)</p> <p>I think it [therapist being thin] would just probably make you feel <u>bigger</u> because you feel <u>bigger</u> than you are anyway (Nina)</p>	<p>Data Extracts:</p> <p>She [therapist] was sort of fashionable and kind of gave off the impression that she looked after herself the other three [therapists and CPNs] didn’t it was kind of like, just like baggy T-shirts and jeans and stuff like that, and I just kind of thought “Mmm” it’s like they didn’t really sort of make the effort (Sophie)</p> <p>One day she did come in wearing <u>shoes</u> that I didn’t like and we d-, that did come up in the session (Nina)</p> <p>If they [therapist] wore lots of black and baggy stuff then you might think, you know, that they’re a bit conscious or something (Katie)</p> <p>You’re making all sorts of assumptions as a client about what’s going on in, in terms of anything that’s physically obvious even if they dress weird (Hayley)</p>	<p>Data Extracts:</p> <p>I would find it quite difficult if, if, the counsellor was like attaining like a size zero type thing, so I guess what I would want would just be a healthy attitude towards, towards both towards food and towards body (Hayley)</p> <p>Not either sort of one end or the other but you could just tell that they [therapist] were really confident and lived a normal life (Susie)</p> <p>I feel like they’ve [therapist] got to be sort of just healthy kind of just just a, it’s weird because I’ve got it in my head but you know not underweight and not overweight (Sophie)</p> <p>I think I would have appreciated kind of a, I don’t know, a [therapist who was a] twelve, size twelve or something (Sam)</p>

Code: Thin practitioners (cont.)	Code: Practitioners' clothing (cont.)	Code: Ideal weight for an ED practitioner (cont.)
<p>[A] skinny therapist I would have seen as a competitor, you know, "Right" (Amy)</p> <p>If they're [thin therapist] like, oh, you know, "So d-, you know, how much do you eat?" and I'd almost be really tempted to be like "Well, how much do <u>you</u> eat?" (Susie)</p> <p>My CAT therapist was quite thin but erm I didn't feel bothered by it in any kind of way (Katie)</p> <p>I did have one counsellor who was really skinny and I used to hate her for being skinny (Sarah)</p>	<p>Say I'd met her [new therapist] and she'd been in dreadlocks and wearing flowery things and and weird sandals I'd be like, that would really influence how I felt I'd think "er, okay, yeah, quir-, you know, eccentric, bleugh" and I'd be thinking "God are we going to get the tarot cards out in a minute or, you know, I would have that that's not my thing and it, other people that's <u>definitely</u> their thing but that's not mine, <u>at all</u> (Amy)</p>	<p>I think seeing a therapist who was a kind of size twelve or, or more, would be fine but I equally I wouldn't want to see somebody who was much <u>bigger</u> than that either, so I guess there's a really kind of fine line a size fourteen would, would be okay I guess (Claire)</p> <p>I think there's a lot to be said <u>for</u> somebody [therapist] who <u>conforms</u> to, let's not necessarily say my ideal but let's say the average ideal of a healthy body for me I'd say a size <u>ten</u> if it was for a lady, if it was for a man somebody who's not sitting there <u>bulging</u> over his what have you (Megan)</p>

Appendix 7: Thematic Map Demonstrating the Relationship between Codes and Themes

Below is the thematic map for the three themes presented in the Analysis above. It shows the relationship between the codes and themes and the way in which the three themes represent the interviewees' thoughts, feelings and beliefs about the issue in question.



Appendix 8: Author Notes, Definitions and Labels for Theme "Wearing Eating Disorder Glasses"

Author Notes about the Theme and its Subthemes

This theme will describe the interviewees' observational behaviours in relation to body- and food-related stimuli. The characteristics of these behaviours will be presented in the three subthemes: 'Automatic, attuned nature of observations', 'Tendency towards comparisons' and 'Awareness of skewed nature of observations.' These subthemes will be illustrated using interview extracts and contradictions both within and between the women's narratives will be given where appropriate.

Definitions and Labels for the Themes Subthemes

'Automatic, attuned nature of observations.' This subtheme will demonstrate the automaticity of the women's observational behaviours and their apparent attunement to body- and food-related visual stimuli. In particular it will:

- highlight variations in the women's awareness of their observational tendencies (e.g., Lucy and Sophie's overt statements about "sizing people up" and "scoping them out" respectively, will be contrasted with Katie saying on the one hand that she is not bothered by a person's appearance and doesn't really "take it in", yet on the other hand remarking that speculating about a therapist before seeing them for the first time is one of the "biggest" things she and her friends with an ED do)
- talk about the way in which the women seemed to accept their observational tendencies as a normal part of their daily routine
- present evidence of the women observing the clothes people wear and the way in which those clothes look on them
- discuss the ways in which the women observed the quantity and types of food being eaten by others

‘Tendency towards comparisons.’ This subtheme will highlight the women’s tendency to make comparisons between their own body and eating and that of others – especially when the other is their therapist. It will:

- demonstrate the automatic, sometimes uncontrollable nature of the women’s comparison-making
- illustrate the ways in which the women’s food consumption comparisons in particular sometimes appeared to be framed so as to emphasis or de-emphasise their own eating (e.g., Alice’s description of her consumption when out for lunch with friends and Katie’s description of her eating in comparison to that of her therapist)

‘Awareness of skewed nature of observations.’ This subtheme depicts the women’s awareness of their skewed perceptions of body size and their apparent lack of awareness of the potential for their food-related observations to also be skewed. In particular it will:

- present evidence that the women seemed to see their skewed perception of body-related stimuli as a normative part of the ED experience
- contrast some of the women’s (e.g., Sarah and Sam) acceptance of the skewed nature of their observations with Claire’s apparent annoyance at it
- discuss Hayley’s awareness (from a place of recovery) of the way in which her perceptions of food had been skewed when she had an ED and how this contrasts with Alice and Katie’s eating comparisons (presented in the previous subtheme) which seemed to lack such awareness

Appendix 9: Journal Choice and Rationale

The journal article has been written as a Brief Report for submission to *Eating Disorders: The Journal of Treatment and Prevention*. The journal Aims and Scope say that:

“As the incidence and awareness of eating disorders continues to rise, it has become apparent that there is a need for a comprehensive source detailing the multidisciplinary approaches to the treatment and education of this growing problem. *Eating Disorders* places itself in the epicenter of this innovative work. *Eating Disorders* is contemporary and wide ranging and takes a fundamentally practical, humanistic, compassionate view of clients and their presenting problems. You’ll find a multidisciplinary perspective that considers the essential cultural, social, familial, and personal elements that not only foster eating-related problems, but also furnish clues that facilitate the most effective possible therapies and treatment approaches.”

The explicit commitment towards taking a “fundamentally practical, humanistic, compassionate view of clients and their presenting problems”, and the “multidisciplinary” perspective espoused by *Eating Disorders* made it an appealing choice as it fitted well with the stance adopted in the thesis as a whole. *Eating Disorders* also felt like an appropriate journal to submit to due to its breadth of readership, which includes: “psychiatrists, psychologists, college counselors, marriage and family counselors, dieticians, nutritionists, social workers, and professionals at eating disorder treatment facilities”. A broad readership felt particularly important as the findings of the study are relevant not only for ED therapists, but for all practitioners working with clients who have an ED.

The decision to submit a Brief Report was based on a request from the Journal Editor who had been “intrigued” by, but unable to publish, a previous longer version of the article. Although Brief Reports in the Journal are generally six to ten double-spaced pages, the Editor said he would be happy with an article that ran ten to 15 double-spaced pages. All other Journal specifications had to be adhered to (e.g., the manuscript had to be

typewritten with margins of at least one inch on all sides; manuscript pages had to be numbered consecutively throughout the paper; and a shortened version of the title suitable for the running head had to be supplied). The journal article has been submitted and is pending peer review.