The Experience of Relationships, Puberty and Adolescence for Eating Disorder Clients

By

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Abstract

The aim of this research was to investigate the experience of relationships, puberty and adolescence for clients suffering with an eating disorder. Four semi-structured interviews were carried out with psychotherapists who have each worked for over 10 years with this cohort of client. Over 150 codes were extracted from the interview data using Thematic Analysis methodology from which the 4 main themes of relating, identity, conflict and complexity were identified. Clients suffering with an eating disorder who present for therapy, as with the general population, have had multiple influences and experiences throughout their early years, adolescence, into adulthood and beyond. Unlike the general population however, some influences and experiences appear to have been problematic for this cohort. This research suggests that the problematic influences and experiences fall under the themes of relating, identity and conflict, and together they combine to form a complex set of life experiences, resulting in a need for 'control' and 'understanding' which an eating disorder appears to fulfil.

Chapter 1 – Introduction

1.1 Background and Context

> "*Treatment of the eating disorders has become a major mental health issue of the twenty first century*." (Gilbert, 2014, p1)

Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder are recognised as the most prevalent eating disorders with at least half of people with an eating disorder fitting some, but not necessarily all, of the criteria for these disorders. (Gilbert, 2014) As a result it can be difficult to classify them as falling neatly into either one or other of these eating disorder groups. This difficulty in correctly diagnosing individuals with an eating disorder can prevent them being referred to proper health care or being hospitalised if needed, according to Hoek and Van Hoeken (2003).

Anorexia Nervosa is characterised by an intense fear of gaining weight or becoming fat, even though the individual may be underweight, along with a disturbance in the way in which one's body weight or shape is experienced. It is defined by a restriction of energy intake relative to requirements, leading to a body weight being less than 15% of what would be expected for individuals of a given age, sex, developmental trajectory and physical health. Body weight or shape influences self-evaluation disproportionately and is accompanied with a denial of the seriousness of the current low body weight. In contrast, an individual suffering with Bulimia Nervosa may maintain a body weight within the normal range expected for their age, sex and height, but will make determined efforts to purge themselves of any food eaten, sometimes following a binge episode, and often following 'normal' food intake. Because a body weight within the normal range may be maintained, it is less obvious than anorexia nervosa and as a result can go unnoticed for longer. An individual suffering with Binge Eating Disorder will usually gain a significant amount of bodyweight due to the frequent and recurrent binge

eating of large quantities of food as unlike bulimia nervosa there are no subsequent purging episodes.

Eating disorders are considered to be complex mental health disorders and causes are spoken about in terms of the interaction of multiple risk factors, but despite this, much research has focused on single event or situational causes. The study of the aetiology of eating disorders can be extremely challenging therefore when a single cause is looked for (Rikani et. al., 2013, p1). However, research carried out by Hoek and Van Hoeken (2003) has suggested that the prevalence rates of anorexia nervosa and bulimia nervosa increase during the transition period from adolescence to adulthood. First introduced by Bowly in 1988 Attachment Theory describes the relationship between a child and its primary caregiver. Categorised as either secure or insecure, the importance of attachment in the development of the self and our identity has been demonstrated in research carried out by John Bowlby and Mary Ainsworth along with many other theorists such as Crittenden where her Dynamic Maturational Model (DMM) describes behavioural disorders which may result from childhood experiences within the context of family attachment relationships. "*When the relationships fail to protect the child, more extreme strategies are organized to wrest some measure of safety and comfort from an otherwise threatening environment."*(Crittenden, 2005, p27) The 'more extreme strategies' referred to by Crittenden could include the use of food and extreme eating behaviours as a method of control and establishing more safety and comfort where the family environment or relationships are experienced as threatening.

While much research has focused on the mother/daughter dyad in the life of an individual who develops an eating disorder (Bruch, 1978; Canetti et al., 2008; Bachar et al. 2008, and Ogden & Steward, 2000), research carried out on the paternal relationship appears to be scarcer. This is surprising when we consider how this relationship can

consist of complex layers of emotions, feelings and experiences between a father and his daughter. In the years leading up to and during adolescence the father is often the key male figure in a young girl's life, and at this time when her femininity and sexuality is developing, acknowledgement by this key man at such a confusing time of her life can only be seen as important. A strong and secure relationship with her father can go a long way in helping a daughter to feel attractive and competent, and to validate her newly emerging identity as a woman. If a father gives too much attention however and oversteps cultural, societal and/or personal boundaries, the results could be devastating, not just to him personally, or for his daughter, but for the wider family too. Too much attention from her father and she may feel that he is being intrusive or even sexually threatening, too little or indeed being suddenly treated as 'untouchable' and she may feel ugly, undesirable and invalidated. This is a highly complex and sophisticated time and experience for any father and his daughter; indeed it has been suggested by Barry and Ohlson (1985) that incestuous impulses may arise in both father and daughter at the onset of adolescent sexual development, and as a result the father may withdraw from his daughter who may experience this withdrawal as a cold rejection. The term 'counter-incest' was used to highlight this defensive reaction-formation on the father's part which they suggest could lead to a negative self-image for the daughter (Barry &Ohlson 1985, p1).

This study intends to add to the above body of work by exploring how relationships and experiences before and at the time of adolescence and the experience of puberty may influence the development of an eating disorder.

1.2 Research Aims and objectives

This study aims to investigate the experience of relationships, puberty and adolescence for clients suffering with an eating disorder.

Research Objectives

i) To identify the role of others in eating disorder client experiences preceding and during puberty or adolescence.

ii) To examine influences preceding and during puberty or adolescence on the development of the individual suffering with an eating disorder.

iii) To identify eating disorder client experiences of difficulties with self and others.

iv) To examine how the combination of all of the above life experiences preceding and during puberty or adolescence may influence the development of an eating disorder.

v) To highlight and comment on therapists' experiences and responses in the treatment and recovery process with individuals suffering with an eating disorder.

It is hoped the results will inform psychotherapists working with clients who have had negative experiences before and during puberty and adolescence and gone on to develop an eating disorder where these experiences may have contributed as causative factors.

Chapter 2 - Literature Review

2.1 Introduction

Early accounts of anorexia nervosa postulated sexual issues as being relevant to the predisposition to the disorder. Lasegue (1873) viewed problems in heterosexual relationships as associated with the onset of anorexia nervosa. In letters sent to Fleiss in 1902, Freud described Anorexia Nervosa as a *"melancholia occurring when sexuality is undeveloped"* (Freud, 1954, P201) while Janet considered Anorexia Nervosa to be "*a form of hysterical sexual frustration*" (Janet, 1929, p92) Abraham and Beumont (1982) carried out research on the varieties of psychosexual experience in patients with anorexia nervosa. They identified 4 distinct groups in terms of sexual activity and experience among 28 female patients suffering from Anorexia Nervosa. A wide spectrum of sexual knowledge, behaviour and attitudes was evident across the 4 groups with sexual behaviours ranging from no sexual experience to promiscuous activity. One group were characterised by *"minimal psychosexual development*" and a "*denial of their own sexuality*" and according to the research "*a sexual challenge is often seen by the patients as a precipitant to their illness*" with patients in this group finding "*discussions relating to sex very difficult but will often talk of their need for a companion*" (Abraham and Beumont, 1982, p11) Schmidt et. al. (1997) concluded that problems with sexuality seem to be specific in triggering the onset of anorexia nervosa while Raboch and Faltus (1991) suggest that in treating women with anorexia nervosa, discussion of sexual problems should be part of the treatment process.

Research carried out by Bulik (2002) and Fornani and Dancyger (2003) suggest physical changes of puberty have effects on body satisfaction and self-esteem. We know puberty and development to adulthood is a traumatic time for both boys and girls, and

Crisp (1980) suggests anorexia nervosa could be a way of turning back the clock to obtain a bodyweight and image suitable for a more innocent and protected time of life where the individual was more accepting of their body. In their research *The Father-Daughter Dilemma: Incest and Counter-Incest,* Barry and Ohlson (1985) suggest a father who had been "*very close in the early developmental years, with father being warm, making good physical contact, holding, caressing and generally attending to his daughter*", "*became frightened of his desires and withdrew to protect against his incestuous feelings",* becoming *"rigid, cold, withdrawn, formal and often very strict*". (Barry and Ohlson, 1985, p2) This could be a time where the daughter's response results in an attempt to recapture the previously close relationship she had with her father by returning to a pre-pubertal stage as suggested above by Crisp. Indeed, Barry and Ohlson go on to suggest that she may become obese, anorexic or become clinically depressed and that from her point of view physical attractiveness and sexuality account for her fathers' withdrawal in her mind, seeing changes in her own body as the problem rather than her fathers' reaction (Barry and Ohlson, 1985, p2)

In their research "*Anorexia Nervosa and sexuality in women: A review."* Ghizzani and Montomoli (2000) acknowledge that Anorexia Nervosa most often appears in adolescence, with disturbance in body shape and weight being defining features. They go on to state that only a broad multifactor perspective can explain the entire clinical pattern, but that self-esteem depends on body image (Ghizzani & Montomoli, 2000, p1) Acknowledging endocrine imbalance, neurological disease and genetic factors are important, they also state that "*in most cases psychological factors are believed to be paramount*" (Ghizzani & Montomoli, 2000, p2). The suggestion by Bancroft (1989) that severe anorexia is a method for avoiding a sexual and mature role is also supported by Laufer (1996) who suggests that physical changes during adolescence lead to a refusal

to integrate the new sexuality with their previously childlike physical image, and that patients attempt to control their bodies to prevent physical change taking place in order to remain passively dependent on their parents.

In her book *Therapy for Eating Disorders*, Gilbert (2014) refers to early psychoanalytic theories which postulated that "*the refusal to eat in Anorexia Nervosa was a symbolic repudiation of sexuality, especially fantasies and wishes surrounding oral impregnation and implicating strongly the presence of oedipal conflict*" (Gilbert, 2014, p29) In 1980 Crisp wrote in his book *Anorexia Nervosa: Let Me Be* that Anorexia Nervosa is a result of a reaction to puberty or a 'flight from growth', that the illness enabled the adolescent patient to regress to a simpler existence in an attempt to avoid emotional upheavals and take less personal responsibility by eating less and maintaining a pre-pubertal weight. Becoming frightened by physical and emotional changes, the patient attempts to stop this process of growing older by starving herself down to a pre-pubertal weight. The fears of adulthood and responsibility are then replaced by a fear of losing control of weight. His main treatment principle was for the patients to acknowledge that Anorexia Nervosa was an avoidant strategy and treatment through psychotherapy then revolved around abandoning that position. Buvat-Herbaut, Hebbinckays, Lemaire, and Buvat (1983) carried out comparative research on two groups, an anorectic group and a non eating disordered group of female adolescents, which compared attitudes toward physiological aspects of sexual maturation and sexuality. The results of this research suggest that weight loss could have been used as a protection against sexuality, and 13 of the 31 individuals in the study indicated that sexual problems were major precipitants of their illness.

Comparing sexual maturity and social conformity, Haimes and Katz (1988) concluded restrictors scored in the high range of social conformity on the Loevinger Scale,

significantly higher than bulimic subjects but also higher than what they classed as normal women (from normative data in the literature). They went on to suggest "*the above-normal scores of restrictors on this scale can be understood as reflecting a compensatory hypersensitive responsiveness to externally imposed social values"* (Haimes & Katz, 1988, p339) Furthermore, they go on to suggest characteristics uncovered in their research are antecedents, rather than concomitants or consequences, of the eating disorder and that these characteristics concern sexual and social attitudes, behaviours and conformity to social expectations. That finding could be important for this study when viewed in terms of its relationship with the results of research carried out by Barry and Ohlson (1985), outlined above.

Kerr, Skok and McLaughun (1991) conducted a review on characteristics common to females who exhibit anorexic or bulimic behaviour and found subjects in their research suffering from anorexia nervosa displayed over controlling egos and suggested this control is a defence against the general lack of autonomy felt by anorexics. They continue by citing research carried out by Johnson (1982) stating that many clinicians are of the opinion that the desire of anorexics is to be in a pre-puberty state which results in starvation behaviour. There is a desire for control over the body and eating, due to all the new internal and external pressures that adolescence brings. The role and impact of puberty on eating disorders is discussed further by McNicholas, Dooley, McNamara and Lennon (2012) in their research titled *The Impact of Self-Reported Pubertal Status and Pubertal Timing on Disordered Eating in Irish Adolescents.* They conclude from this research that puberty itself is a risk factor for disordered eating in girls.While puberty may be a time which has been cited as a decisive time in the development of an eating disorder, this may be for many reasons. Scott (1987) refers to speculation that anorexia nervosa is *"a rejection of adult femininity and a refusal to*

accept the inevitability of becoming a sexually mature woman" (Scott, 1987, p200). In their research, Ghizzani and Montomoli (2000) claimed that most patients develop anorexia during adolescence but draw attention to the fact that an altered balance of ovarian steroids and central nervous system neurotransmitters could be influencing the lack of sexual interest in individuals with anorexia. They also claim that their findings support the hypothesis that difficulties in sexual functioning seen in Anorexia Nervosa patients have an origin as complex as that of the eating disorders. This claim related to complexity is supported by Rikani et.al. (2013) who claim previous evidence for biological, psychological, developmental and sociocultural effects on the development of eating disorders have not been conclusive and that the huge body of research that has been carried out on possible risk factors "*failed to uncover the exact aetiology"* of eating disorders but also failed to understand "*the interaction between different causes of eating disorders" (*Rikani et.al., 2013, p1)

There can be no doubt that body cachexia, the degree of body satisfaction and dissatisfaction, has a direct impact on self-esteem. Our first sense of our own bodies' 'acceptability' to others in society comes from our earliest relationships and environment. In other words, our relationships with parents and siblings and our family environment are paramount in terms of how we perceive ourselves, and our resulting self-esteem. Research has shown that figure dissatisfaction is associated with the symptoms of eating disorders and that the severity of body dissatisfaction is correlated with worsening of disordered eating *(*Rikani et.al., 2013, p3).

Bowlby (2008) highlighted the complex nature of and need for attachment in human beings. Research carried out by Kuopers, VanLoenhout, Van der Ark and Bekker (2016) gives us an insight into just how important relationship and attachment is in relation to the symptoms seen in eating disorder patients. In their research they

concluded that patients suffering with eating disorders showed a higher prevalence of insecure attachment, more autonomy problems and a lower level of mentalization. It is worth noting the significance of the finding on mentalization, as it has been defined by Bateman and Fonagy (2012) as 'the ability to understand the mental states of oneself and……is acquired in a transactional process between the individual and attachment figures.' It goes without saying that an inability to understand one's own mental state is a difficult situation to be in should the individual be in therapy to try to overcome an eating disorder, where the first step is to admit there is a problem in the first place. Furthermore, as we know, individuals suffering with eating disorders address uncomfortable feelings and emotions through physical means, i.e. their bodies, rather than trying to understand their own mental states and address problems there. However it could be that they cannot do so due to these suggested lower capacities of mentalisation.

The general topic of intergenerational trauma has been widely researched (Graff, 2017, Stephens, 2015) Intergenerational influences on patients with eating disorders are an exception however, with searches showing fewer studies in this area. Jozefik and Pilecki (2010) have conducted research on autonomy and intimacy in families of origin of the parents of patients with eating disorders. Their research included the family of origin of both the mother and father, and their results indicated that parents of eating disorder patients had significant difficulties in autonomous functioning and intimacy as compared to parents of healthy females and of depressed females, respectively (Jozefik and Pileck, 2010, p79) The implications of these results have several important aspects, outlined below, when we try to understand relationships within families and how they influence the development of an eating disorder.

The family as a system:

Firstly, regarding the family as a complex autonomous system, Jozefik and Pilecki (2010) suggest that difficulties in autonomy and intimacy in the family of parents of patients with eating disorders result from the inability of a family to function independently. Furthermore, they observed that families of patients with an eating disorder, specifically anorexia nervosa and bulimia nervosa, are more inclined to comply with external social expectations rather than take their own position and make their own decisions on what is right for them, and that this may in fact be a manifestation of "*difficulties in the formation of their own life targets and families standards of conduct*" (Jozefik and Pileck, 2010, p84) If a desire for social acceptance and therefore compliance with external social pressures is a driving force for females raised in these families, then resisting these pressures during the time of adolescence and puberty, a time when identity, self-esteem, body image and self-image are all being formed, can be an extremely difficult time. Developing an identity and self-image based on external expectations rather than an internal sense of self and comfort with one's own reality could be severely challenging at this time and later in life, and thus a core identity can be established which is so deeply rooted as to resist any challenge, analysis or modification, a theme which will be familiar to anyone working with clients who are suffering with an eating disorder. The families of bulimic and anorexic patients appear to pay a lot of attention to the way they are perceived by others according to research carried out by Roberto (1986) and White (1983), not least in how they are perceived in terms of physical appearance. Leung, Schwartzman and Steiger (1996) conducted research in an attempt to understand family systems and their influence on the development of eating disorders. They concluded that adolescent self-image dissatisfaction is directly impacted when the family over estimates the importance of

physical appearance and body weight, and that this may directly influence the development of an eating disorder (Jozefik and Pileck, 2010, p84). Internalising the idea of a perfect self-image is a particular risk factor cited by Pike and Rodin (1991), especially when it concerns females who come from a family that put a high value or pay great attention to the opinions of others and how that opinion is influenced by physical appearance.

Identity:

Castellini concludes that "*eating disorders are conditions in which the process of self-identity construction is interfered with by a profound uneasiness toward one's own body*" (Castellini, 2017, p59), and that in eating disorders "*the external reality of the body and the inner subjective perception do not match*" (Castellini, 2017, p53), or a feeling of estrangement within itself occurs as a result of not establishing a harmonious relationship between the internal representation of the body and the body itself. "*The main psychological disturbances experienced resulting from this situation then are impairments in overall identity development and the failure to establish multiple and diverse domains of self-definition, especially in the crucial period of adolescence*." (Castellini, 2017, p53) When an individual struggles with forming and recognising a sense of self and his own identity, this leads to a difficulty presenting a coherent self to others. In order to establish a distinct self that can be presented to others then, an eating disorder may be established and relied on, as it gives a strong identity recognisable by and attended to by others. It is widely accepted that eating disorders are associated with a dysfunctional evaluation of self-worth. Fairburn (2010) reports that people with eating disorders define themselves largely, if not exclusively, by their body shape and ability to control weight, while those not suffering with an eating disorder are more inclined to evaluate or define themselves in other domains such as work, quality of relationships,

sport, physical ability or their status as a parent etc. Bruch suggested that the levels of dissatisfaction with body image seen in persons with eating disorders reflect a maladaptive "*search for selfhood and a self-respecting identity*" (Bruch, 1979, p255)

Marital Relationships:

Another factor cited by Jozefik and Pileck (2010) which may make it difficult to search for help for a child with an eating disorder is difficulties in marital relationships which make it difficult for the parents to maintain feelings of independence, emotional intimacy and support. These factors could promote a sense of powerlessness, a factor which could influence the sufferers' ability, willingness and hope to look for and avail of help.

Mother-daughter and father-daughter relationships:

Patient-parent relationships are directly addressed by Jozefik and Pileck. They conclude that experiences from the maternal family experience specifically relating to attachment are significant in shaping the mother-child relationship, and that "*difficulties in individualisation accompanied with a lack of intimacy, support and trust in the families of mothers and females with bulimic symptoms, including Bulimia and Anorexia Nervosa binge/purge type, could have created complications in the process of shaping daughters' identity and in establishing stable and safe bonds*" (Jozefik and Pileck, 2010, p84), making it a difficult task for daughters to then establish their own individual identity and maintain a stable and supportive relationship with their mother. They also suggest that where there has been a problem with autonomy and intimacy in the parents' family of origin "*this process may be reinforced by the fathers of bulimic patients because they also have problems with autonomy*." and go on to explain "*A parallel relationship can be seen between fathers and daughters. Fathers may experience difficulties in separation because they have never experienced support and security.*"

(Jozefik and Pileck, 2010, p84) This family modelling of insecurity and difficulty in developing autonomy and individual identity and the transgenerational influences shown is particularly worrying when we consider how difficult it is to break a pattern of thinking and behaviour of eating disorder clients, however it can give an indication of what to look for and maybe where to begin. Recent research carried out by Gale, Cluett and Laver-Bradbury (2013) support the view that dysfunctional family systems contribute to increased rates of eating disorders. They have referenced Steiger, Stotland, Ghadririan and Whitehead (1995) in their research who reported that families of anorexia sufferers have tended to be enmeshed in their relationships and avoidant of conflict, limiting the autonomy of individual members. In their research, Gale et. al. (2013) reported on 8 studies in which they identified father-child relationship themes around conflict and communication, parental protection and psychological control, emotional regulation, self-esteem and self-perfectionism, which they claimed all appeared to influence the child's level of self-determining autonomy and which appeared to have an influence on the development of maladaptive eating attitudes and psychopathology.

2.2 Why is it necessary to do this research?

Eating Disorders such as Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder have been researched extensively in the past with a view to identifying individual causes. The research outlined above has shown causes for eating disorders increase during the transition period from adolescence to adulthood and how there is a complexity of influences rather than a single cause that leads to the development of an eating disorder. This study intends to investigate the experiences of relationships, puberty and adolescence along with related influences that may contribute to the development of an eating disorder.

Chapter 3 – Methodology

3.1 Research Design

Quantitative research is used in situations where something can be accurately measured and analysed using statistical techniques, whereas qualitative research is used where it may be extremely difficult or impossible to measure something. As the objective of this research is to explore clients' past experiences and how these experiences have influenced the development of disordered eating behaviours rather than collect quantitative data for analysis, it has been decided to use qualitative methodologies for the analysis of data collected. Qualitative analysis enables the researcher to gain an understanding of experiences and processes (Harper and Thompson, 2012) and there are several qualitative methodologies which require a detailed analysis of material in order to understand the processes which led to a particular outcome or behaviour. The qualitative approach allows for an examination of individual meaning and experience which is appropriate for this particular piece of work which aims to acquire an understanding of the experience of relationships, puberty and adolescence for clients suffering with an eating disorder. Thematic Analysis is a particular form of qualitative research that facilitates the identification and analysis of themes within interviews. The themes being researched in this thesis will be based on client experiences which are described during therapy that may indicate a negative experience of relationships, puberty and adolescence for clients and the influence these negative experiences may have had on the development of an eating disorder. Thematic analysis is therefore used in this research in an attempt to identify these themes and to understand if these experiences are common to clients with eating disorders.

3.2 Sample

Purposive sampling was used in order to select participants who have direct experience in the area being researched. A sample rather than a complete population is required in qualitative research (McLeod, 2003) and this research initially set out to use a sample size of six professionals working with clients with eating disorders. These six professionals were to be selected from eating disorder clinics to ensure an adequate experience base and the selection criteria also included the requirement that each therapist be practicing for over 10 years. However it was felt data saturation was reached after 4 interviews and the researcher was of the opinion that further interviews would add nothing significant to the quality or quantity of the research data. The research population consisted of three female and one male psychotherapist. Each participant worked in a dedicated eating disorder clinic, operated their own private practice, came from different training backgrounds and held different professional accreditation. Participant demographics are given in Table 1 below.

Table 1: *Participant Demographics*

Therapist	**Gender**	**Years**	**Training**	**Approach**	**Professional Accreditation**
Patricia	F	15	MSc. Psychotherapy	Psychoanalytic, Psychodynamic, CBT, Person Centered	ICP, APPI
Mary	F	27	Psycholinguistic Motivational Therapy	Motivational	AED US
Katherine	F	16	BSc. Psychotherapy	Humanistic, Integrative, CBT.	IACP, IAHIP, EAP
Paul	M	33	MA Psychotherapy	Integrative, Psychodynamic.	IACP, IACAT, BAAT, HCPC

3.3 Reflexivity

Reflexivity is a process whereby the researcher reflects on himself in order to ensure an effective and impartial analysis is carried out. This involves the researcher taking time to consciously examine and then acknowledge any assumptions and preconceptions he brings to the research and that may shape the outcome. In this study the researcher wishes to understand if and how the experiences of relationships, puberty and adolescence for clients may have influenced the development of an eating disorder. In order to extract a wide volume of data to support or reject this hypothesis, the researcher formulated questions which were designed to be open ended and not phrased in a manner that would support or deny any of the researcher's assumptions.

3.4 Recruitment

Recruiting therapists with over 10 years' experience with eating disorders proved difficult. The initial approach involved reviewing eating disorder clinic websites in an attempt to identify therapists with the required number of years' experience working with clients who suffered with an eating disorder. However this information was not always readily available and required direct contact with the therapist to assess suitability for inclusion in the sample. Upon inclusion in the sample each therapist was emailed copies of a Question Sheet (Appendix A), Information Sheet (Appendix B), Consent Form (Appendix C) and Therapist Demographic Sheet (Appendix D). These were all forwarded to participants in advance of the interview.

3.5 Method of Data Collection

In order to collect a detailed description of clients' experiences, data was collected through face to face semi-structured interviews with therapists. The questions used were

common to all interviews and were structured and delivered in a manner to ensure consistency. Each interview was conducted within one hour, the average interview length being 48 minutes, and were recorded for accuracy of recall and transcribed verbatim for coding purposes. Before each interview started, the participant was advised of the confidential nature of the interview and their right to withdraw from both the interview and the research at any stage. Interviews involved the researcher asking 15 questions and following up with further questions relating to each one when clarity was required. This method allowed for the flexibility which is characteristic of qualitative interviewing, a method which facilitates the encouragement of participants to elaborate or add additional information for clarity.

3.6 Method of Data Analysis

After each interview the researcher listened to the recording several times in order to become totally familiar with the content, but also to become familiar with the participants reactions and the inflections in their speech upon answering each question. This then facilitated comparison of common elements or codes within and across each interview. Information gleaned from these interviews was coded and separated out from the interview transcripts for analysis. Initial coding involved making notes to identify important elements of answers to the questions posed. As coding continued several key themes and sub-themes emerged. These themes were then used as headings in an excel spreadsheet with the corresponding coded data inserted under them. All data was then reviewed in an attempt to consolidate all findings into a coherent narrative.

3.7 Ethical Considerations

A research proposal was submitted to the DBS Ethics Committee in 2017 and after consideration approval was granted to conduct the study. Informed consent is necessary

in an ethical study and so in order to facilitate participants giving their informed consent, the nature, purpose and consequences of the research was outlined in a written document which was provided prior to the interview taking place (see Appendix B). Participants were informed of the voluntary nature of participation, their right to withdraw at any stage and that they had the choice to decide what was appropriate to disclose during the interviews. Each participant was requested to provide written consent in the form of a consent form (See Appendix C).

In order to ensure anonymity of clients and practitioners, client and practitioner names have been anonymised and interview records have been coded, password protected and stored securely. The end results of the research will be made available to participants if requested.

Chapter 4 – Findings

4.1 Introduction

This chapter reveals the themes which emerged from the four semi-structured interviews. The interviews were conducted with therapists who have each been working for over 10 years with clients suffering with eating disorders. Four interview recordings were transcribed and coded using the thematic analysis method from which several main themes emerged. Themes within qualitative analysis are topics that relate to the research question and which arise as part of a pattern within the dataset (Braun and Clarke, 2008). Many themes emerged during the semi-structured interviews conducted for this research, and any one theme could make a future research topic in itself.

The 5 principal themes chosen to be discussed below are;

1. Relating
2. Identity
3. Conflict
4. Complexity
5. Therapists experiences

The majority of participants' comments during the interviews relate to women or young girls presenting for treatment. The absence of men with eating disorders presenting for treatment was commented on by participants and is referred to in the discussion section of this report.

4.2 Theme 1: Relating

The first theme to be discussed is around relationships and relating. John Bowlby's attachment theory attempts to explain how and why we interact in a particular manner with others in our environment and how those interactions go on to influence our own behaviours in the future. The family is our first environment and influences us heavily

in terms of who we become and how we position ourselves in the world. Under this theme of 'relating', the roles and interactions of others in a client's experiences that may influence the development of an eating disorder are examined. Specifically, comments made during interviews regarding experiences in relationships and relating within the family are discussed.

While much research has been referred to in the literature review section above regarding complexity, family relationships were no exception when it came to the interviews conducted for this research. Comments were made that referred to complex relationships between siblings, sisters, brothers, mothers and fathers.

For example, Katherine made a comment regarding sibling rivalry;

> *"...even sibling rivalry, there's eating disorder in the family, I'd be better than you, you can't manage this but I can be thinner than you because I'm in more control. Of course you're not in control of an eating disorder, it's controlling you."*

and went on to make the following comment which included relationships with both fathers and brothers;

> *"I'd imagine it's a very difficult piece for fathers. Girls, particularly when they are in puberty and growing up, how to be sensitive around that, and yet keep enough distance that the girl doesn't feel encroached upon, humiliated or.....I think it's a very tentative piece for fathers. And for brothers, they are part of that too."*

Much research has been carried out on relationships between mothers and individuals with eating disorders and this research highlights them as complex, sometimes enmeshed and/or conflicted. The mother/daughter relationship, with its difficulties and complexity, was referred to by Patricia when she said "…there's often a really difficult mother daughter relationship with clients." She expanded on this comment by saying

> *"… so I suppose in terms of the mother, like, well thinking about it psychoanalytically, that for the girl, the relationship with the mother, it is not as straightforward separating out, so the closeness to the mother is much more long lasting, it's much more complicated, it never ends in a nice neat tidy package, the way it might for, for a boy it's much more simpler, and the mother daughter*

relationship, that whole process is really much messier and it's really much more entangled up with feelings and images of body shape and that, and it really can be problematic."

The particular and unique nature regarding the experience of relationships with the father was commented on, particularly when it came to their relationship with daughters. Again the complexity of the father's role and his influence was evident in a comment by Patricia;

"...what you see in the eating disorder is the failure of the paternal function. So that's not necessarily the father obviously, the father can be fine, but that what you see is that when you start to peel back the layers of an eating disorder what you see is there has been a lack of support for the mechanism by which somebody stands in their own two shoes and says "this is who I am.""

Paul, referring to the early father/daughter relationship as well as the period of adolescence, commented:

"....there can be a very close bond in childhood, father and daughter, and yes, in puberty and adolescence, that can get strained. It can get strained anyway in adolescence. It can be very hard on the daughter to feel that this, that the idealised daddy doesn't get her anymore or has become critical."

Continuing in this theme and commenting on the impact of a fathers' comments, Katherine referred to one of her clients:

"One, only recently, said, "my father constantly compared me to my friends and this thing of, your friends are gorgeous, look at the boobs on her, look at the shape of her, she's massive" and he still does it, and what that did to her – "they were gorgeous, so I mustn't have been if he spent all that time".... so she was able to identify that, and it had a huge effect on her whole body image and her own struggle to want to be like them, because in her eyes this was the ideal to him because if he is talking about them and not saying the same to her there is something wrong with her. That's how she interpreted it."

We can see in this the direct influence of the father on the daughters' developing sexuality and emerging sense of self, to be addressed in the following section under the theme of 'identity'.

4.3 Theme 2: Identity

The theme of 'identity' was evident throughout all four interviews and highlights influences on the development of the individual's relationship with self that may contribute to the development of an eating disorder. Paul was quite clear in his assessment when he said "The core of it is the damaged internal relationship, you know that self-loathing…"

And this was echoed by Katherine who suggested:

> *"I think a lot of people who experience an eating disorder, there's a huge disregard of self, almost a self-hatred and the capacity to just build a positive relationship with themselves is very weak, it's a real struggle for them."*

When questioned why this might be, Katherine referred back to our discussion on relationships saying:

> *"You said something else there that reminded me of something around the maturity piece. I think the other bit around maturity, most of them struggle to accept the maturity in their bodies, so as their bodies are maturing and changing shape and growing, there is a real disregard and disrespect for it, "I can't bear this, I can't bear the look of it, can't bear my changing shape, I can't bear that I have breasts", and the maturity around that as their bodies mature, most of them are not happy about that. A real struggle with it."*

Again, while acknowledging that physical changes in the body do have an influence on how identity and sense of self is formed, Patricia named the complexity of the experience, commenting "It's not just about your body changing, it's about how you think about yourself in the world."

A regular reference throughout the interviews was to sexuality and developing sexuality specifically. Katherine referred above to the maturing body and how this can be a difficult experience. However, while discussing the same theme, Patricia was of the view that:

> *"…. it's not as simple as that, there's lots of other bits to it, and it's not just a physical thing, it's not just about the physical body, ……there's such a revival of everything else that's gone before, and the subjective meaning of developing into an adult is a crucial part really."*

This theme of developing into an adult was also addressed by Mary when she spoke about emotional maturity;

> *"....people are afraid to grow up, sure we have a whole society that are afraid to grow up, some people didn't grow up until later, they grow up and then take responsibility. People often say "I'll be 18, I'll be on my own", and I tell them, when you are 18 you actually, really it just means you take responsibility. So, emotional maturity is recovery. Not growing up is not being emotionally mature, in a world that promotes emotional maturity."*

Patricia commented on a poor sense of identity being physically manifested when the process of understanding the self goes awry:

> *"....that actually it goes down to that core sense of identity, of who they are and how they build that up and that there's something in that that goes awry and that's played out in the body then."*

When it goes wrong, much of what has been referred to above under the themes of relating and identity can create an experience of conflict, both internally with the self and externally with others for the client suffering with an eating disorder. How this was referred to during the interviews is discussed below under the heading of 'Conflict'.

4.4 Theme 3: Conflict

That individuals suffering with an eating disorder are conflicted within themselves is evidenced from the vignettes below which show the sources of conflict are many and varied, with quite a few being centred on the conflict of not wanting to mature but being faced with that reality nonetheless. Conflict related to sexuality was discussed by all participants as a factor for their eating disorder clients. For example, Katherine said;

> *"My sense is that not all of them would name it as that but it seems to be that there is some type of, I wouldn't say sexual dysfunction but certainly some type of repression, some type of sexual repression or a difficulty to be a full sexual being without guilt or self-consciousness or fear of rejection."*

Strongly linked to sexuality is enjoyment, and the desire to enjoy. When there is a conflict with sexuality this may translate into the wider area of enjoyment and focus on food. Patricia said;

> *"And you can translate that into sexuality in terms of being free and having a desire and knowing what it feels like to allow your body to enjoy. And "it's ok it's ok for me to like this, it's ok for me to feel these things, it's ok for me to have my own desires, or my own desires that are different to my mum's or my parents desires, they want me to be x, but I want to be y." And when there is something about that, that is problematic."*

Speaking about conflicts that arise during treatment and recovery, Patricia highlighted the conflict that exists in the relationship the individual has with their own maturity or sexuality. Patricia said;

> *"….it's a very significant thing when somebody gets their period back, it's you know it's very difficult….it's certainly very difficult, and very mixed emotions about it you know, the conflict is that part of them would be pleased that they managed to, but there would be a part that would be absolutely horrified that they would allow themselves to."*

Patricia also commented on individuals who are conflicted upon first attending for treatment, in that they know what they don't want, but are afraid of what they do need:

> *"….they have that conflict in their head and that they are maybe coming to you because they don't want to, you know, they don't necessarily want the approach of food only, well after coming to me anyway, so they're very wary of what I'm going to say… so…. I would see it in the first few sessions of my job is trying to establish some kind of trust…."*

Wanting life and situations to remain the same can create conflict when life is moving onward whether we like it or not. Katherine highlights this when she said:

> *"…they just see this is a developmental piece that has happened for them, they wouldn't name it as that, so change in school, the breakup of a relationship, the divorce of their parents, whatever it might be, something has happened and they'd say this was a period in my life that was very difficult, but they would never say this is the cause of the eating disorder and I don't know if I would use that phrase either."*

When individuals fear rejection and do not feel safe in taking their own place in relationship to others, a conflict arises for them when they have to choose between their

needs and the needs, or wants, of others. This is clear from a comment from Patricia who said "… eating disorder clients are very much pleasing and they wouldn't want to cause a row."

When the thoughts and beliefs of the client suffering with an eating disorder conflict with what they hear during therapy, a therapist can find it very difficult to challenge them to encourage a new way of thinking. This was discussed by Katherine when she said;

> *"…. and I suppose for a lot of clients, they believe their own thoughts and they see them as facts and as truths and buy into them. To challenge that and to try to change it, it's quite difficult. It's really difficult."*

Attachment theory is referred to above in section 4.2 on relating and how attachment style can influence how we relate to others. Problems around relating to others when the client has conflicting feelings are referred to by Patricia when she says;

> *"...a big part of recovery from an eating disorder is about being able to tolerate ambivalence. So it is being able to understand that things are not black and white that relationships are complicated and messy and that you can love and hate the same person, and that's fine. So it's being able to move to that middle position."*

The behaviours displayed by individuals suffering with eating disorders can bring the individual into conflict with friends, family members and others, and this was referred to by Paul who said that often their behaviour is seen as wilful, or there is incomprehension of it. This conflict can prove to be difficult when individuals return to their home environment. Paul continued to explain;

> *"….they can relapse and come back, they have to be quite persistent, and returning to their home environment, the situations that are triggering, it can be very difficult."*

The preceding themes of relating, identity and conflict are just three of several themes which emerged during the interviews that contributed to the complex nature of influences and experiences for clients. This is discussed in the section on 'Complexity' below.

4.5 Theme 4: Complexity.

This theme highlights the variety of client life experiences preceding and during puberty or adolescence that may influence the development of an eating disorder. The interview transcripts were dissected and participant comments were placed against several sub themes in order to structure and make sense of the data. One of these sub themes related to the causes of eating disorders and the responses from participants indicated that there are indeed a complex set of experiences and situations brought to therapy by clients. Mary put it very directly when she said there is never just one cause, and when the time is right she goes back to the past with her client.

While Paul referred to a particular set of conditions rather than just a single cause:

> *".... it's like they do know, that it sometimes it takes another level to get to it, but you know there are sometimes multiple causes although sometimes a particular set of conditions that have kind of set them up to respond in a particular way to when traumatic events happen or difficult events happen."*

Katherine spoke about the multi-faceted nature of causes and then went on to specifically name several possibilities indicating the complex nature of contributing factors;

> *"I think it's multi-faceted, there's loads of reasons for it….it seems to be teenage years, often the onset of adolescence, the start of secondary school, body self-awareness, self-image, pressure, it seems to be a lot of what happens, and then obviously depending on what's going on in their family…. So there's loads of things I think contribute to it and interestingly, when clients have stayed a long time and we've continued to look at the past, they are able to say actually, that it came long before that."*

While Katherine spoke about the multi-faceted nature of causes, Patricia used the term 'layers' to describe the process of clients identifying possible contributors:

> *"So say at the beginning, you're talking about causes, and they talk about not liking themselves or something happening with a boyfriend or not being happy with the body weight or shape, and that kind of stuff. When you're working long-term with people then you start to peel back the layers and start to go over and over everything again and again. I suppose what I would see often is that… what it means to be a woman really, what it means to…to develop, and what is that real idea, I suppose, of becoming. I suppose I would think of it, and the work I have*

done on it…something about, at a certain point, something about being them and all that entails has been problematic for them."

As we know, teenage years are a time of immense change both physically, socially, in terms of how we relate to others and in taking responsibility for ourselves. This period and the complex nature of all that goes on at that time were highlighted by participants as a time of onset for eating disorders for many clients. Katherine pointed out"…. it seems to be teenage years, often the onset of adolescence, the start of secondary school…."

This time period was supported by Patricia who said;

"So if you look at all the points that an eating disorder develops, say transition year is a good example, someone comes out of junior cert year where they have a goal, they have an exam and they like that because they have structures and they can work really hard and they can do really well and they have all these kind of external markers that gives them a sense of who they are, so I am a good student, I know how to study, I can do well if I put my work in, people around me all think I'm great and support me because I'm working so hard, all of those kind of things, and then they go on to transition year and suddenly all those things have fallen away, so they're not there anymore it's not about that anymore. It's about what do you enjoy? Where is your desire? It's about who are you as a person? What work experiences are you going to do? What do you like doing? And there's none of these external markers to kind of give you a sense of who you are, and if you don't have that inner sense then that's going to be problematic."

Paul also reported that this time period may be significant;

"Well, quite often they report the early teenage years, some go back to childhood I've heard, you know, some say it begun around 7 but there may be family conditions that dispose them to developing an eating disorder later on but often it is around puberty."

He made an interesting observation in this comment regarding 'family conditions', and also in his earlier comment he referred to "a particular set of conditions that have kind of set them up to respond in a particular way which was discussed in the first theme of 'relating'.

Understanding the *role* of an eating disorder and what it is doing for the person was raised during several of the interviews.

Patricia said;

> *"…I think my understanding of an eating disorder is as a coping mechanism, in that it's functioning for them in some way, it's doing something for them…"*

The eating disorder facilitating a sense of control was also raised by Paul who said;

> *"…all the changes, you know the sexual maturing, the changes in schools, the changes in social circles, the peer pressures, bullying, bullying is often, yes that crops up again and again. And here can be a perceived sense of lack of control or chaos or experiencing the internal world as chaotic. There may be a chaotic home life or it might not appear chaotic but it might be emotionally chaotic. So, restricting eating gives a huge sense of control and achievement…"*

Katherine also agreed with the eating disorder facilitating control, stating;

> *"And the other bit being, of course and it's classic with eating disorders, whatever was going on for them, "I felt out of control", it was a way I could control things, I could control my food, control what I do, control how I look and that made me feel in control of everything that I wasn't in control of" when really what they are saying is that they didn't feel in control of their emotions. Are we meant to be in control of them or are we meant to experience? And yet when something is overwhelming, I think it's "I don't want this, I can't manage it, I can't cope with it" and food becomes the way to control, because it's rarely about food, it's what it symbolises, I think."*

The above vignettes give a sense of the complexity of influences which are experienced by eating disorder clients. How the therapists work with eating disorder clients, the difficulties they encounter as a result of the complexities of influences and their responses are discussed below in theme 5.

4.6 Theme 5: Therapists experiences and responses

This section aims to highlight therapists' experiences and responses working with individuals suffering with an eating disorder. While the complexities and difficulties of an eating disorder are many and varied as outlined in the sections above, they are not confined to the sufferer alone. Each participant referred to the complexities and difficulties in working with this cohort of clients, with a range of responses from fear,

sadness, anguish, guilt and even jealousy being highlighted. Reflecting the seriousness of the illness and possible outcomes for the client Katherine said;

> *"….so yeah, a range of emotions from fear, fear is a huge one that I'm not going to be able to support this person, you know I don't know what I'm doing, this is so entrenched, nobody has been able to help them, how will I be able to?"*

While acknowledging the fear in this statement, Katherine is also referring to the element of self-doubt that can be an issue for therapists when working alone with these clients. Later she referred to the experience of isolation this can bring, while she also suggested it would be beneficial to have the support of a multidisciplinary team. She said;

> *"I suppose not having all the resources, in terms of a multi-disciplinary team which would be brilliant, that kind of leaves me feeling a little bit isolated sometimes and yet a lot of them end up linking in with external services because they have to, to get the support, you know they need a nutritionist, often a psychiatrist, a doctor, different things…"*

Paul described the emotional difficulties he faced while working with these clients, saying;

> *" I find that out of all the work I do for some reason the work with people with eating disorders, mostly women with eating disorders, affects me emotionally almost more than any other work I do…..the sheer emotional pain they're in."*

He was then asked to name the emotion that he feels and Paul immediately replied *"Anguish"*

Also referring to her experience of the client's emotional pain Katherine said;

> *"I suppose the other response would be upset. I'd feel quite sad sitting with some of them, just the suffering, the pain, their distress can be quite difficult to sit into it."*

Katherine also said;

> *"One thing to say is that it's very difficult to work with in terms of recovery….Recovery is really slow. Slow and yes, difficult as well. It takes a long time to make the changes to change the mind-set, to work on the behaviour, to work on the causes, the family of origin stuff; it's slow, slow, slow. And lifelong. I don't think somebody goes through this and need not worry again. It's always there and people would say the recovery follows them. They still watch what they*

eat, they will still notice if they have overeaten, they still have temptations to purge and they are still working on distorted thinking. I don't think it ever goes. It's not a case that "I've mastered this so I can forget about it." It's "I'm recovering from an eating disorder" and that would be their whole lives and how they can slip. They can be in recovery for years and then fall back again."

Acknowledging the inclination of eating disorder clients to please others, Patricia explained that when initially working with these clients it can be easy to develop a therapeutic relationship with them because "….eating disorder clients are very much pleasing and they wouldn't want to cause a row." This point of view of the therapeutic relationship was supported by Mary when she said "I find the eating distress clients a little easier to be honest." In terms of establishing the therapeutic relationship with clients Mary said "I try to practice simplicity. So you have to have very clear boundaries, and firm and loving."

Referring to the difficulties of this work, Katherine went on to say that;

"*At times I felt quite angry that the change isn't happening and there is all this talk and nothing is shifting and frustrated with myself because I feel maybe I just I don't have the skills and the resources, frustrated with the client because there's no change, guilty one might feel like that and bad…."*

While the therapist's difficulties in terms of frustration, anger or sadness can be understood by anyone who has experience working with an intractable mind-set in clients, Katherine also referred to the experience of identification with her clients when she said;

"...and then the other one which is interesting and I noticed it, most people who present to me with eating disorders would be young girls or women. There haven't been any men which is interesting, so it has all been women. There would be moments where I felt jealous, I wish I could look like that, I wish I could have the control and that is real distorted thinking because in my mind it's like "do you hear yourself?", this is what I get drawn into."

The above experiences and responses referred to by the therapists of fear, isolation, guilt, jealousy, anger can also be seen in the clients they are working with. Processes of

projection, transference and countertransference operating in these therapeutic relationships are discussed in chapter 5.

4.7 Conclusion

This section discussed the main themes which emerged from the data set examined. It can be seen how the combination of the themes of relating, identity and conflict in themselves influence the fourth theme, the complexity of experiences, which can lead one to develop an eating disorder. While much of the individual pieces of research read as part of the literature review above looked for a single cause for eating disorders, the finding from this research indicates complex and multifactorial influences and experiences related to the themes described leading to eating disorders.

The next chapter will examine and discuss the themes which emerged from this study while comparing them to the literature researched and referred to in the literature review section, chapter 2.

Chapter 5 – Discussion

5.1 Introduction

There are many dynamic and changing influences on individuals through the early years and during puberty and adolescence including family systems, attachment, sexuality, self-esteem and identity, relationship issues and personal abilities such as mentalization as highlighted in the research above, all which demonstrate the complexity of experiences to be navigated. The themes of relating, identity, conflict and complexity which emerged from this study support research carried out by Hoek and Van Hoeken (2003) which has suggested that the prevalence rates of Anorexia Nervosa and Bulimia Nervosa increase during the transition period from adolescence to adulthood, a time when these themes are at the forefront of an individual's experiences. As highlighted by Rikani et. al. (2013) a single cause for the aetiology of eating disorders can be extremely challenging to pinpoint (Rikani et. al., 2013, p1). However, the influence of experiences of relationships and relating before and during puberty and adolescence on the development of an eating disorder is clear from the findings outlined above. Each therapist interviewed for this research came from a different training background but highlighted similar experiences with clients, indicating that initial training and methods of working with clients did not influence what the clients brought or what the therapist heard in clinical practice which spoke to the commonality in client experience.

The overall aim of this research was to investigate the experience of relationships, puberty and adolescence for clients suffering with an eating disorder, and how these experiences may have influenced the development of an eating disorder. Existing literature relating to causes of eating disorders was reviewed and discussed in chapter 2 above. Chapter 4 highlighted the themes which emerged from the semi-structured

interviews conducted for this research study. This chapter aims to discuss the findings from chapter 4 in relation to the literature reviewed in chapter 2.

5.2 Summary of findings of this research

5.2.1 Relating

> *"Tailoring treatments to improve attachment functioning for patients with an eating disorder will likely result in better outcomes for those suffering from these particularly burdensome disorders."* (Tasca & Ritchie, 2011)

The above quotation highlights the importance of our relationships with others, that our inclination to 'attach' or 'relate' can be used as a tool by the therapist, and that these early experiences of relating may have influenced the development of an eating disorder for some clients discussed during the research interviews. That we as human beings need security and safety in our relationships in order to grow and develop as well rounded and autonomous individuals has been well established. Many theories exist that attempt to describe our need for relating with others as well as *how* we behave and relate with others. For example, Bowlby's Attachment Theory suggests we are born with a biologically programmed tendency to seek an attachment figure and stay close for safety reasons. Object Relations Theory suggests the way we relate to others and situations in our adult lives is shaped and influenced by family experiences we had during infancy and formative years. The description Eric Bern gives of his Transactional Analysis Theory shows us how we can be influenced by early interactions with others, more often than not with family members. The following description of 'transactions' between individuals is given in his book 'Games People Play'; *"The unit of social intercourse is called a transaction. If two or more people encounter each other…sooner or later one of them will speak, or give some other indication of acknowledging the presence of the other. This is called transactional stimulus. Another person will then say or do*

something which is in some way related to the stimulus, that is called the transactional response." (Berne, 1964, p29) In other words, we will base or modify our behaviours depending on interactions with others. When these others are seen as secure and trustworthy we will behave one way. When we experience these interactions or relationships as threatening we will behave in another way. How we are met or engaged with by the 'other' will prompt us to feel secure or threatened in that relationship, and this will lead to us modifying our behaviour in a way that ensures our greatest chance of safety. However this modification in behaviour may not serve us well in the long term, and at some point we may seek another behaviour or behaviours to redress the balance, at times unconsciously. This is what is being referred to by the therapists in this study when they speak of the eating disorder as a way of coping or control. For example Paul referred to an eating disorder as "… a coping mechanism to cope with other stuff…." Patricia described it as"…I think my understanding of an eating disorder is as a coping mechanism…" while Katherine said "….food becomes the way to control…" One reason an eating disorder can be used for control or for coping is for affect regulation (Barth, 1994). Despite the negative long term effects of an eating disorder, many people will describe a sense of calm after a binge or after they have purged, or as Patricia referred to, a sense of cleanliness "…then when they exercise they feel cleansed…they sweat and they feel cleansed…" The element of control in relation to self, and others, for example the mother and the father, came up in the interviews with each therapist. Paul spoke about positive feedback being received from others when the client exercises control over self, for example that restricting eating gives a huge sense of control and achievements, also in the initial stages positive feedback, you know, that “oh you’ve lost weight, you are looking good”

The influence of relationships with the father was referred to by the participants in different ways. For example, Paul referred to the importance of the influence of the father and the culture of the family while from a psychoanalytic point of view Patricia referred to the importance of the father in the paternal function when she said that within the parental couple that the father did not hold the place of desire for the mother which translates in terms of the person's confidence to know who they are, and be who they are, in the world. Relationships with the mother are possibly the closest relationship individuals will have in early years. When this relationship becomes problematic it can have a huge effect on individuals and much research has addressed this relationship and its influence on eating disorders, for example Bacher et. al. (2008), Ogden & Steward (2000), and Pike & Rodin (1991). The influence of the mother/daughter relationship was acknowledged many times in this study, for example by Patricia in her comment "…there's often a really difficult mother daughter relationship with clients", by Paul when he said "But time and time again, it's the mother/daughter relationship." and by Katherine when she said;

> *"…because that's the primary care giver and there's a mixture it seems in the relationship from mother and daughter with each other of enmeshment, hostility, rejection, closeness, accumulation of hugely different dynamics, none of it easy".*

As highlighted above in the referenced texts and vignettes from the interviews conducted for this research, relationships with others are extremely important to the development and security of self for the client. That the relationship with self, father, mother and others has been a problematic experience raised by the eating disorder clients in therapy and highlighted by each participant testifies to the importance and influence of relationships for this cohort of client in the development of their disorder.

5.2.2 Identity

Individuation is a process by which individuals in society become differentiated from one another.The nature of attachments we form to early caregivers is one of the major influences on how we develop an individual identity and develop the confidence to move away from undifferentiated existence to being an autonomous individual. According to Gessel and Ilg a child's development is as a result of the process of maturation, in which "*the child's growth or development is influenced by two major forces. First, the child is a product of his or her environment. But more fundamentally the child's development is directed from within, by the action of the genes*." (Gessel, and Ilg, 1943, p41). The process of individuation is heavily influenced by the family and culture one is born into, and historical influences going back more than a single generation have been shown to have an influence on the development of an eating disorder, as shown in research carried out by Jozefik and Pilecki (2010), Steiger et. al (1995), White (1983) and Roberto (1986). That intergenerational influences on individuation and identity exist has been shown in the above research; however we do not need to go outside the immediate family to find influences on the development of identity, and to see how these influences feature for the individual with an eating disorder who presents for therapy. Our relationship with ourselves is intimately tied to our bodies and how we experience them (Castellini, 2017, Buvat-Herbaut et.al.,1983, Laufer, 1996), and the development of sexuality is a key component of our identity. Where there are conflicting messages around the development of the sexual self, behaviours may be developed to help the individual navigate the resulting emotions and feelings that arise. Many researchers and writers have made connections between sexuality and eating disorder behaviours, for example Crisp (1980), Abraham and Beumont (1982), Buvat-Herbaut (1983), Barry and Ohlson (1985), Scott (1987), Fornari

and Dancyger (2003), Ghizzani and Montomoli (2000), Haimes and Katz (1988) and McNicholas et.al. (2012). In agreement with the research referred to above, participants in this study have each referred to the sexual development of their eating disorder clients and how the time of adolescence and puberty has influenced the development of the eating disorder. A comment made by Katherine describes very well how a father's comment to his daughter about her friend's developing sexuality connects sexual development and the development of eating disorder behaviours. Katherine said;

> "*My father constantly compared me to my friends and this thing of "your friends are gorgeous, look at the boobs on her, look at the shape of her, she's massive."..."they were gorgeous, so I mustn't have been if he spent all that time".... so she was able to identify that, and it had a huge effect on her whole body image and her own struggle to want to be like them because in her eyes this was the ideal to him, because if he is talking about them and not saying the same to her there is something wrong with her. That's how she interpreted it.*"

The body and how a client suffering with an eating disorder experiences their body is an important factor during therapy. This was highlighted by research carried out by Daly when she spoke about *"self-disclosure as it relates to the inescapable presence of the body in treatment, and the female clinician's ability to bring her physical body into clinical discussions during an encounter with a female client with an eating disorder."* (Daly, 2016, p47) This was also highlighted during the interview with Patricia when she said she would be more conscious of her body shape and what she looks like for the eating disorder client…of how they perceive her, and what she is saying.

The time of puberty and adolescence is one of many changes and indeed emotional upheaval and adjustments, not just physical but in terms of developing an identity, sense of self and how we position ourselves in the world of relationships and within ourselves. It is a time which has been referred to by many researchers as a time where eating disorders appear and are used by the individual to cope with these changes (Bary and Ohlson, 1985, Bulik, 2002, Crisp 1980, Fornari and Dancyger, 2003, Gilbert, 2014,

Laufer, 1996). The research referred to above on adolescence and puberty is supported in this study by participant's experience of clients using an eating disorder as a coping behaviour during the development and formation of identity at the time of puberty and adolescence as shown in the participant vignettes in chapter 4 above.

5.2.3 Conflict

According to Freud dreams, jokes, slips of the tongue, and other symptoms are indications of concealed and conflicting desires (Freud, 1901) These desires which have a power of their own can be in conflict and his psychoanalytic theories tried to account for how these conflicts give rise to unintentional expression through the mechanisms above. Dreams and other unconscious acts conceal even as they reveal wishes that we would rather not face more directly. According to Eric Erikson as a child develops and matures, he will experience emotional dilemmas which he will have to negotiate, and in these negotiations will be an important relationship between the child's internal development and conflicts or dilemmas inherent in the relational world. (Dallos and Draper, 2010) As highlighted by Freud, Erikson and many others, conflict is a daily experience for most, not least for the developing child. In a family that places a high value on everyone getting on well for example, saying what you think or feel may lead to tension and argument and threaten the bonds that hold the family together, so the avoidance of direct expression of intense feelings may be encouraged within families that fear conflict among the family members. Rules, sometimes unspoken, designed to keep a family living together in harmony, may have negative consequences for children who then feel they cannot express or be themselves for fear of provoking conflict. In this situation there appears to be no acceptable way to disagree and be different to other family members, which poses a difficulty when an individual is trying to establish their own identity and understand their own experiences and opinions through testing them

against those of others. When rules prevent true expression of feelings then attempts to accept and resolve these feelings are thwarted and according to Siegel, Brisman and Weinshel feelings which are pent up in this way "*may lead to psychological symptoms as expressed in an eating disorder*." (Siegel, Brisman, Weinshel, 2009, p61) This was a theme which was raised by the participants in this study. Typical of comments relating to the avoidance of conflict included one from Patricia who said "… eating disorder clients are very much pleasing and they wouldn't want to cause a row." Avoiding conflict by pleasing others does not allow an individual take his or her place in relation to others and this can lead to development of poor self-esteem as described by Mary when she said "….a person has to speak for themselves, but I think a person with ED is coming from a place of very minor self-esteem."

When a child's 'wants' conflict with what the parent thinks is best for him and the child rebels, a parent may withdraw love or use shame, guilt or power in order to force the child to comply. In order to avoid humiliation or even abandonment, the child may become compliant, indicating an outward '*yes*', but harbour an internal resentment and wilfulness containing an unspoken '*no*', thus setting up a conflicting internal structure. In his book *Healing Developmental Trauma* Heller (2012) introduces five adaptive strategies or 'survival styles' the child develops as ways of coping with the conflicts experienced when its core needs are not met. The 'Autonomy' survival style is characterised by self-assertion and any overt expressions of independence and autonomy are experienced as dangerous and to be avoided (Heller, 2012, p71) According to Heller, what was once a struggle with their parents is now internalised resulting in a constant conflict between the internalised demanding parent and the withholding child, leading the individual feeling bound by internal contradictions of these two roles. He suggests this leads to extreme ambivalence and a resulting

immobilisation which is characteristic of this survival style. During the interviews for this study, clients with eating disorders were described as pleasing, avoiding of conflict with an ambivalent attachment style, and having had conflict with parents or conflict being a feature of the family environment. The avoidance of conflict and willingness to please has been referred to in participant comments above, while examples of the ambivalent attachment style being referred to is shown by the following comment by Katherine who said "….the dominant attachment style…..I'd say most of them have an insecure ambivalent attachment style…"

Conflict and communication were highlighted as key themes by Gale et.al. (2013) that appear to influence a child's level of self-determining autonomy, which in turn can impact maladaptive eating attitudes and psychopathology.

5.2.4 Complexity

> *"Eating disorders are often viewed as complex illnesses that are hard to understand and difficult to treat."* (Mountford, Tatham, Turner and Waller, 2017)

There is common belief that with the right mind set virtually all conflicts or feelings of indecision are resolvable, and with this assumption or expectation individuals present to therapy expecting the therapist to 'fix' them or their situation. But the reality is in many instances such an assumption may be unrealistic. With every decision comes a loss, disappointment, limitation, so it is inevitable some amount of conflict will exist if the individual has not developed a core sense of self, trust or identity that is capable of withstanding loss, challenge to self or threat of annihilation. This conflict is inherent in ambivalence that can cause an emotional or existential crisis. Attempting to understand is a drive to find meaning, to know or to understand who one is, and in the therapeutic setting this is true for both the client and the practitioner. A certain amount of ambivalence is normal, and even healthy in our lives, and it could be argued that the

importance or goal of therapy is to reduce this 'wanting to know' or 'understand' for both therapist and client, and be comfortable in the 'not knowing' or 'lack', to be comfortable in the ambivalent aspect of being, between knowing and not knowing at any particular time. Control is closely linked to 'knowing' as it covers over or defends against the 'lack', and the aspect of control has been addressed in several comments by the participants as an issue for clients suffering with an eating disorder. Much research has been carried out that point to the complexity of eating disorders and their causes, indicating that they involve a range of psychological, biological and sociocultural risk factors. These factors interact differently for different individuals resulting in diverse experiences, perspectives and even symptoms for individuals suffering with an eating disorder. In the analysis of the semi-structured interviews conducted for this study, many Thematic Analysis 'Codes' were identified which, when collated and analysed were grouped together to form the themes of Relating, Identity, Conflict, Complexity and Therapists Experiences. Approximately 150 codes were extracted from the interview data (see Appendix E) indicating the variety and complexity of situations and experiences mentioned in the interviews which influence an individual who develops an eating disorder. These include perfectionism, body image dissatisfaction, thinking and behaviour inflexibility, stigma around weight, internalisation of an ideal appearance or weight, media and social media influences, relationship experiences, loss, anxiety, trauma or abuse among many others. This finding of complexity supports existing research, for example by Rikani et.al (2013), Mountford et.al (2017) and Startup, Mountford, Lavender & Schmidt (2015).

Cultural factors have been shown to influence the degree of body satisfaction and dissatisfaction which is an integral part of self-esteem. Participants in this study spoke about the influence of social media and clients comparing their bodies to others, to the

therapist's, and indeed vice versa, and how the result of this comparison can determine body satisfaction or dissatisfaction. Research carried out by Cooley and Toray (2001) suggests body dissatisfaction is associated with symptoms of eating disorders. The severity of body dissatisfaction has also been shown to be correlated with the worsening of an eating disorder in research carried out by Striegel-Moore, Silberstein and Frensch (1989). Furthermore, studies have shown that exposure to western culture that values the slim body for women plays an important part in the increase of eating disorders in countries such as Singapore, Japan and Iran. (Nobakht & Dezhkam, 2000 and Ung, 2003).

Rikani et.al (2013) have reported on the role of personality and personality disorders in the development of eating disorders and suggest that personality traits such as perfectionism, stress reactivity and harm avoidance are among many personality traits common in patients with eating disorders. This is in agreement with comments made during the interviews conducted for this study, for example Paul said he noticed a lot with the eating disorder clients that they tend to be high achievers, perfectionists, driven with high levels of control, discipline, highly conscientious and highly self-critical.

The time of adolescence is a time when individuals *"build a sense of self and mark their own identities in a way that makes sense to themselves"* (Castellini, 2017, p53) When the building of an identity is based on a sense of self narrowly centred on the body and how it looks there can be negative implications for an individual, and it has been suggested during interviews for this study that this can lead to internalised messages being played out in the body through an eating disorder. This was suggested by Patricia who she said "…that actually it goes down to that core sense of identity of who they are and how they build that up, and that there's something in that that goes awry and that's played out in the body then." Fairburn (2010) suggests that most people define and

evaluate themselves across many domains, for example work, relationships, sport etc., but individuals with an eating disorder judge themselves to a large extent, and in some cases exclusively, in terms of their body shape, eating habits or ability to control weight. Identity being linked to how the body is perceived or experienced was referred to by the participants in this study, and this is in agreement with research carried out by Skarderud (2007) who showed that changing the body is an attempt to changing one's identity, and that changing the body is a concrete and observable experience of that change.

The quality of the 'therapeutic alliance' is extremely important in treatment outcomes (Graves et.al., 2016) and one necessary component of a successful and strong alliance is trust. Interviews conducted for this research show that trust can be an issue for clients, and initially trust in the therapeutic alliance can be influenced by the fear a client may have when their 'coping' mechanism which is the eating disorder may be removed from them, which after all is the goal of therapy.

As human beings are hardwired for attachment (Bowlby, 1988) the experience of loss can be devastating. The experience of 'loss' however is not always a loss of caregiver, but a loss of security, safety, trust, familiarity or even loss of relationship with self. The experience of loss for eating disorder clients was referred to on many occasions in the interviews with participants and the complexity of situations in which loss can be experienced was captured by Paul when he said "In all sorts of ways, there's maybe the loss of the relationship, they can have the loss of idealised parents, or loss of the life they hadn't had that they wished they had, loss of self, yeah, loss in many respects."

Life experiences are varied and complex for us all. The use of an eating disorder as a means of control and coping has been highlighted both in the interviews conducted for this study and in the research referred to above and in the literature review section. The

following section highlights therapist's experiences in dealing with these complexities when they have contributed to the development of an eating disorder and the individual presents for therapy.

5.2.5 Therapists Experiences

Research carried out by Graves et.al. (2016) found that there is a robust association between therapeutic alliance and outcome, and that alliance is a critical component of effective psychotherapies. The importance of establishing trust early on in the therapeutic relationship has been highlighted by participants in this study. An example of this is a comment by Patricia who said that the first few sessions of her job is trying to establish some kind of trust. A trusting therapeutic relationship is necessary to ensure therapy is engaged in for a significant length of time to facilitate change for the client. The experiences of transference and counter-transferences during therapy were discussed by each participant. As the only male participant, Paul said his experiences of transference and countertransference were linked to his being male in that he was seen as, and at times felt like, a father figure, whereas the other three female participants felt transferences and counter transferences were more complicated. They related experiences ranging from being placed in the role of saviour or rescuer to being expected by clients to take up a mothering role. After time however the clients resisted when the therapist stepped into the space where they began to fulfil these client expectations. Participants' counter transferences ranged from collusion to anguish, fear and jealousy.

The absence of male clients was commented on by each participant in this study. Reasons given to explain this included difficulties of diagnosis, men's lifestyle and use of the gym for body image based on size and shape rather than weight loss, isolation and shame of having an eating disorder which is typically seen as a 'female issue'. In

terms of working with eating disorder clients there was a range of opinions from the work being described by Katherine as fascinating, by Mary who said "But it is a fantastic area. It is a fascinating area…" and Paul who said that the work affects him emotionally almost more than any other work he does.

All participants, though practicing in eating disorder clinics, indicated a need for dedicated training in the area of eating disorders and the lack of specific training for working in this area was raised by all participants. Each participant has been working as a psychotherapist for over 10 years and a common experience was the difficult nature of working with clients suffering with an eating disorder. Working in this area means working with clients who can be in severe emotional distress and anguish, as described by the participants, and the complex nature of causes requires long term patience and dedication to the client.

To conclude, the themes referred to above indicate the complex nature of the influences and experiences that lead to the development of an eating disorder, and just how difficult working with this cohort of client can be.

Chapter 6 - Conclusion

6.1 Summary

Clients who present with an eating disorder are no different from the general population in that there are multiple influences and experiences for us all that we live through and have to make sense of. Many of these influences and experiences we will recognise from the codes listed in Appendix E, and most of us would probably admit to having experienced most if not all of them throughout our early years, adolescence, into adulthood and beyond. However through a complex combination of when and/or how these experiences are perceived, they prove to be problematic for some to the extent that it could be said a form of delusion or even psychosis is set up in which thought and emotions are impaired to the point that the reality of self, identity and how the body is perceived is somewhat distorted and so a need for 'control' and 'understanding' is developed which the eating disorder appears to fulfil. This study was carried out in an attempt to understand the influences and experiences that lead to the development of an eating disorder. The results indicate that the influences and experiences falling under the themes of relating, identity and conflict combine to form a complex set of life experiences that challenge who and what they are in the world, for both themselves and others, that need to be untangled and understood by the client in order to let go of the eating disorder as a means of control.

6.2 Strengths and Limitations

This study benefited from a wide review of current literature and robust interviews with participants who each had over 10 years' experience working with clients' suffering with eating disorders. Initially it was intended to invite six participants to take part in this research. However due to data saturation being achieved after four interviews it was decided to limit participants to 4. As this is a qualitative sample using thematic analysis,

the richness and volume of data obtained during interviews, the homogeneous nature of participant responses coupled with the fact that each one has in excess of 10 years' experience in this field, 4 participants was deemed to be acceptable. Possible limitations include participants self-report conclusion accuracy, the influence of participant's personal experiences with eating disorders and the fact that each participant trained or qualified in different modalities and theories. The limited experience of the researcher in qualitative research, and thematic analysis in particular, is also acknowledged. Due to the word count limit for this study there was much data that had to be omitted that would provide further support for the findings. Annex E gives a list of all codes which were identified in the interviews which will give the reader a sense of the volume of data that could have been expanded on.

6.3 Suggestions for future research

The data compiled for this research indicates some identification of the therapist with the client suffering with an eating disorder. Further research on therapists eating behaviours changing or the development of disordered eating habits being developed as a result of working with these clients is recommended in order to gain further understanding of dangers posed by working in the field of eating disorders.

6.4 Implications for psychotherapy

It is hoped this study will contribute to raising awareness of the difficulties of working with clients suffering with an eating disorder, and the multifactorial and complex nature of experiences that can contribute to the development of an eating disorder. Establishing a strong therapeutic relationship early on in treatment was shown by the participants to be important for the client to fully engage with the therapeutic process and remain in therapy, as was the client developing trust that the therapist appears to understand and

practice appropriate and healthy eating behaviours herself. Due to the serious nature of the possible outcomes for eating disorder clients and potential impacts on the therapist, the importance of appropriate support and supervision, preferably with a supervisor who has experience working with this cohort of client, is also highlighted.

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Appendix A

Questions

1. Can you tell me about what brought you to the work of being a psychotherapist/psychoanalyst?

2. What have you found to be the most difficult or challenging part of working with ED clients?

3. Do therapeutic relationships with ED clients differ from those clients who are not suffering with an ED?

4. Can you tell me about your experiences of transferences and counter transferences when working with female eating disorder clients?

5. How do your eating disorder clients describe the cause or causes for their eating disorder?

6. What is your client's insight into the time of onset of their eating disorder?

7. Can you comment on your eating disorder client's experiences within the framework of attachment theory, specifically attachment style?

8. Can you tell me about how significant relationships are spoken about by this client group, both past and present?

9. The experience of 'Loss' is often a significant issue for psychotherapy clients. Can you comment on your eating disorder client's experiences of loss?

10. Arthur Crisp "*conceptualised anorexia nervosa as a disorder of adolescence, triggered by the onset of puberty*." What is your opinion of this based on clinical experience?

(Crisp, A.H., 1980, *Let Me Be.* New York: Academic Press. Quoted in Gilbert, S., 2014.*Therapy for Eating Disorders*. P30. Los Angeles: SAGE.)

11. From your clinical experience, how important do you think the father/daughter relationship is to this particular cohort of clients?

12. From your clinical experience, how important do you think the mother/daughter relationship is to this particular cohort of clients?

13. Would your clinical experience lead you to agree or disagree with the following statement? "*Fathers of pubescent girls often have difficulty handling their daughters changing body and transition into womanhood….*"

(Heller and LaPierre, *Healing Developmental Trauma*, 2011, p80).

14. How do your female clients with eating disorder talk about sexuality?

15. Is there anything you would like to add or highlight that might inform this research?

Appendix B

MA Thesis - Information Sheet

My name is Kieran Cox and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is an **exploration of relationships and experience in the development and maintenance of an eating disorder.** I will be exploring the views of therapists like you who practice with a humanistic, integrative and psychodynamic perspective in relation to sexuality and sexual development of clients who have presented for treatment for Anorexia Nervosa, Bulimia Nervosa or Binge Eating Disorder.

What is involved?
You have been invited to participate in this research along with a number of other people because you have been identified as an experienced therapist working with clients suffering with an eating disorder. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality
All information obtained from you during the research will be kept confidential. Recordings and notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION:
I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.
I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) **_____**

Signature_____

Date / /

If you have questions regarding your rights as a participant in this research, please contact Dr.Grainne Donohue, Research Coordinator, Dept.of Psychotherapy, School of Arts, Dublin Business School at Grainne.donohue@dbs.ie

Appendix C

MA Thesis - Consent Form

Protocol Title:

Contributing factors in the development and maintenance of an eating disorder.

Please circle the appropriate answer.

I confirm that I have read and understood the Information Form attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered. Yes No

I understand that my participation in this study is entirely voluntary and that I may withdraw at any time, without giving reason. Yes No

I understand that my identity will remain confidential at all times. Yes No

I am aware of the potential risks of this research study. Yes No

I am aware that audio recordings will be made of sessions. Yes No

I have been given a copy of the information leaflet and this consent form for my own records.

Participant signature: _____

Block Capitals: _____

Date: _____

To be completed by the Principal Investigator or his nominee.
I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/her to ask questions on any aspect of the study that concerned them.

Signature: _____ **Block Capitals**: _____ **Date**: / /

Appendix D

MA Thesis - Therapist Demographic Form.

(1) Name:

(2) Age Bracket:

30-40	41-50	51-60	61-70	71+

(3) Duration practicing as a therapist: _____years.

(4) Professional accreditation (*please circle*):

IACP	IAHIP	ICP
PSI	BPS	Other (*please specify*)

(5) What mode of core training did you do?

(6) What level of Psychotherapy qualification do you hold?

(7) Have you any particular training/qualifications for working with eating disorders? *Please specify:*

(8) Have you any particular training or qualifications for working with sexuality? *Please specify:*

(9) How would you best describe your psychotherapeutic approach when working with clients presenting with eating disorders? *(Please circle)*

Integrative	Humanistic
Psychoanalytic	Psychodynamic
CBT	Person-centred
Gestalt	Other *(please specify)*

Appendix E

Codes extracted from interview data.

Ability, Abuse, Acceptance, Adolescence, Ambivalence, Anxiety, Attachment, Avoidance, Awareness, Behaviour, Body shape, Body work, Boundaries, Brothers, Cause, CBT, Change, Changing, Clients experiences, College, Collusion, Communication, Compassion, Competition, Confidence, Conflict/internal conflict, Confusion, Control, Coping, Culture, Desire, Destructive behaviour, Developing, Difference, Direction, Disconnection, Distress, Education, Emotions, Empowerment, Enmeshment, Enthusiasm, Environment, Family, Father, FBT, Fear, Feelings, Freud, Frightened, Future, Growing up, Guilt, Here & Now, Hope, How to live, Hug/Touch, Identity, Image, Independence, Individuality, Insecure, Internal conflict, Isolation, Job/Work, Lack, Language, Learning, Life challenges, Life Skills, Listening, Loss, Maturing/Maturity, Meaning, Mother, Motivation, Not good enough, OCD, Oedipus, Ownership, Pain, Partners, Past, Paternal function, Perfection, Pleasing others, Pleasure, Psychopathology, Puberty, Punishment, Purpose, Recovery, Rejection, Relationship with self, Relationship, Repression, Resistance, Resources, Respect, Responsibility, Reward, Role/Function of an eating disorder, Sadness, Safety, Sameness, School, Secure, Self, Self in relation to others, Self-care, Self-Doubt, Self-esteem, Self-harm, Self-image, Self-respect, Sense of self, Sexual development, Sexuality, Shame, Siblings, Sisters, Skills, Social Media, Society, Soothing, Structure, Suicide, Support, Suppression, Survival, Taking one's own place/position, The 'real' you, Therapeutic Process, Therapeutic Relationship, Therapists experiences, Therapy, Thinking, Time of change, Time of onset, Transference/Counter transference, Transitional Object, Trauma, Treatment, Trust, Unconscious, Understanding self, Upset.