COUNSELLING CLIENTS WITH DISORDERED EATING: A QUALITATIVE STUDY OF THE THERAPISTS' PERSPECTIVE

A thesis submitted in partial fulfillment of the requirements for the

Degree of Master of Counselling

in the University of Canterbury

by Tiffany Parish

2015

Table of Contents

List of Figures

List of Tables

Acknowledgements

I am indebted to the three counsellors who so graciously and willingly gave of their time to our interviews. This research could not have evolved without their openness and honesty in sharing with me their experiences of working with clients with disordered eating. I am grateful for what they have each taught me throughout this process.

To my two academic supervisors I would like to extend my utmost gratitude. To Shanee Barraclough, my primary supervisor, thank you for your gentle guidance, sound advice and continual encouragement throughout this project, your support has been invaluable. To Dr Judi Miller, my secondary supervisor, your expertise and advice has been so appreciated throughout this journey. Thank you both sincerely.

My gratitude must also be extended to my family who has been so patient and supportive throughout this project. I could not have completed this without your encouragement. Thank you to you all.

January 2015

Abstract

Limited research has been conducted into counselling clients who experience difficulties with disordered eating at the sub clinical end of the disordered eating spectrum, in contrast to at the clinical end of the disordered eating spectrum where diagnosed eating disorders present. This current study sought to provide a unique perspective on working therapeutically with clients throughout the disordered eating spectrum by investigating therapists' perspectives of their work with such clients. Interpretative Phenomenological Analysis was used as the methodology in conducting this research. Three practicing counsellors participated in semi-structured interviews through which rich and detailed data was gathered. Analysis of the data revealed four themes: therapists' perspectives of their clinical role; therapists' practice with clients experiencing disordered eating; therapists' perspectives of clients' experiences with disordered eating; and therapists' perspectives of educational aspects of therapy. Overall, the findings suggest that therapeutic work with clients with disordered eating is complex and highly individual and the methods and approaches employed by therapists working with these issues ideally reflect this. Detailed descriptions of the four themes are discussed in relation to existing literature. Implications for practice and possible further research suggestions are also outlined.

Chapter One: Introduction

Many westernised societies today live with an abundance of food. While there have been marked changes in abundance and availability of food over time in many western societies, so too have there been changes in the types of foods consumed and also in personal eating habits. Snacking, eating on the run, eating in the car or at the computer, eating at any time of the day or night are accepted today as very normal behaviours. Add to this the social influences of westernised cultures where slim is idealised. Slim is regularly perceived as success, health and beauty. The diet industry thrives, as does the fitness industry while many attempt to achieve the slim body so idealised in society. Abundance and availability of food, cycles of dieting, conflicting societal messages about food and eating, messages that body shape and size matter, have all contributed to the rise in prevalence of eating disorders and disordered eating behaviours over recent decades, particularly in westernised societies.

Prevalence, etiology and intrigue surrounding eating disorders and disordered eating has heightened social and scientific interest in the topic. Counsellor and founder of Eating Disorders Recovery Centre, Barbara McFarland (1995) explains, "the enigma surrounding the eating disorders has only fuelled the fascination of researchers and clinicians alike" (p. 17). Research and clinical development in the field of eating disorders has seen marked shifts in theoretical thought and clinical practice since the 1930s that continue to evolve (McFarland, 1995), as further explained in the literature review section of this study. Due to the complexities of working with these issues, research such as this current project continue to add to knowledge and understanding of working clinically within the field of disordered eating.

Disordered eating, as defined further in the literature review chapter of this research, encompasses a spectrum of eating behaviours that range from simple dieting to clinically diagnosed eating disorders. Sub clinical disordered eating has attracted less research focus than the clinical categories of diagnosable eating disorders. The aim of this study was to add to the research literature that focused on the perspectives of therapists who work with clients who fall at any point along the disordered eating spectrum.

Treatment For People With Disordered Eating

Along the disordered eating spectrum are difficulties with food and eating that are not severe enough to warrant a clinical diagnosis but nevertheless have evolved into significant issues for which people seek professional help. A large "percentage of women and adolescent girls experience subjective distress because of disordered eating despite never meeting strict criteria for any formal eating disorder diagnosis" (Pike & Striegel-Moore, 1997 p. 102-103). In addition, issues with food, eating and body image are regularly normalised in society, perhaps further encouraging people who struggle with a disordered relationship with food and eating to avoid seeking professional help for these issues.

While professional help and therapy is available for those at the extreme end of the disordered eating spectrum, those with disordered eating that fits elsewhere on the spectrum have more difficulty finding therapy. Jacob (2001) identifies that despite the increasing attention, prevalence and discussion around eating disorders in western society, those struggling with eating distress can feel misunderstood and encounter difficulties finding appropriate help. Orbach (2006) further comments on the undertreated nature of disordered eating: "fat expresses experiences of women today in ways that are seldom examined and even more seldom treated" (p. 15). These authors highlight that disordered eating is a relevant

and prevalent problem but that finding professional help for these issues can be difficult. It is my hope that this research provides new perspective and opportunity for discussion around counselling as effective therapy for these issues. I hope also, that this research provides benefit to both researchers and clinicians working in a therapeutic way with clients experiencing disordered eating.

This Research

This present research has evolved from my own curiosity about treatment, counselling, and how people might access professional help for their disordered relationships with food and eating. I have observed the pain, frustration and sense of hopelessness experienced by people who struggle with disordered eating and difficulties with food. As a counsellor, I have developed an interest in exploring the effectiveness and processes of counselling clients who seek help around these issues.

My initial search of the literature uncovered that there is a relatively small amount of research currently on this topic. I subsequently considered that research in this area would be potentially useful to extend the current literature on disordered eating. This present study differs from current literature and offers a unique perspective on disordered eating. The research involved in-depth interviews with a small number of practitioners who work with disordered eating in a counselling context thus providing an experienced and professional perspective to working clinically with clients experiencing these issues. My hope is that this current study will contribute to knowledge and understanding for practitioners offering counselling for clients with disordered eating while also informing my own practice as a counsellor.

My rationale therefore for conducting this research was to contribute to current literature relating to disordered eating and to present a counsellors' perspective of methods and approaches that they use in their work with clients with these issues. In order to address this, the following research question was used:

> What are the methods and approaches used by counsellors who work with clients with disordered eating and how effective do the counsellors find these?

This current research encompasses five chapters to answer this question. Chapter two contains a review of current literature relating to topics relevant to this research. Chapter three introduces and explains the methodology used in this study. Chapter four contains analysis of the data collected and chapter five follows with the discussion, implications for practice, strengths and limitations, recommendations for further research and conclusion.

The focus of this research was the perspectives of therapists who work with clients with disordered eating and each of the terms 'counsellor', 'therapist', 'clinician' and 'participant' demonstrate relevant terms to refer to the subjects of this study. For clarity and consistency, I have chosen to use two terms, 'participant' and 'therapist' interchangeably throughout this research to refer to the study subjects. The term 'participant' was chosen with relevance to the participants taking part in interviews. The term 'therapist' was chosen because it is hoped that the findings from this study might be useful for professionals (including but not exclusively, counsellors) who work with clients seeking help with disordered eating issues and the term 'therapist' seemed a broad term to encompass a range of professions.

The following literature review seeks to define key concepts relevant to this research and to explore current literature pertaining to counselling and therapy with clients who experience disordered eating. Theoretical models of counselling are also introduced and discussed.

Chapter Two: Literature Review

The overall focus of this research project was on investigating therapists' perspectives of the methods and approaches they use in their work with clients experiencing disordered eating. The following literature review sought to explore the nature of disordered eating, the complexities involved in counselling clients with these issues and also to present literature pertaining to methods and approaches currently used in therapeutic work with these clients.

It is pertinent to note at the beginning of this section that significant difficulties were encountered sourcing literature that specifically related to counselling clients at any point along the disordered eating spectrum, while plenty of literature was found relating to counselling clients with eating disorders (at the clinical end of the spectrum). Significant difficulties were also encountered sourcing research-based literature relating to clinicians' perspectives of counselling clients with disordered eating[1]. The limited literature relating to practitioners' experiences of working in a counselling capacity with clients along the disordered eating spectrum provided an avenue for this current research to present a unique perspective to begin to address a gap in current literature.

This literature review begins with definitions of key terms relevant to this current study. Following this, various models of working with clients with disordered eating, including eating disorders are presented followed by concluding comments.

[1] Towards completion of this current study, a title of Doctoral research became available (Santos, 2014) however there was no full access to this research at the time of writing.

Definition of Key Terms

Given the complex, multiple and at times overlapping nature of the terminology, an understanding of several key terms as they relate to this research is useful for clarity and understanding of the data and findings.

Disordered Eating

The term 'disordered eating' refers to eating-related problems along a spectrum that ranges from simple dieting through to clinically diagnosed eating disorders (American Psychiatric Association, 2006). It is emphasized that this description includes eating disorders in the spectrum of disordered eating and while eating disorders are not the specific focus of this research, it is important to note that they are included in the spectrum (see Figure 1). For the purposes of this research in interviewing therapists who work with clients with disordered eating, it is important to acknowledge the whole spectrum. It is not possible to exclude eating disorders because the clients who are experiencing disordered eating referred to in this research can be at any point along the disordered eating spectrum.

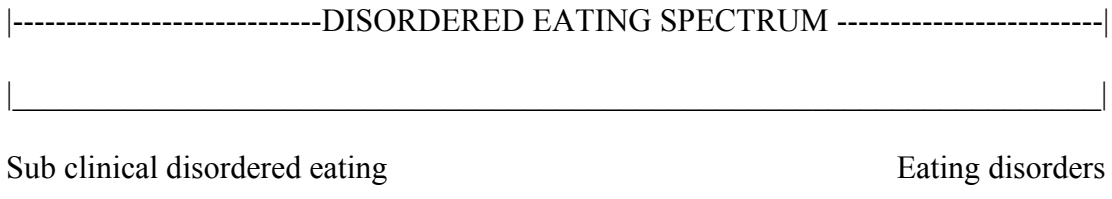

Figure 1: Spectrum of Disordered Eating

To further explain the term disordered eating, as it relates to this research, the following definition is also relevant: "disordered eating includes irregular, chaotic eating patterns which

may reflect some but not all symptoms of recognized eating disorders… Behaviours or relationships with food which are obsessive, irregular or chaotic may fall under the category of disordered eating when they cause a level of discomfort or disruption to a person's life" (Eating Disorders Victoria, 2011). The behaviours which identify disordered eating as defined by Pereira & Alvarenga (2007 p. 142) can be described "as troublesome eating behaviours, such as purgative practices, bingeing, food restriction and other inadequate methods to lose or control weight, which occur less frequently or are less severe than those required to meet the full criteria for the diagnosis of an ED (eating disorder)". These chosen definitions reflect the continuum nature of the disordered eating spectrum, which is the focus of this research.

Eating Disorders

According to the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM 5) (American Psychiatric Association, 2013), "feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning" (p. 329). Diagnostic criteria is outlined in the DSM 5 (American Psychiatric Association, 2013) for the following eating disorders: pica; rumination disorder; avoidant/restrictive food intake disorder; anorexia nervosa; bulimia nervosa and binge-eating disorder. Included also, are two additional categories, other specified feeding or eating disorder, and unspecified feeding or eating disorder where characteristics of the above eating disorders are present without meeting the full diagnostic criteria (American Psychiatric Association, 2013).

It must be noted, that unlike eating disorders for which there are specific diagnostic criteria, disordered eating behaviours have no specific diagnostic criteria (Pereira &

Alvarenga, 2007). Standardised instruments used in eating disorder assessments can also be used to identify and evaluate disordered eating behaviours, cognitions, and distortions in body image and weight (Pereira & Alvarenga, 2007). This is an important point in relation to this current research because much of the literature reviewed for this study identifies methods that have been used with specific eating disorders (in light of the limited literature relating specifically to work with the full disordered eating spectrum). However, it is pertinent to remind the reader that the specific focus of this research was on therapists' work with clients falling anywhere on the disordered eating spectrum rather than their work specifically with clients who have an eating disorder diagnosis. Literature reviewed for this study therefore includes models of therapy that have been used in the treatment of specific eating disorders (with varied success) which are relevant to the findings of this current research.

Normal Eating

Pereira & Alvarenga (2007) suggest that in order to understand disordered eating, normal eating must first be defined. "Normal eating includes the ingestion of healthy foods, the intake of a mixed and balanced diet that contains enough nutrients and calories to meet the body's needs, and a positive attitude about food (no labeling of foods as 'good' or 'bad,' 'healthy' or 'fattening,' which can lead to feelings of guilt and anxiety)" (p. 141). Understanding what normal eating looks like provides a benchmark against which the level of an individual's disordered thoughts and behaviours relating to food can be measured for clarity and understanding.

In conducting the literature search for this study, utilising the University of Canterbury's research portal of journals, databases, and catalogues, I used a number of search terms to find literature relating to therapy with a focus on disordered eating. I had difficulty 'naming' or

'finding a term' that encompassed the problem I was researching (as described in more detail in the methods section of this study). I used the terms 'weight management', 'struggles with food and eating', 'disordered eating', 'eating disorder', 'EDNOS' (Eating Disorders Not Otherwise Specified), 'difficulties with food', 'disturbed eating' as search terms, among others, in the process of finding literature on this topic. The terminology I have chosen to use has changed throughout this project as I have developed my own understanding of the topic and I ultimately arrived at the term 'disordered eating' after conducting the interviews for this project and discussing my confusion and difficulties with the terminology used with the interview participants. Given the difficulty around terminology that I encountered in conducting this study, it is hoped that this research might provide some clarity around the definitions of disordered eating as a further contribution to literature in this field.

Counselling

It also seems appropriate to define counselling and the counsellor due to these being central and fundamental terms in this research. "Counselling involves the formation of professional relationships based on ethical values and principles. Counsellors seek to assist clients to increase their understanding of themselves and their relationships with others, to develop more resourceful ways of living, and to bring about change in their lives. Counselling includes relationships formed with individuals, couples, families, groups, communities and organisations". (New Zealand Association of Counsellors, 2012, p. 3). As McLeod (2013) suggests, counselling provides the context, while theory and techniques are delivered through the counsellor, highlighting that "the basic tool of counselling is the person of the counsellor" (p. 400).

The development of a trusting, comfortable therapeutic relationship is at the foundation of sound counselling skills and is widely accepted across numerous theoretical approaches. Humanist theorist Carl Rogers developed six core conditions for developing the therapeutic relationship: psychological contact, incongruent client, therapist congruency, unconditional positive regard, therapist empathy and communication of empathy (Jones-Smith, 2012). The therapeutic relationship between client and counsellor has repeatedly been found to be more important for clients than the use of techniques in therapy (McLeod, 2013; Mearns & Thorne, 2007). Numerous studies have identified that the most significant contribution to the value of a client's therapy is the quality of the relationship built with their counsellor (Jacob, 2001; Lambert, 1989; McLeod, 2013). This highlights the significance and importance of the development of a quality therapeutic relationship as a central element in the effectiveness of therapy.

The centrality of the therapeutic relationship is also evidenced in the literature on therapy with clients with disordered eating in the results from a ten week treatment programme involving eleven late adolescent women experiencing disordered eating where participants were asked to discuss their thoughts, feelings and beliefs about their treatment and recovery. The results identified that having someone who is non-judgmental with whom they could talk openly and share thoughts with was the most helpful aspect of treatment (Protinsky & Marek, 1997). Similarly, the healing nature of the patient-therapist relationship is highlighted in the therapist's account of a male client with anorexia nervosa, in an interview 33 years after the beginning of treatment (Crisp, 1996). The therapist, in response to the client's reflections on therapy, is reminded of the importance of listening, non-judgment and effective communication in successful therapy (Crisp, 1996). These examples provide evidence that development of good therapeutic relationship is an essential aspect of successful counselling

and is important to address before reviewing the literature on specific models of therapy that follow.

Models of Therapy with Eating Disorders and Disordered Eating

As previously described, limited literature was found relating to models of therapy used with disordered eating compared with clinically diagnosed eating disorders. While therapy with diagnosed eating disorders was not the specific focus of this research, it seems pertinent to include this literature in the current project to demonstrate the effectiveness of varying therapeutic approaches with difficulties that clients experience along the spectrum of disordered eating, at sub-clinical as well as at clinical points on the continuum.

McFarland (1995) identifies four waves in the clinical treatment of eating disorders since the 1930s. Firstly, the psychodynamic approach, viewing eating disorders as a psychological condition; secondly, cognitive behavioural approaches, focusing on altering distorted cognitions relating to destructive eating patterns; thirdly, systemic theory, looking at family systems and the individual within family relationships and fourthly solution-focused therapy, focusing on developing solutions to a problem through building on existing strengths and resources (McFarland 1995). Parts of these therapeutic approaches can overlap. The following outlines each of these therapeutic perspectives with respect to disordered relationships with food and eating.

Psychoanalytic and Feminist Perspective

Psychodynamic theory, founded in the work of Freud and theorists who followed, posits that: "(1) a therapist must take into account the unconscious factors in a client's life; (2) individuals use ego defense mechanisms to deal with anxiety, and (3) one's early upbringing

in the family is the source of many difficulties presented in therapy" (Jones-Smith, 2012, p. 73). In therapy, this approach recognises unconscious drives and the repression of these drives in making sense of clients' difficulties. Ogden (2010) suggests that psychoanalytic psychotherapy is often the main therapeutic approach used in hospitals and therapy centres in the treatment of anorexia and bulimia. However, Ogden (2010) also identifies that evidence for the effectiveness of this type of treatment is limited and often contradictory.

As is widely recognised, females are disproportionately represented compared with males in experiencing difficulties with food, eating and body image issues. Psychotherapist Susie Orbach (2006) presents the psychoanalytic approach as helpful in understanding and exploring the roots of eating difficulties but highlights that psychoanalysis without consideration of the feminist perspective is insufficient. This feminist perspective is highlighted by Pike & Striegel-Moore (1997) who suggest, "disordered eating and eating disorders constitute problematic resolutions to significant issues intrinsic to growing up female in today's society" (p. 97). The feminist perspective illuminates the role of the social environment into which females are born, and in which the personal experiences uncovered in psychoanalysis can be understood (Orbach, 2006). Orbach (2006) further suggests that treatment for women struggling with compulsive eating lies in uncovering and examining the unconscious motivations behind their eating.

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is widely used as a therapeutic approach in treatment for clients with eating disorders. Von Ranson & Robinson's (2006) survey identified which psychotherapeutic treatments were most favoured by clinicians in their work

with eating disorder clients. CBT was identified as the most frequently used therapeutic approach, whereby 59.6% of the total sample size of 52 clinicians favoured this approach.

Literature suggests that CBT is regarded as an effective treatment model with bulimia nervosa (Arnow, 1996; Lowe, Bunnell, Neeren, Chernyak, & Greberman, 2011; Ogden, 2010). "The primary aim of cognitive-behavioural therapy is to produce cognitive change; and behavioural experiments and cognitive restructuring are central characteristics" (Cooper, Fairburn & Hawker, 2003, p. 3). As such, the cognitive aspects of treatment focus on linking thoughts and feelings, self monitoring, learning new skills, approaching therapy as a collaboration between client and therapist with the client as the expert in their problem and providing regular feedback, while the behavioural aspects of treatment focus on breaking cycles, journalling and understanding normal and regular eating (Ogden, 2010). It is reported that CBT is regarded as a 'first-line' treatment approach for bulimia nervosa because treatment is short-term, produces good outcomes and maintenance of gains (Arnow, 1996). Substantive evidence on the effectiveness of CBT with anorexia nervosa is lacking to date (Ogden, 2010). CBT was favoured by clinicians working with eating disordered clients in von Ranson & Robinson's (2006) study because it was supported by research and was consistent with clinicians' theoretical preferences. This does not however, necessarily mean that CBT is the best approach. While the focus of this current research is on the disordered eating spectrum, rather than with diagnosed eating disorders specifically, the perspectives of the counsellors in this present research on their potential use and effectiveness of CBT techniques with the clients they work with might provide a new and additional perspective on the use of this therapeutic model with clients experiencing disordered eating.

Systems Theory

Systems theory views the family as a whole functioning unit, situated within larger systems of community, city and nation (Jones-Smith, 2012). Each family member influences other family members and when one part or person in the system changes, it affects all family members (Jones-Smith, 2012). This provides a unique perspective for the client to view and work with disordered eating, as the focus in therapy changes from the individual to the family system as the central focus. Ogden (2010) posits four central components in the analysis of eating disorders using a family systems approach: "systems as communicative acts; the homeostatic family; the role of boundaries; and conflict avoidance" (p. 264). While encouraging results with this model of therapy have been documented with adolescent and adult patients with anorexia and bulimia (Fishman, 1996), Ogden (2010) emphasizes that evidence for the effectiveness of family therapy is however not robust and sometimes contradictory. Ogden (2010) also suggests that a core difficulty with treating eating disorders with family therapy is the engagement of family members, particularly as the family is often perceived as being at blame for the development of the eating disorder. The literature reviewed suggests that systems therapy receives mixed results in treatment for eating disorders.

Solution Focused Therapy

As a post-modern approach, solution-focused therapy offers a differing clinical influence from the three previously described therapeutic approaches in the development of treatments for eating disorders. From a psychoanalytic understanding of symptoms, to management of symptoms through CBT, to a focus on family systems, the solution-focused perspective focuses on the development of solutions using a client's inherent resilience and competency (McFarland, 1995). The unique perspective of the solution focused therapeutic approach,

whereby the origins of the problem are not a focus of the therapy session, rather a focus on a client's preferred future *without* the problem, provides a different approach to treating disordered eating. The solution-focused approach respects the perspective of clients in determining their own progress for improvement. Jacob (2001) conducted a qualitative research project with clients in her counselling practice, working with eating disorders using solution-focused therapy. After a three year follow-up period, findings identified that 95% of clients had made progress during therapy and had been satisfied with treatment. Most of these clients continued to make progress post therapy (Jacob, 2001). In a similar follow up study, twenty four clients who had received individual solution focused based therapy at the Eating Disorders Recovery Centre, Cincinnati, found that 84% of clients stated that they had met their counselling goals, their situation had improved for 66%, there were improvements in other areas of clients lives for 71%, and 79% had not needed additional counselling since their therapy had finished (McFarland, 1995). These studies provide evidence of effectiveness of the solution-focused approach in therapy for clients with disordered eating.

Because the focus of this current research was on approaches and methods used by therapists in their work with clients experiencing disordered eating, I was interested in what therapists might say about solution-focused therapy as a model in their own work, given the effectiveness of this approach with clients experiencing these difficulties in the literature reviewed for this study.

Narrative Therapy

Another post-modern approach is narrative therapy. A central technique used in Narrative Therapy is 'externalising' whereby people's problems or difficulties are positioned outside of themselves using language and imagery in order to separate the person from their problem

(Morgan, 2000; Ramey, Tarulli, Frijters, & Fisher, 2009). "Externalising involves naming, objectifying and even personifying the problem" (Ramey et al., 2009, p. 263). Furthermore, the externalising technique positions the problem as the problem rather than the client seeing themselves as the problem (Morgan, 2000; Treadgold, Treadgold & Treadgold, 2009). Jacob (2001) describes her integration of the externalising technique in her solution-focused counselling work with clients with eating disorders, describing that many of her clients see themselves as the problem, often witnessing them say 'I *am* an anorexic' or 'I *am* a bulimic' (p. 65). She uses the externalising technique to gently encourage a client to place the problem outside of themselves, which creates separation from it and "opportunity to form an alliance against the eating disorder" (Jacob, 2001, p. 65).

Literature demonstrates that the externalizing technique used in narrative therapy has been effective when used in treatment for both anorexia and bulimia. McFarland (1995) highlights a case study where her work involved a family with a child who has bulimia where externalising was used to create an objective position from which to observe the power of the bulimia and its effect on the family. This case demonstrated the effectiveness of externalising to reframe the problem and discover new meanings in the difficulty being experienced. In their own personal account of receiving narrative therapy as a family in order to treat their daughter's anorexia, Treadgold et al., (2009) describe the use of externalising as an integral part of the eventual recovery of their daughter. Furthermore, a case study involving a 28 year old woman with anorexia nervosa whose successful treatment involved 10 weeks of Narrative Therapy, demonstrates the potential for this method of treatment (Scott, Hanstock, & Patterson-Kane, 2013). Therapy involved a significant focus on externalising the eating disorder, enabling the client to explore her own values and beliefs and the conflicting voice of

the eating disorder. These accounts present and demonstrate effectiveness in the use of techniques from narrative therapy in clinical work with clients with eating disorders.

It is hoped that perspectives of the therapists taking part in this current research on their potential use of narrative therapy, particularly the externalizing technique in work with clients experiencing disordered eating might complement or contribute to current literature on the integration of narrative therapy in therapeutic work with these issues.

Mindfulness

In reviewing literature for this current study, it became evident that a further model of therapy has also demonstrated effectiveness with clients with disordered eating. This model is Mindfulness.

Literature on mindful eating suggests that dysfunctional and destructive relationships with food and eating can be transformed through mindful practices. "Mindfulness is a way of living that has been practised over twenty-six hundred years by millions of people to help them transform their suffering into peace and joy" (Hanh & Cheung, 2011, p. 34). As a paeditrician and Zen teacher, Jan Chozen Bays (2009) highlights that difficulty and suffering with food and eating can be transformed into appreciation and enjoyment of food and eating. "When mindful eating is ignored, it causes pervasive and unnecessary suffering. When mindfulness is applied to eating, a world of discovery and delight opens" (Bays, 2009, p. xx).

As a practice of attending to any present moment in a non-judgmental way while focusing on internal reactivity (Caldwell, Baime & Wolever, 2012), mindfulness offers an alternative approach in gaining awareness of and understanding eating patterns and behaviours that are

problematic. “Mindfulness-based eating approaches support intuitive or attuned eating, an approach… that helps individuals recognize internal cues in support of enhanced self-regulation” (Caldwell et al., 2012, p. 269). In eating mindfully, people become aware of the act of eating and learn to understand their eating behaviours and why they eat the way they do. This awareness then becomes the cornerstone from where change can occur.

The mindful approach places the individual in control of their outcome. Hanh & Cheung (2011), as followers and teachers of mindful practices with eating issues, highlight that the process of mindful eating and changing eating behaviours mindfully, requires an individual to create personal goals for eating healthy foods, partaking in physical activity, to focus on a future without eating issues, to not dwell on past mistakes or failures, to be compassionate with the self and allow setbacks while acknowledging that there has been success, and that this is a journey of small steps; that the answers lie inside of each person. These teachings as part of a mindful approach to wellness also overlap with other therapeutic models of therapy, such as CBT, solution-focused therapy and narrative therapy. This begins to highlight that similar or complimentary components can be found in different models of therapy and these can be integrated to provide therapy that is specific and individual according to client needs.

Integrative Approach

Just as disordered eating is regarded as complex, so too are treatment modalities used by therapists. Werne (1996) highlights that a creative therapeutic approach which integrates concepts and techniques from multiple modalities into one treatment approach reflects the multifaceted nature of the difficulties experienced by those struggling with disordered eating. Further research describes the integration of models and their effectiveness depending on clients’ needs. Protinsky & Marek (1997) conducted a qualitative study involving eleven late

adolescent women with disordered eating, aged between 18-22 years old in a ten week intensive treatment programme using systems therapy, CBT, solution-focused and feminist theories to investigate the emotional, physical and communal needs of young women with problem eating. Interviews where participants discussed their thoughts, feelings and beliefs about treatment and recovery from disordered eating were conducted. The results highlighted that two factors were fundamental in recovery for these women, 'differentiation' and 'connection', a need for finding themselves individually and a need to be connected with others (Protinsky & Marek, 1997).

This study highlights the effectiveness of working with the deep personal aspects of disordered eating and also exploring the family system and the individual within that system. "In the treatment of eating disorders, it is easy to become overfocused on the psychological symptoms that are so prevalent, such as depression, low self-esteem, perfectionism, and body image. However, these young women have informed us about the importance of the developmental and family systems contexts that must be addressed in order for treatment to be successful" (Protinsky & Marek, 1997, p. 68). This research is important because it involves interviews with clients about their treatment and recovery, using semi-structured interviews that were audiotaped, transcribed and themes generated to bring about these two factors. While this study identified that in the case of disordered eating, focusing on family systems and development of individuality was beneficial in successful treatment, it also identified the integrated use of a number of therapeutic models in effective work with clients with disordered eating.

Further to the integration of therapeutic models , a new framework for counselling theory and practice developed by Cooper & McLeod (2011) is the 'pluralistic' approach. Central to

the pluralist perspective is the assumption that there is not one, single, best therapeutic model and that working within a pluralist framework is flexible, responsive and collaborative (Cooper & McLeod, 2011). As an integrative model itself, the pluralist approach holds the underlying assumptions that: (1) many different things can be helpful for different clients at different times (for example CBT could be helpful *and* some mindful techniques at different stages of therapy); and (2) knowing what is going to be helpful to clients is determined through discussion between therapist and client (Cooper & McLeod, 2011). This perspective holds the client at the centre of therapy, developing a collaborative relationship whereby hopes and goals for therapy are discussed with the therapist drawing on a range of methods to achieve these goals, while also acknowledging that different clients might benefit from different things at different times (Cooper & McLeod, 2011). This pluralist approach holds potential for integration and implementation of new frameworks around which working with clients experiencing disordered eating can develop.

Each of these therapeutic approaches demonstrates differing perspectives of working clinically with eating disorders (within the disordered eating spectrum). There appears to be no one approach that is used consistently and each approach appears to focus on different and specific difficulties experienced by those with eating disorders, further highlighting the complexity of these issues.

Discussion

The reviewed literature highlights different approaches being used by therapists who work with clients on the disordered eating spectrum. This chapter began with a definition of terms in order to clarify the use of the term disordered eating, which I settled upon as a result of conducting this research into the perspectives of therapists who work with clients

experiencing these difficulties. The chapter continued on to describe the way that approaches have changed over time and highlights that most research focuses on the effectiveness, or not, of particular approaches. Given the complexity, the range of models and their effectiveness at times, with some clients, my hope is that this present research explores in detail, in a qualitative way, what individual therapists are doing and finding to approach and work with this complexity.

While the literature reviewed in this chapter has a focus on treatment approaches with eating disorders, my interest in this current research is how these approaches may be used within the full disordered eating spectrum. The following research question was used in order to address these interests.

Research Question

The research question for this current study is:

> What are the methods and approaches used by counsellors who work with clients with disordered eating and how effective do the counsellors find these?

The following chapter seeks to describe the methodology and methods employed in conducting this study and to provide the rationale for choosing these methods in order to answer this research question.

Chapter Three: Methods

This chapter presents the methodology and methods used in this research project. The methodology of a research project refers to the theoretical perspective and general logic pertaining to the research; the method refers to specific techniques applied during data collection, for example interviews, surveys or observations (Bogdan & Biklen, 2007). In this qualitative research project, the theoretical framework used has been Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009), using semi-structured interviewing as a method for data collection. In this section, both methodology and methods will be discussed separately. A description of the study participants and method of recruitment is followed by data collection and analysis of data. Ethical considerations and rigour and trustworthiness pertaining to this study conclude this chapter.

Methodology

My primary interest in conducting this research was to seek the perspectives of practitioners who currently work with clients experiencing disordered eating. Given that counselling is essentially a talking approach, it felt appropriate that research which enabled participants to voice their opinions, describe the nuances of meaning and engage in interaction with myself as researcher would be most appropriate. For this reason, I decided that qualitative research was most fitting.

Qualitative Approach

As a whole, "qualitative research is a naturalistic, interpretative approach concerned with understanding the meanings which people attach to phenomena (actions, decisions, beliefs, values etc.) within their social worlds" (Snape & Spencer, 2003, p. 3). Central to this present research project was the phenomenon of practitioners' experiences of working with clients

who struggle with disordered eating. Through qualitative research, participants can have a voice. While this voice is documented and recorded by the researcher, the interpretative nature of qualitative research suggests that rather than a 'truth', what is achieved is "an interpretation of reality grounded in the empirical world" (Bogdan & Biklen, 2007 p. 27). This interpretative nature of qualitative research provides opportunity through which opinions can be heard and analysed in order to gain perspectives and purposeful insight into a phenomenon of interest and from which understanding can develop. Gaining insight into clinical ways of working with clients presenting with disordered eating was central to this project and therefore, a qualitative methodology provided an ideal framework around which this research project was based.

Furthermore, conducting research in counselling, focusing on therapists' perspectives provides an opportunity to learn from practitioners' clinical experience for the benefit not only of other practitioners, but more importantly, their clients. "The purpose of research is to enhance knowledge, to enable us to know more about the way counselling and psychotherapy operate and how or why they are effective (or perhaps ineffective)" (McLeod, 2007, p. 2).

Conducting counselling research through qualitative methods provides a unique perspective of a phenomenon through lived experience and personal accounts of this. Qualitative research provides an avenue for developing understanding and knowledge about the world that differs from the knowledge gained through other research methods (McLeod, 2007). It is through analysing and interpreting data from qualitative research methods that opportunities for unique and insightful perspectives develop. It is this insightfulness and uniqueness that underlies my motivation in conducting this research project.

McLeod (2007) describes three ways in which qualitative research can develop knowledge and ways of knowing; through knowledge of the other; through knowledge of phenomena (phenomenological perspective); and reflexive knowledge. This study will use a phenomenological approach to attempt to answer the research question.

Phenomenological approach

The decision to use a phenomenological approach for this study centred around my intention to look at a phenomenon of interest: the methods and approaches used by counselling professionals when working with clients who seek help with disordered eating. Phenomenological research identifies "the common meaning for several individuals of their lived experiences of a concept or a phenomenon" (Creswell, 2013, p. 76). Bogdan & Biklen (2007) further add that phenomenology attempts "to understand the meaning of events and interactions to ordinary people in particular situations" (p. 25). These aspects of phenomenological research fitted with the purpose of this study whereby I was interested in investigating the phenomenon of interest from the perspectives of 'ordinary people' (professional counsellors) who have expertise and experience in this area.

Phenomenological research is interpretive by nature. Using phenomenological research methods requires the researcher to be aware of and ensure that researcher biases or perspectives are minimised from interpretations by acknowledging their presence and being vigilant about their potential effect. "All forms of phenomenological research are committed to staying very close to the text that is being analysed, ensuring that it is the participant's account (rather than the researcher's theoretical framework or their hypothesis) which drives the interpretation" (Willig, 2012, p. 36). Furthermore, Moustakas (1994) highlights that in order to remove the researchers' preconceptions, biases and prior knowledge of the

phenomenon from influencing the investigation, the researcher must be "completely open, receptive, and naïve in listening to and hearing research participants describe their experience of the phenomenon being investigated" (p. 22). In order to remain open, receptive and naïve in the analysis of my participants' accounts I was conscious and careful to describe accurately the perspectives of my participants and in considering any potential bias at all stages throughout the conducting of this study. I did this in a number of ways. Firstly, I kept a research journal in which I documented among other things, my own post interview reflections. I was also aware of questioning my own biases throughout the collating and organising of the data into themes. On a number of occasions I reorganised the data into different themes that seemed to fit more accurately according to the perspectives of the participants (refer data analysis section). In addition, as described in detail in the rigour section of this chapter, I engaged a fellow postgraduate student to check my transcript coding for accurate and unbiased thematic categorising.

Interpretative Phenomenological Analysis

A recently developed qualitative methodology that is phenomenological due to its focus on examining and making sense of lived experiences is Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009; Smith & Osborn, 2003). Encouraged by the use of IPA where these methods have "afforded us illuminating perspectives upon personal relationships and processes, or professional interventions and contexts" (Smith et al., 2009, p. 206), I began looking into IPA as an appropriate framework around which to base this present research, focusing on professional perspectives to gain understanding in working therapeutically with clients with disordered eating.

A number of features typical of IPA research appeared relevant to this present study. Smith et al., (2009) identify three core elements in IPA research; a concern with lived experience, an interpretive (hermeneutic) inquiry and an idiographic focus. Each of these elements seemed relevant to the purpose and aims of this study and are examined and explained in further detail.

Lived experience. As a phenomenological methodology, IPA by nature has a focus on the lived experience. Both the purpose and aim of this present study was to gain insight into the experiences of counselling professionals working in the field of interest. Therefore, interviewing professionals to gain rich and detailed accounts of their lived experiences as clinicians with this clientele was crucial to the effectiveness of this study.

Hermeneutic inquiry. IPA is interpretative and is therefore based on hermeneutics, the theory of interpretation (Smith et al., 2009). The research question central to this study focused on the experiences and understandings of the phenomenon of interest; counselling clients with disordered eating from the therapists' perspective. The openness and exploratory nature of this question highlighted my intention to look for and interpret meaning in participant responses in order to gain insight and knowledge in working effectively with clients with these struggles.

Idiographic focus. IPA is also idiographic. Idiography refers to a concern for the particular; being particular in detail and analysis by being thorough and systematic, and being concerned with a particular phenomenon, with particular people within a particular context (Smith et al., 2009). The present study focused on a small sample of participants who were chosen for their professional expertise in the phenomenon of interest, (counselling clients with disordered

eating). This sample was therefore purposively selected, highlighting the idiographic nature of this study.

IPA also views human beings as individuals who want to make sense of their experiences and as such, sees participants' accounts of their experiences as individual attempts at making sense of these experiences (Smith et al., 2009). Access to participants' experiences are informed by what the participant chooses to tell us about that experience and as an IPA researcher, these individual accounts are then interpreted by the researcher to understand the participants' experience (Smith et al., 2009).

IPA methodology also suited the present study in that it was my intention to interview a small number of participants for in-depth accounts of their experiences working with clients with disordered eating. Smith et al., (2009) identify that a feature of IPA is the usually small number of participants in any one study and these participants would ordinarily be formed from an homogenous group of individuals in order to examine similarities and differences in detail within the sample. This account of typical sample size and makeup in IPA studies matched the intended sample I had planned for this study, further influencing my decision to base this project around an IPA framework.

Method

Semi-structured Interviewing

Semi-structured interviewing was chosen as the most appropriate method of data collection for this study. McLeod (1999) suggests that commonly, semi-structured interviewing is used in qualitative research in counselling, which involves an invitation to the participant to speak freely about topics presented by the interviewer. In semi-structured interviewing, the

researcher prepares a number of questions which are designed to guide rather than dictate where the interview goes and allows flexibility with the direction of the interview so that if the participant presents an idea or area of interest, this can be pursued (Eatough & Smith, 2008). This concept fitted well with the purposes of this study to investigate the experiences of my participants working with a specific clientele. Semi-structured interviewing provided opportunity for valuable information or understanding to be gained about further ways of working with these clients that might not have previously been considered. Furthermore, data collection in IPA research often takes the form of semi-structured interviews (Smith et al., 2009). This therefore seemed the most appropriate method to employ for data collection in this project.

The aim of this study was to obtain broad perspectives with the intention of identifying key themes that emerged. "With semi-structured interviews you are confident of getting comparable data across subjects" (Bogdan & Biklen, 2007, p. 104) and this therefore further identified that semi-structured interviewing was an appropriate method of data collection for the purpose of this study.

Questions were prepared as a guide for the interview. The aim of structuring a guide is to develop a framework for the interview to enable a comfortable interaction where the participant can talk freely and openly, at length, and which results in a detailed account of the phenomenon under investigation (Smith et al., 2009). This worked well. I had a guide, which I used to introduce topics of interest in this research but I remained flexible with this guide so that more in depth discussion could take place around a further area of interest that might come up in conversation. Only one participant requested a copy of the interview guide prior to our interview taking place.

The interviews conducted were recorded on a voice recorder. “The aim of all qualitative data collection techniques is to generate a qualitative *text* which will form the basis for analysis and interpretation” (McLeod, 1999, p. 123). Smith et al., (2009) further suggest that data collection that invites participants to “offer a rich, detailed, first-person account of their experiences” (p. 56) is ideally suited to an IPA study. In the case of the present study, the format by which data were collected, semi-structured interviewing produced a recording that was then transcribed. This transcription then formed the text that was used in the analysis stage of this project.

Participants

Purposive Sampling

Selecting participants for this study was considered purposive sampling. “This means that samples are selected purposively (rather than through probability methods) because they can offer a research project insight into a particular experience” (Smith et al., 2009, p. 48). Creswell (2013) similarly, identifies that in phenomenological research, an essential requirement of participants is that they have experience of the phenomenon under investigation. Because I was interested in investigating the experiences of my participants in working with a particular clientele, it was important that the chosen participants had expertise in the area of interest. Each participant chosen for this research had specialised clinical experience working in a counselling capacity with clients who experience disordered eating, and this work either has done, or currently does, constitute a significant part of their clinical work. The selection of participants was based on their ability to provide a perspective on the phenomenon under investigation, thereby “they ‘represent’ a perspective, rather than a population” (Smith et al., 2009, p. 49). This perspective on the phenomenon of interest

matched the purpose of this current research project and informed my decision to seek participants for this study purposively.

Sample Size

In order to collect useful but manageable data for this study, sample size was an important consideration. Smith et al., (2009) highlight that because detailed accounts from the individual experiences of participants forms the data in an IPA study, quality of data rather than quantity is most important. Hence small sample sizes are encouraged. Three to six participants is generally suggested in order to develop meaningful similarities and differences while keeping the data manageable (Smith et al., 2009). Smith et al., (2009) further suggest the benefit of three participants in an IPA study by highlighting that this number allows the development of (in effect) three case studies, with opportunity to then analyse similarities and differences between the cases. In the present study I used this guideline to determine the sample size I intended to use, and I found three participants to be a very effective sample size.

Recruitment

Three participants were recruited for this project. Smith et al (2009) identify that in purposive sampling, participants are contacted via referral, opportunities (by way of personal contacts) or snowballing (referral from participants). Each of these referral pathways has been relevant and used in the present study in initiating contact with potential participants. Had I been unsuccessful in contacting participants by these means, I had also intended to advertise for participants through the New Zealand Association of Counsellors (NZAC) around New Zealand or to make contact with counsellors who work with eating issues outside of New Zealand.

Two participants I initially approached by way of opportunity through personal contact at counselling functions. A potential third participant was contacted by way of snowballing and a subsequent third participant was approached by way of referral from another counsellor. After initial personal conversations about my research, each participant was invited to receive further information regarding the project if they were interested in receiving this. Each contact agreed to receive further information. Further information encompassed a Participation Information Sheet (Appendix B or C) and a Consent Form (Appendix D or E). Changes were made to the terminology used on the Participant Information Sheet as the interviews progressed based on questions raised by participants. Therefore the initial two and potential third participant received Participant Information Sheet and Consent Form (Appendix B and D) and the subsequent third participant received Participant Information Sheet and Consent Form (Appendix C and E). Both the Participant Information Sheet and Consent Form provided my contact details in the case of any questions they might have about the project prior to conducting the interview. Telephone conversations with each participant followed after a period of approximately two weeks. Two participants had questions about the project that were answered during these telephone conversations. One participant decided not to take part. Informed consent was obtained prior to interviewing by way of signing the consent form provided.

Data collection

Each participant was interviewed once. The duration of the interviews was between one, and one and a half hours and interviews were conducted at mutually agreed private locations, each at a place of work for my participants. Glesne (1999) suggests that the setting in which an interview takes place needs to be convenient, available, appropriate, quiet, physically comfortable and private. Each of the locations agreed upon met all of these criteria.

The interviews were recorded on a dictaphone and a mobile phone (as a back up). At the conclusion of the interview the participants were offered a copy of the transcription of their interview and each participant requested this. The recordings were then transcribed to produce a written account and record of each interview for the data analysis stage of this project. A transcript of their interview was sent to participants. None of the participants chose to make any changes to their transcript.

The process that was undertaken in the conducting of the interviews for this study is outlined in the following table (see Table 1).

Table 1

Process in Conducting Interviews

- Contact made with first participant
- Interview conducted with first participant
- Interview transcribed
- Contact made with second participant
- Interview conducted with second participant
- Interview transcribed
- Copies of transcribed interviews sent to first and second participants
- Contact made with potential third participant
- Participant decided not to take part in research
- Contact made with third participant
- Changes made to Participant Information Sheet (based on questions raised from previous participants prior to their interviews)
- Interview conducted with third participant
- Interview transcribed
- Copy of transcribed interview sent to third participant

Data Analysis

The transcribed interviews produced descriptive qualitative data from which key themes were identified and analysed. This process was guided by the step-by-step approach to analysing data using an IPA framework suggested by Smith and Osborn (2003).

Step One: Looking for themes in the first case. This step began with reading and re-reading the first transcribed interview, in order to become as familiar with it as possible, taking initial notes and highlighting sections of text that were noted as interesting or significant segments. Smith and Osborn (2003) suggest the notes created are likely to highlight similarities and differences, amplifications and contradictions in the data collected. This was the case in this present research. These notes and text were subsequently reviewed and general, broad categories of interesting themes were then created.

Step Two: Connecting the themes. The emerging themes were then reviewed to make possible connections between them. Regularly, the pieces of data were checked against the original transcript to ensure the thematic categorising fitted with the context within which the data originated from. This is consistent with Smith & Osborn (2003) who suggest that emerging themes are checked against the transcript to ensure connections are consistent with the primary source. The themes were then clustered. Some of these became stand-alone themes (superordinate themes) and others could be grouped together (subthemes).

Step Three: Repeating for other cases. These stages were repeated for each set of data. Data were added to the themes from the first case and new themes were also added. The names of some themes changed as new data was incorporated. Finally, each superordinate theme and subtheme was written out and placed visually on the ground in order to move and

reorganise them into a logical order. As suggested (Smith et al., 2009) graphically representing the superordinate and sub themes in a table (in this case on the floor) was a useful step in organising and making sense of the presentation of the data.

Step Four: Writing. The table of themes created in the previous step became the framework for writing the data analysis section. Each theme was described and illustrated by verbatim accounts from the interview transcripts.

These themes were then explored and discussed in depth in the discussion section of this thesis.

Ethical Considerations

Ethical considerations were important in conducting this research. Approval was sought and granted from the University of Canterbury Human Ethics Committee prior to beginning work on this project (see Appendix A).

Informed consent was obtained from each participant prior to conducting the interview. Each participant was informed of the voluntary nature of this research and that they had the right to withdraw from the project at any stage, including the withdrawal of any information gathered. None of the participants chose to do this.

The primary ethical consideration of this project was the anonymity of my participants. Anonymity rather than confidentiality is all that can be offered in qualitative research (Smith et al., 2009). While I knew the identity of the participants, I could assure them that with

respect to the data, their identity would not be made public. Pseudonyms were used at all stages of data analysis and discussion to protect the participants' identities.

While snowballing was used in making initial contact with one participant for this study, the suggested participant and information regarding their work is already in the public domain.

Rigour

In order to demonstrate rigour in the collating and categorising of the data collected in this research, a number of pages of transcript were peer reviewed by a fellow postgraduate student. This student reviewed my initial coding categories directly from transcript data checking for applicability of the categories I had used. This student also offered alternative categories where she saw fit. Out of a total of 38 pages of transcript over the three interviews, seven pages were peer reviewed, totalling 18.4% of the complete data collected. Over these pages, I had coded 25 segments of text to broad categories and she suggested alternatives or additions to ten of these categories. We discussed together the rationale for her suggestions and I reviewed each of the suggested alternatives she presented. All suggestions were relevant, and six of her suggestions became integrated into the ultimate themes I chose after coding subsequent transcripts. Three alternative suggestions were not ultimately applicable to my research question and I believed one fitted less well than the category I chose to use.

I subsequently also took this transcript to my primary academic supervisor and we discussed the first two pages of coding which included nine of my initial codes and three peer reviewed suggested alternatives or additions. We discussed the process of coding and my engagement with the data. Both of these processes in reviewing the codes and categorising the

data collected, provided opportunity for a personal critique and reflection of my process in analysing and understanding the data. Through the discussions I had with both my peer and academic supervisor, I saw how each piece of potential data could be categorised very differently according to different perspectives. This not only highlighted to me the highly interpretative nature of qualitative research but it also resulted in my reflection and review of the reasons I had chosen to code particular pieces of transcript to particular categories.

Chapter Four: Results

The aim of the current study was to investigate and explore methods and approaches used by counsellors when working with clients experiencing disordered eating. The data, obtained through semi-structured interviewing as previously described, were collated and organised into four superordinate themes. Within these themes, sub themes emerged. While not distinct and stand alone, these subthemes nevertheless became a framework from which the data could be organised and presented. A description of the superordinate themes and subthemes is outlined in the following table (see Table 2).

Table 2

Superordinate Themes and Subthemes

Theme One: Therapists' Perspectives of their Clinical Role
- a. Building Trust
- b. Holding the torch

Theme Two: Therapists' Practice with Clients Experiencing Disordered Eating
- a. Multi-faceted Approach
- b. Client Directed
- c. Holistic Perspective
- d. Interactive Work
- e. Safety / Multidisciplinary Team

Theme Three: Therapists' Perspectives of Clients' Experiences with Disordered Eating
- a. Deep Private Struggles
- b. The Tapestry Unfolding
- c. Internal Focus
- d. Recognising Hunger
- e. Destructive Cycle
- f. Slowing Down / Noticing
- g. Relationship with Self
- h. Developing New Skills
- i. Normalising Struggles with Food

Theme Four: Therapists' Perspectives of Educational Aspects of Therapy
- a. Nutrition and Regular Eating
- b. Societal Pressures and Effects

The superordinate and subthemes are explored in detail in this chapter. Extracts from the interview transcripts are included to illustrate these themes, allowing the voices of the participants in this study to be heard.

Theme One: Therapists' Perspectives of their Clinical Role.

This first theme centres on the work as a counsellor with disordered eating. Participants reported that the therapist-client relationship was a critical component in the journey of recovery from disordered eating.

(a) First Session / Building Trust. Two participants discussed the importance of building rapport and trust with the client, not only as an acknowledgement of the sensitive and delicate nature of the work but also so that the client knows they have a choice whether to come again or if they feel safe to return for more sessions:

> *"it's about building that rapport and that trust cos with some clients that's you know, can be a barrier, that their lack of trust because maybe they've been through services or their own childhood experiences… it's about building that rapport and that trust with that client so that they know that they have a choice to come back or not"*

The initial meeting was highlighted by one participant as the critical time of engagement and provides an opportunity to be very present with the client and their story:

> *"that first initial meeting is so sensitive… for me, all of my training and tools are very much in the background and it's about being really present and gentle and um compassionate and creating a space – it's a sacred space and where someone's able to share, often I'm the first person that the person's told, so it's really honouring the privilege and the courage that it's taken for this person to divulge something that often they're quite ashamed of"*

(b) Holding the Torch. All participants in this research described their role as counsellor as one of being alongside the client on their journey of recovery, which was demonstrated in the following comments:

> *"I'm simply there as somebody that kind of holds the torch for them 'cos I can't do anything for them other than you know, be… a conduit to their wanting to self observe and to learn new pathways to discovering, feeling easier and worthy so that they can start treating themselves well"*

One participant's perspective of the role as a therapist was of gentle guidance and encouragement to continue with the work the client is doing:

> *"They don't know the way… they don't know how to walk there. They know they want to be there but my job is to say 'put one foot in front of another like this and just keep coming, keep trusting, and you will get there but you can't wish yourself there, you can't direct yourself there and you can't hate yourself there but there is a way to get there'"*

Theme Two: Therapists' Practice with Clients Experiencing Disordered Eating

All participants in this study spoke in a general sense of underlying approaches relating to their counselling work with clients with disordered eating.

(a) Multi-faceted Approach. None of the counsellors interviewed for this research used one particular model in their work with clients. They unanimously spoke of a multi-faceted approach to their work, directed by the client and their hopes and needs in counselling, rather than working with a specific model or within a set framework.

> *"for me to work successfully with disordered eating, whether it's on any part of the spectrum, it's disordered eating and body image and all, right through to anorexia, it's about giving hope and um being in the moment and having your tools there but not, I*

don't, I don't work with a map… so trusting what's alive in the client and in the room to guide the next move… I work with what is present so I don't enforce something on the clients"

Throughout the participant's accounts, providing flexibility and being client directed emerged as clear requirements of therapy:

"one week I might work on some CBT stuff but… then there'll be other times that it will be like they're just feeling so incredibly anxious, we'll focus the session on that, anxiousness"

(b) Client Directed. Participants in this study spoke on numerous occasions about the work being directed by the client:

"and if some of them want something more structured each week, that's fine. You know, so I'll do whatever's going to work best for them as long as it's safe"

Furthermore, respecting that the client knows what is best for them:

"so really it's about um opportunities for conversations around what's going on for them in their life cos they're the expert, I'm not the expert of them"

The sensitive nature of the work and working in a gentle manner, allowing the client to direct the path of recovery was exemplified in the following account:

"I always ask them what's important for them, where they want to, what they need and um I think it's very scary for somebody outside to say 'oh, I'm noticing the way that you talk, it sounds like you don't value yourself an awful lot' when you're feeling so fragile so I'm very very careful"

Two participants shared that the model underlying their work, as a counsellor is Person Centred Therapy:

"the base which I guess I adhere to is really Rogerian, of unconditional positive regard"

"My whole foundation is client-centred"

(c) Holistic Perspective. Two participants described working with clients in a holistic rather than clinical way, which they noted was preferred by and suited some clients:

"work in perhaps a more holistic way in terms of a person not just presenting with an eating disorder or eating difficulties but certainly in my work, see the person as a whole human being; that the eating disorder isn't who they are it's, it's almost as if it's external, trying to attach itself and … they have this greatness within that they, they might not even know is there or recognise"

(d) Interactive Work. All of the participants described working interactively or using different methods to demonstrate or experience or collaborate together with their clients at various times during therapy. One participant spoke of using needs and feelings cards, one spoke of preparing food and providing tastings of different foods, and a third commented:

"I work in lots of different ways – so interactive stuff, using the whiteboard, um in one of the other rooms, there's really large sheets of paper, writing it on that, all sorts of things"

Another participant gave accounts of reading excerpts together with clients and discussing the content afterwards. Two participants described demonstrating mindful eating with clients:

"we do some lovely little exercises with people where they are allowed to savour a piece of chocolate over – it takes about six or seven minutes for me to take them through this kind of very peaceful… experiential thing around eating slowly and really noticing… the evocative emotions"

(e) Safety / Multidisciplinary Team. Working safely was highlighted as an essential and critical part of work with clients experiencing disordered eating and was brought up by each of the participants in their work with clients to ensure safety for both the client and the

therapist. Each spoke of the importance of involving other professionals in their combined care of the client, in particular the client's GP. Each of their perspectives are given:

> *"they need to have some resource loop back to have somebody seeing them medically, so I can't work safely as a therapist outside a multidisciplinary team… I have that in part in my contract that I know the name of their GP and that we have that contract around… if you disclose something that you or somebody else, particularly a child is at risk, you have a conversation with them about making that situation safe"*

> *"part of the requirement… is that they're regularly medically monitored by their GP because, and I say to them, that's because I'm not medically qualified, I have no idea what's going on inside your body and I can't hold that risk and so for us working together, that's the safest thing to do"*

> *"…who else knows about this? And often I'm the first person… 'have you talked, considered talking to your GP?' and, and for me it's a really gentle approach"*

Theme Three: Therapists' Perspectives of Clients' Experiences of Disordered Eating.

This third theme highlights the complex and often painful myriad of issues that underlie disordered eating. Throughout participant interviews, the individual and personal difficulties experienced by clients with disordered eating, presenting in individual and personal ways was evident. These deeply personal and often private issues were identified by all participants in this study and were described as both conscious and unconscious factors resulting in a loss of self or unfulfillment in some way that has developed into a disordered relationship with food.

(a) Deep Private Struggles. Two participants highlighted that in disordered eating, food is the vehicle through which personal and deep struggles are contended with. There is often times a deep conflict with self worth or loss of self in some degree:

> *"We very rarely talk about food … it's about nourishment at a deep level and with anorexia it's like I can't receive anything. I'm undeserving, I'm unworthy, and for them to even be at a session to feel like they are worthy of my time is huge … I witness again and again a self hatred and a self invalidation. I'm wrong, I'm wrong for being me; there's something wrong with me, I'm deeply flawed in some way"*

Another participant further described difficulties that can lie behind disordered eating:

> *"It's about your sexuality; it's about your personality; it's about self-belief; it's around the way that you perceive you have a place or you don't, and the only way you can fit in and it's stuff that's missing … or things that are in the way of allowing somebody to come all together and say 'I'm whole'"*

The lonely, isolated and painful place that clients can find themselves in and the use of food as a substitute was highlighted in the following participant's comment:

> *"they've drunk in all this negative stuff and it's stuck to them. And displacing it in all sorts of projected ways and it plays out in their relationships; it plays out in their own relationship with themselves and um it's a very lonely place. Very lonely place and of course, you know, food doesn't argue"*

One participant also shared a perception of the depth and degree of personal pain that is both underlying disordered eating and is also a part of recognising what is going on:

> *"there's that kind of very sensitive part of the client bringing a very precious and private and sensitive delicate part; it's very fragile, it's kind of where a client's kind of most fractured sense of themselves so it's very hurt and there's a lot of pain in that and um shame and guilt and disgust and self loathing and all that so it's a big thing… and*

it takes a huge amount of guts and when you're in the thick of it and it's been straining for a long, long time it's a horrible, horrible thing to come out into the world and get real with it"

A client's perception of people's perspectives and their own perspective of themselves was highlighted on a number of occasions throughout the interviews as further demonstrating the internal conflicts present in disordered eating:

"the belief that if only their weight could be, or only if they could change themselves then everything's going to be ok and actually their worth isn't important as long as everyone else believes they're ok … how they felt they had to adapt and um not feel safe in their own skins if you like, as themselves"

(b) The Tapestry Unfolding. A metaphor of weaving and unfolding was used by two participants in this study to describe the intricacy and depth of what lies beneath disordered eating and the process of gently uncovering what lies there:

"they might come totally overwhelmed with all these things… then that person starts to drop into how they are doing with all of that and then the conversation begins, and then it starts to weave like this tapestry of actually I've spent my life being a good girl and food's the only thing that I feel like is just for me and is me, it's my way of rebelling, it's my way of sneaking and doing something naughty and I do all this stuff at church that I hate doing and um yeah, that I'm always looking after everyone else…"

One participant described the experience of unfolding what lies beneath disordered eating for the client and the deep experience that it becomes for both the client and therapist:

"a conversation that I might be having in a session and if it's something that is not directly addressed but it kind of comes out kind of as the weave, the pattern appears in what we are talking about, then it's usually a very kind of spiritual and sensitive and

and and deep place where the client is kind of reaching out from… kind of bring somebody else from outside in trust, even though they perhaps don't trust what might be the outcome of sharing and exploring that… and then of course it's a very you know, kind of heartfelt moment"

(c) Work is Internally Focused. Participants identified that a large part of the work with disordered eating focuses on internal factors for clients, learning to listen to the cues of their body. One participant highlighted that not listening to body signals can be part of the perpetuation of disordered eating:

"because to get regular eating, because you can't trust your body anymore, because you're not listening to it or because often you've gone long enough the hunger signal won't be there, that if you're used to going to 4 o'clock without eating um, your body will sort of get used to that but it won't function well but often people yeah, say 'I just don't get hungry'. You don't get hungry cos you're used to not eating and maybe cos your stomach's shrunk and you're used to this pattern"

It was further identified that being unaware or not recognising body signals can also have a role to play in other physical symptoms:

"they don't make the links associated from their bodies and… we deal with this amazing vehicle but we don't know how to run it so people often don't realise that they don't feel good and they're exhausted and they can't concentrate, it's 'cos they haven't got enough fuel in the system and they can't just run by will"

Tuning in to the body and learning to trust and understand its signals was identified as an important aspect of therapy:

"helping them reclaim body trust, that with our set point, your metabolism will speed up if you eat more than you would usually eat and it will slow down if you eat less

because you are built for survival, your body wants to keep you in this range um so you can actually relax and um trust your body"

Learning to work with the body was emphasised as a key factor:

"but then it's the process of how do I actually make the changes and trusting; relearning body trust and body wonderment – that our bodies are actually incredible and they know what to do; they know how to breathe, they know how to digest, they know to metabolise, they know how to regulate themselves and we live in a society that's so externally focused that most, all of my clients have lost that internal 'how do I *feel?' 'what do* I *want?' 'What do I* want *to eat?'"*

(d) Recognising Hunger. Each participant in this study pointed out the difficulties many people have in recognising when their body is hungry. Recognising hunger and what hunger feels like in the body was highlighted as a key factor in learning to understand what it is the body needs:

"so 'what does hunger feel like for you and where in your body do you feel that?' because generally clients… are quite disassociated from their bodies and that's where I find if you just do the head work or the work on food, it's like cutting off a weed at the ground level so you might be able to change the eating but you're not actually digging it out at the roots"

One participant described tuning in to the internal hunger signal as a reclaiming of something wonderful and honouring it by giving the body what it is asking for:

"so reclaiming it, of 'what do I want, am I hungry? Yes, what do I feel like? Do I feel like crunchy, do I feel like salty, do I feel like hot, cold, smooth? Mmm what do I feel like?' and then um, eating it mindfully"

Another participant noted how difficult it can be, in people's busy lives and where noticing internal cues to hunger can get lost:

"if people are very busy hiding in lots of activity and stress it's going to be very difficult to come back down to your basic innate noticing your hunger, setting the table, having some grace around it you know and… literally saying you are worth having a nice meal and enjoying the food"

Two participants described their use of variations of the hunger scale as a useful tool to use with clients to demonstrate the differing degrees of hunger and the effects of the introduction of food at varying points on the scale:

"the hunger scale's really important because a lot of people, it's only the really extreme signals that they'll recognise as hunger; it's a really growly stomach or they're about to pass out or feeling really faint… so learning to listen to the subtle cues"

(e) Slowing down / Noticing. Slowing down, becoming aware of thoughts and feelings and noticing what cues the body is giving was noted by two participants in their accounts as a crucial part of connecting to the underlying difficulties with food:

"people becoming aware of what they're eating and why, and just slowing it down and asking this question 'am I hungry?' cos we've often forgotten what hungry feels like…"

It was further highlighted that slowing eating down also provides space to reengage with the enjoyment and nourishment of food and eating:

"we're caught up in this, we're so out there of meeting who we think we need to be um that we eat on the run or we medicate with food so… the sacrament of sitting with a meal and nourishing, of receiving nourishment is lost"

One participant suggested that slowing down and being mindful about food choices and about eating and savouring food also helps to recognise when the body is actually full:

"instead of eating the whole cheesecake and sitting on the couch, you might take the cheesecake out of the fridge, put it on the bench, cut a slice off and sit at the table and

eat mindfully, so you're likely to be more satisfied and you don't eat the whole cheesecake"

One participant uses the format used by Alcoholics Anonymous (AA) as a useful tool to bring into sessions with clients to encourage awareness of internal cues:

"I quite like the AA HALT of 'am I Hungry? Angry? Lonely? Or Tired?' so checking in with what actually do I need and rather than medicating, actually attending to that need… once you're aware, consciousness is everything and then you go 'oh, so I'm feeling like I want some family time' or 'I want a cuddle', 'I want some nurturing'…"

One participant demonstrated that slowing it down provides opportunity to develop connections and awareness of feelings so that the client can intervene in the process and engage with an alternative thought or behaviour:

"it's the mix of starting to… be present when people are purging so that they're not numb and disassociating, so they're slowing the process down, that they're noticing what times they're wanting to binge, what feelings are going on for them… so it's strategies that manage"

(f) Destructive Cycle. Participants spoke of the destructive cycle of bingeing and restricting food, which highlights for clients the difficult and dangerous cognitive and behavioural patterns that perpetuate disordered eating. Each participant spoke of this cycle and the destructiveness of it from biological and emotional perspectives:

"so we start feeling bad about our bodies and who we are which then has a negative effect on our self esteem um and who we are so, so we don't feel acceptable just as we are, whatever shape or size or how we look so we have a thought, whether it's conscious or unconscious about dieting and restricting… we might last for a week or a couple of weeks but then when we restrict, which a diet always is, in whatever format, then that induces psychological as well as physical cravings and we can't maintain it

so we go off it and very often we binge… so sweet, fatty, junk foods, whatever you want to call it so then of course, what does that do? We start thinking we're a failure and we hate ourselves and we feel fat and guilty and useless and, so you know it just goes all round like this"

Similarly, one participant typified the reaction to explaining this destructive cycle in counselling sessions:

"and I show people and they go 'that's exactly what I do' – I feel bad about myself, I have low self esteem, poor body image, so I go on a diet, then I feel deprived , physically and psychologically, and then I go off the diet, eat, for some people that will be eating an apple, for some people, bingeing, and then they feel really bad about themselves, I'm a failure, or they feel like well I've blown it now, I may as well eat the whole lot, go to the supermarket, fill the trolley, binge and purge for the rest of the night because I'll never do it again and tomorrow I'll be good"

(g) Relationship with Self. Two participants specifically described engaging with, accepting and developing a relationship with the self is an integral part of the process of healing from disordered eating:

"people who… still can't let go of that addiction because they just don't feel safe enough to step off it for long enough – it's a learned self soothing that has to come um, and to kind of accept yourself, warts and all"

Another participant described acceptance and acknowledgement of who the client is, as a person:

"the relationship with self… that self love, that I matter, and I'm allowed, I have permission, I don't have to be what I think the world needs me to be to be okay or to be loved and um, it's been, cos when women reclaim that, then they bring that, which is

innately feminine aspect to the table and it feeds men's souls as well cos I think men ache for it as much as women do"

The connection with food and disassociation with the self for both women and increasingly for men also, was highlighted by one participant:

"because women are the nourishers, the nurturers, the food preparers so for women it's food and increasingly it's becoming for men as well… it's food cos it's all they're dealing with; that's what they're aching for, it's 'feed me' 'where do I matter?' 'where do I come in?' 'I'm being a wife, a mother, I'm working part time, I'm trying to do the housework…"

The compassionate gentle approach of the therapist was identified by one participant as essential in this process of connecting with the self:

"my aim is to help people recognise that they truly deserve to feel well in themselves and that includes self value and self worth and ah, appreciation that they've done the best with the tools that they've got and that's that's of no shame – that this shame's come from somewhere else and that they get to understand that and um to make some more informed decisions so they grow to a standing that it's safe to take some more adult decisions around looking out for themselves"

(h) Developing New Skills. Participants identified Cognitive Behavioural Therapy (CBT) as a useful model to use where strategies could be helpful to challenge thoughts and behaviours around food:

"part of the CBT model… in challenging some of those faulty inaccurate thoughts around food, so moving away from good food, bad food, I should, I shouldn't, can't – cos any restriction or deprivation of any kind of food, even if it's chocolate or chips, it's going to set them up to binge or just not have that peaceful, harmonious relationship with food"

Furthermore:

> *"some people identify more with how they are feeling rather than what their thoughts are so we might look at that first and then how that might influence what some of their thoughts are"*

One participant illustrated that intervening and changing old habits is part of the journey of recovery and that CBT techniques can be useful in doing this:

> *"for some when they get home from work… they go straight to the kitchen. That might not be the best thing for them, at least initially, while you're still learning to to get back into some different habits and new ways of being so it might be that instead of going straight to the kitchen, they go to their bedroom, and they take off their work clothes, put on their casual clothes or they, if it's a nice day, they might go sit in the garden and read a book – or just something that breaks that old habit cos we want to develop new pathways"*

Another participant identified that CBT is useful to bring to a session to highlight that change lies with the client and that choices are always available as demonstrated in the following comment:

> *"it's always a choice to act or to not act or to feed this anxiety thought and repeat it and if you do CBT it's really clear for people this thought, I've had this feeling in my body, which creates this emotion, which creates this behaviour and I can go in that loop or I can change that loop at any of those points"*

Participants noted that CBT has limitations but was used unanimously by the each of the participants as a tool when useful in sessions:

> *"CBT – it's one of my tools in my kitty but it's not a one trip pony – it's not the answer to everything"*

It was noted by a further participant that this is a model that does not suit all clients:

"for some people, the CBT stuff doesn't work so well but generally speaking, at least some aspects of that they can grasp…"

(i) Normalising Struggles with Food. Normalising and discussing the difficulties many people have with food and eating was presented as a useful conversation to have in counselling as one participant notes:

"it's very easy for people to feel pathologised and labelled and for it to be clinical… for me it's wanting to create the antithesis of this where it's actually um normalised in some ways – you know, we're all on the continuum really – I don't think I have met a woman that hasn't had to reflect on body image and food… so not pathologising but very much looking at a continuum of how we are with our bodies and living in the culture that we live in… as a woman and increasingly men"

One participant also illustrated that normalising struggles with food and eating can serve to remove some of the shame and guilt that is regularly a part of disordered eating:

"that takes away some of the shame and guilt as well, actually these thoughts that you're thinking, do you know that nearly everybody that isn't eating enough that's doing this has the same messages, the same voices so it's not you. It's what the eating disorder tells you, and it's lies…"

One participant highlighted the usefulness of bringing narrative therapy and externalizing (see literature review section for an explanation of this technique) into sessions when looking at the voices of disordered eating or the eating disorder as noted:

"one of the tools… is narrative, so externalising, so you're looking at the voice of the eating disorder"

One participant also described techniques from Acceptance and Commitment Therapy (ACT) and narrative therapy to gain some distance from disordered eating can be useful:

"as soon as you name something then it's no longer you so you start to get a little bit of distance to observe it and then you start to see um yeah, the patterns and the effect"

Theme Four: Therapists' Perspectives of Educational Aspects of Therapy.

Participants unanimously described education as an essential part of their work with clients around disordered eating.

(a) Nutrition and Regular Eating. Each participant described covering topics such as regular eating, nutritional eating and the effects of food on the body as part of their work with clients:

"for a lot of people with eating issues, education and information is a huge part of it because their eating is so disordered over the years.. even just thinking about food and how they're going to do it; portion sizes, nutrition, basic nutrition, basic cooking… they might be having um fruit as part of their eating… but they might eat the same fruit every day"

Eating regularly, the effects of dieting and understanding the body's regulation system was noted by participants as integral in understanding what is going on in the body to perpetuate the cycle of disordered eating:

"Working with disordered eating, there's a balance between education which there's often a huge need for… and people always *say 'oh my gosh, why didn't I know this?'… stuff that's about regular eating, about the Minnesota Starvation Experiment, about the binge diet cycle… of the things that perpetuate disordered eating and about set point, about metabolism and yeah, those things make a huge difference"*

It was clear that participants felt that discussion about what normal eating looks like for people who are not disordered in their eating provided a useful perspective to discuss together:

"what normal eating looks like, and I'll talk about um what normal eating looks like for people that aren't obsessed with food, eat what they feel like when they feel like it, and because they're not hung up about it, usually their body is a really good weight because they're not disordered and they're not obsessing and they're not making food good or bad"

Two participants spoke of the relevance of discussing energy, blood sugar levels, the effects of certain foods, and the effects of eating and not eating on the body:

"This is what happens to your blood sugar levels when you don't eat and that when you're really hungry it's very hard to make a good food choice, that physiologically you're going to be craving high sugar, high fat and those things are going to push those levels up, not stay in your body long and then plummet so really educating around eating regularly, eating protein at meals, things that will sustain and keep a steady blood sugar level"

"so even just working on basic things like… energy levels and long periods of time without eating and how that impacts on their energy and all those other things like concentration and focus and mood and when they have something to eat… maybe around carbohydrates and protein that um, and I do sort of an energy graph with them"

One participant highlighted the effect eating certain foods or not eating at all has on the brain and physical wellbeing:

"and then we look at things like, you know, sleep and concentration and memory and you know the regularity and routines and how important all that is and connecting the food, not just about the body because I think um, so many people focus on food and nutrition for the body and they forget the brain, and so I incorporate all that in the

work that I do with the clients because it's such a huge huge part of it… so, even with clients that are really fearful about eating certain foods, um I might come in in a slightly different way of working with them, that we focus on talking about, well it won't be specifically food, it will be things like energy and nutrition and fuel that might help you think more clearly so I'll come in more on a brain angle"

One participant also pointed out that education around different types of food was also sometimes necessary:

"to have a look at their own patterns; to have a look at their own food consumption and to challenge some of those patterns um around regular eating, the types of eating, education around fats, carbohydrates, pulses, roughage and fibre and to um sort of provide tastings in different foods so that they have the opportunity to see… it can be um very easy to start actually nourishing themselves… because they've perhaps not understood that some of the food choices they've made have been very highly refined foods"

(b) Societal Pressures and Effects. All participants also discussed the value in having conversations with clients around contradictory messages in society about food, eating, body image and ideals. It was clearly demonstrated that participants saw this as an important and integral component of work with clients with disordered eating:

"so society… we might do a brainstorm on the whiteboard… what do they know; where do they get messages like that leads them to believe this; what are the messages generally that we get out there and who do we get them from so there'll be things like you know, the media, magazines, models um and now of course the internet… what does society say about how we should look and how our bodies should be… there's that thin ideal and we've got to be beautiful and, and the illusion or the inaccuracy of someone who is slim or thin is healthy… and what are the other messages that we get

around food? Well on one hand it's all about health and fitness so like exercise equipment, gyms, vitamin pills, um cosmetics, surgery at the extreme end and on the other end it's like well we've got all these fast food places or smorgasbords where it's like 'eat as much as you like for this price'… all these incredibly contradictory messages, it's no wonder that we don't have this harmonious relationship with ourselves and with food"

The normalising of these constructs and mixed messages in society was typified in another participant's account:

"it's so normalised, every time we turn on the tv it's reinforced this is what I should look like, every time we're in a doctors surgery, every time we're anywhere there's magazines, there is this ideal and… in our current society the ideal is smaller than it's ever been, and people don't realise that it's a construct, that it's not a truth and that's often a part of the work, is actually what's real, what's true, how much of this is a construct and it's subjective… There's very little that's actually an objective truth and helping people look back through time that the ideals have changed and the cultures have changed and pre tv in Fiji there was no eating disorders, no body image problems, bring TV in and the women, yeah, bulimia, major eating disorders because we cant help but compare ourselves to what's glamorised, idealised, and is being force fed to men and women, that this equals success"

A further participant addressed issues of profiteering from food and ideals in society, highlighting this in the following account:

"society and marketing and the food industry and it's all set up to kind of keep perpetuating that negative cycle because it makes multi billions… people always seeking to try to change themselves and now, you know, in the last 10-15 years the

actual cosmetic surgery, liposuctions and nip and tuck… the body's under attack and the food trade doesn't care what it sells you as long as they can make a big profit"

One participant highlighted the connection between messages in society and the loss of self in the following way:

"we live in a really patriarchal society which is about doing, pushing, achieving, rational, linear thinking and they are really important qualities but without being balanced with the feminine aspect um of intuition, of feeling, of nourishing we end up with a really polarised society… it's about the masculine and feminine aspects and that for each person to be whole, they need to have both aspects… but because of society, those feminine attributes have not been valued and they've actually been shamed in some ways… so that's part of the losing of the self"

The loss of self is further examined:

"it's about the deepest aspect of who we are and that is what's starving and that's… why we're in an epidemic of women that are really detached from themselves… we marinate in this culture of not being good enough and it's really hard when it's so normalised and it's so everywhere and be able to step back and witness actually is this healthy, what impact has this had on me?"

Polarised messages fed from society further accentuate the difficulties in understanding beliefs that are internalised about food, eating and body image as one participant highlights:

"so it's a really um starving society and so I think food is the most innate way of nourishment… most people have a real love hate with it; they love food but they feel out of control around food so there's this kind of polarised, very normalised polarising of food… of this is healthy, this is unhealthy, this is fattening, this is slimming, this is good, this is bad and then aware of our languaging of 'oh, you're looking good, have you lost weight?'"

These four superordinate themes and 18 sub themes are addressed and discussed in the following chapter in relation to literature reviewed.

Chapter Five: Discussion

The aim of the current research was to contribute to the limited literature on counselling clients throughout the spectrum of disordered eating. This was addressed by conducting semi-structured interviews with three counsellors who work with clients experiencing disordered eating, and discussing counselling approaches to supporting their clients to work through these issues. A qualitative research approach was used to provide a means by which the counsellors could share their professional experiences.

An Interpretative phenomenological framework was used to analyse the interview transcripts. Four themes emerged from the analysis of the participants' verbal accounts: therapists' perspectives of their clinical role; therapists' practice with clients experiencing disordered eating; therapists' perspectives of clients' experiences with disordered eating; and therapists' perspectives of educational aspects of therapy. Findings from the data analysis will be summarised and discussed in this section. Implications for practice, strengths and limitations to this study and recommendations for further research are also documented followed by a conclusion.

Summary of Findings Related to Existing Literature

Theme One: Therapists' Perspectives of their Clinical Role

Building rapport and developing a trusting relationship with the client and providing space, gentleness and opportunity for a client to share, was identified by participants as an important component in their clinical work with clients experiencing disordered eating. Through therapists' accounts in the current study, it was highlighted that providing an environment in which the client can feel safe, where trust and rapport can develop and where the therapist can

be very present for the client is necessary when working with the very deep and sensitive issues that are often present in disordered eating. This finding is consistent with literature that emphasises the important role of the therapeutic relationship in successful clinical outcomes (Jacob, 2001; McLeod, 2013). McFarland (1995) states "the quality and dynamics of the therapeutic relationship are especially crucial in treating eating disorder clients for several reasons" (p. 65) further stating that these reasons include a client's shame and disgust, uncertainty about altering eating patterns for fear of weight gain, disclosure of eating and purging behaviours and fear of loss of control over food. These complex and private issues often present in clients experiencing disordered eating were identified in this current study as significant and sensitive difficulties that clients bring to therapy and provide a rationale for why participants in this study place significant importance on developing a safe and trustworthy relationship with their clients.

Theme Two: Therapists' Practice with Clients Experiencing Disordered Eating

It seems pertinent to remind the reader at the beginning of this section that there is limited research pertaining to counselling treatment for clients with disordered eating across the full disordered eating spectrum as opposed to specifically with clinically diagnosed eating disorders. As previously discussed, disordered eating encompasses a range of behaviours, often identified as similar but less severe difficulties than those experienced by clients clinically diagnosed with an eating disorder. Therefore due to its relevance, research relating to clinically diagnosed eating disorders has been included in this discussion.

The findings identify that in their work with clients experiencing disordered eating, the therapists in this study prefer to use flexible and integrative models in their work. Therapists identified that their clinical work encompasses more than working with a particular model or

following a predictable therapeutic path or road map. This concept is consistent with findings from von Ranson & Robinson's (2006) research where 'eclectic' models were preferred as primary treatment approaches by clinicians working with eating disordered clients. Similarly, Werne (1996) describes the move towards embracing multiple theoretical and therapeutic perspectives in contemporary treatment of eating disorders. Therapists in this study also described their preference for offering flexible treatment that is guided by the client and what they might bring to therapy. This idea closely aligns with findings from von Ranson & Robinsons' (2006) study on therapeutic approaches used by clinicians working with eating disordered clients, where flexibility was identified as the second most important reason for clinicians choosing their primary treatment approach. Additionally, Caldwell et al., (2012), suggests the importance of offering flexible programmes to fit client's individual preferences in treatment (for obesity and weight loss) and this was highlighted through participants in their research expressing which elements of the programme they had found helpful.

A key finding from this research was the therapists's emphasis on the importance and adherence to client directed therapy whereby the client is central to the direction therapy takes. This fits well with literature on the therapeutic relationship with clients who have disordered eating. McFarland (1995) states that working with clients with eating disorders requires that the "client and therapist work together cooperatively, with the client functioning as the 'expert' in her treatment and defining the goal of therapy" (p. 35). Two clinicians in the current study also volunteered to elaborate on their strong therapeutic alliance to person-centred principles. Literature supports that the therapeutic conditions at the core of person-centred counselling that require the counsellor to be congruent; to offer unconditional positive regard and acceptance; and to communicate empathy to clients are central elements in creating an environment where client growth can occur (Mearns & Thorne, 2007). It is widely

accepted that these conditions have evolved into core counselling skills, used across many therapeutic models. Person-centred therapy holds the view that "the client knows best. It is the client who knows what hurts and where the pain lies and it is the client who, in the analysis, will discover the way forward" (Mearns & Thorne, 2007, p. 1). This is also a central assumption of solution-focused therapy whereby the client is regarded as the expert in his or her life and is further supported by literature. "The solution-focused therapist views each and every client as a unique human being in the context of her reality" (McFarland, 1995, p. 68). These principles while at the core of numerous therapeutic models were identified by participants in this study as a fundamental element of therapeutic work with clients with disordered eating.

While solution-focused therapy was highlighted in the literature review section as being an effective approach when working with clients with disordered eating, none of the therapists interviewed for this current study specifically mentioned this approach in their work. While not specifically mentioned, examples were given of elements of the solution-focused approach that overlap into other models of therapy (as previously mentioned), for example: positioning the client as the expert in their problem and therapy being client directed. Given the effectiveness of this approach in the literature reviewed, it might have been interesting to have included in this current study, the perspective of a therapist working with clients with disordered eating who identified as a solution-focused practitioner. This might have contributed to the present research by offering a complementary, similar or additional perspective on methods and approaches used in work with clients with these difficulties. This might present a potential avenue for further qualitative research in this area.

As an integrative therapeutic model, a pluralist perspective complements the findings of this current study. Participants have described the collaborative nature of the therapeutic relationship and the varied and integrated models they engage with in therapy, while also identifying that different clients benefit from different techniques at different times. The pluralistic approach therefore appears to fit very well with therapy with clients who are experiencing disordered eating. While acknowledging overlaps between the pluralistic approach and integrative or eclectic approaches, I see one significant element of the pluralistic perspective that differs from integrative models as potentially useful in work with clients experiencing disordered eating; an openness to embrace an infinite source of theories and practices from many domains (for example physiology). Of particular interest to counselling clients with disordered eating, might be human physiological processes and functions, based on the findings from this research whereby therapists find that discussions around differing effects of food on body functions and systems are found by clients with disordered eating to be useful conversations to have in therapy. Future research exploring in depth the pluralistic view of counselling clients with disordered relationships with food could be of benefit in further developing this current research.

The findings in this research provide evidence that counsellors engage interactive exercises into their work with clients who experience disordered eating. An example is mindful eating. Two participants mentioned that they include mindful eating exercises with clients. Consistent with literature, mindful eating exercises are identified as valuable experiences to bring awareness and attention to food and the process of eating that can begin to transform the actual experience of eating (Bays, 2009; Hanh & Cheung, 2011) for people with a disordered relationship with food. Other interactive activities, for example using needs and feelings cards, preparing and tasting different foods, using paper or a whiteboard and reading together

were mentioned by participants as useful to use in counselling sessions when working with various aspects or difficulties a client might be experiencing with disordered eating.

Therapists in this study unanimously highlighted the importance of working safely with the client, describing the importance of (where applicable), the involvement of the client's physician and in some cases a multidisciplinary team in the combined care of a client with disordered eating. As described by one therapist, the multidisciplinary team might involve other health care professionals involved in education or overseeing the client medically. When working with clients with disordered eating or eating disorders, the involvement of, or referral to, a client's physician is supported by literature (von Ranson & Robinson, 2006). Also supported in literature is the involvement of a multidisciplinary team with disordered eating when comorbid conditions are present (Pereira & Alvarenga, 2007). Furthermore, the American Psychiatric Association (2006) has developed guidelines for treatment plans around the integration of medical care when working with eating disorders. Despite the focus of this research being on the full disordered eating spectrum, the findings in this study show that for the therapists involved, working safely with their clients was paramount.

Theme Three: Therapists' Perspectives of Clients' Experiences with Disordered Eating

A central finding as described by all participants of this research was the internal focus of therapeutic work with clients experiencing disordered eating.

Therapists in this current study spoke of clients describing in therapy, deep, sometimes private, sometimes painful, oftentimes interwoven and always very personal aspects of their struggles with disordered eating. This was consistent in literature as a significant and central factor when working with clients with disordered eating and with eating disorders (Bays,

2009; Jacob, 2001; McFarland, 1995; Orbach 2006; Pike & Striegel-Moore 1997). Participants in this study explained further that the deep conflict with self worth or loss of self was particularly significant for many clients struggling with disordered eating as McFarland (1995) also suggests. This can extend to sexuality issues, self-belief, place in the world, and that a substantial emphasis in therapy is on addressing these complex and personal issues.

Therapists also described the shame, guilt and disgust common in the stories of clients they see with disordered eating. Participants explained that this personal pain experienced by clients is often displaced and projected in many ways in a client's life, particularly into relationships (including relationships with themselves). Participants also described the complex, intricate and interwoven aspects to the manifestation of disordered eating in a client's life and the enormity of uncovering that as an experience for the client. These themes are reflected in Orbach (2006) whereby an understanding and exploration into the psychoanalytic aspects of a client's struggles with disordered eating, alongside a feminist theoretical perspective offer much towards a client gaining freedom from their difficulties with food and eating.

The findings in this research provide evidence through the experiences of therapists working with clients with disordered eating that learning to recognise and listen to internal hunger and physiological cues, and identify, acknowledge and act upon those cues are an important element in therapeutic work. These signals can often be difficult to recognise. Learning to eat regularly, to trust the body's hunger cues, and understanding metabolism were identified by participants as helpful for clients with disordered eating. Bays (2009) similarly notes the importance of recognising hunger through tuning into sensations, thoughts and emotions in understanding and knowing when the body is hungry for food. Participants in this

study spoke of bringing value to eating by slowing it down, bringing mindful practices into the act of eating and savouring food, of enjoying eating and the nourishment it offers, and creating an atmosphere where food is valued and appreciated. Participants suggested these are helpful approaches to discuss in therapy with clients with disordered eating as opportunities for new experiences and behaviours around food and eating. One therapist in this current study expressed the usefulness of the HALT technique, used in alcohol dependency work to help clients develop awareness of internal bodily cues. Jacob (2001) similarly, uses this technique in counselling work with clients with disordered eating and eating disorders where clients feel they do not have control of their disordered eating behaviours.

All therapists in this current study spoke about the destructive cycle of failed dieting and the ensuing physiological and psychological effects in feelings of guilt and negativity, which can further develop into lowered self esteem and body dissatisfaction. Therapists identified the usefulness of discussing this cycle in therapy with clients with disordered eating, highlighting the physical and emotional effects of this, and the subsequent effect this often has on perpetuating the disordered eating cycle. As supported in literature (Jacob, 2001) this destructive cycle is documented as regularly developing as a result of dieting.

Another key finding of this present research was the view of participants that it was very important for clients to develop a relationship with the self, allowing acceptance, engagement and acknowledgement of the self to help develop a self love and self belief in their journey towards recovery from disordered eating. This is consistent with views from the school of mindfulness, where learning to listen to the body with compassion; to treat the self with a loving heart and with acceptance and affirmation, without judgement, is part of ending one's struggles with weight and food (Hanh & Cheung, 2011). This mindful perspective aligns with

the findings of this study around the importance of integrating acceptance and self-love into therapy for clients experiencing disordered eating.

Participants in this study described their use of CBT techniques where appropriate during their counselling work with clients with disordered eating. We know from previous research that CBT is a commonly used approach with clients with particular eating disorders such as bulimia nervosa (Arnow, 1996; von Ranson & Robinson, 2006). Participants in this study provided support for the literature that encourages the use of CBT as part of the therapeutic process in challenging thoughts, feelings and behaviours around food and/or body image (Cooper et al., 2003; Ogden, 2010). It was however identified that CBT has some limitations and therapists in this study noted that while some CBT techniques can be useful in work with clients with disordered eating, this is not always the case. As supported in literature by Ogden (2010), CBT as a stand alone model was identified as more effective with certain eating disorders such as bulimia nervosa but less effective with other eating disorders, such as anorexia nervosa. However, as a part of an integrated treatment approach for clients with disordered eating, CBT has been found to be useful (Protinsky & Marek, 1997).

Discussing and highlighting during therapy the normalisation of struggling with food and eating was also found by participants in this study to be a valuable part of therapy with clients experiencing disordered eating, in order that new perspectives can develop around current thoughts and behaviours. One therapist in the current study expressed that understanding that destructive thoughts around food can be normal for many people, can begin to remove shame and guilt that a client might be experiencing about their eating behaviours. This is reflected in the literature whereby Orbach (2006) explores the normalization of struggles with food and eating by presenting a myriad of ways food represents role and conflict in womens' lives.

Identified also, by participants in this study, as useful techniques in therapy with clients with disordered eating is the externalising technique from Narrative Therapy. Participants described using externalising to separate disordered eating from the self to gain distance from it in order to work with it and view it with a new perspective. As described in previous research, Narrative Therapy, especially the utilisation of externalisation techniques can be an effective technique in therapy with clients with disordered eating (Jacob, 2001; Scott et al, 2013; Treadgold et al., 2009).

This theme explores therapists' perspectives of the experiences of clients with disordered eating and highlights the complex and intricate nature of these difficulties. Just as these difficulties are complex, so too, are the treatment modalities used in therapy. This complexity is highlighted in literature (Werne, 1996) whereby concepts and techniques from varying models are integrated into treatment approaches specific to the clients needs. Protinsky & Marek (1997) similarly provide evidence for the effectiveness of an integrated treatment approach for clients experiencing disordered eating.

Theme Four: Therapists' Perspectives of Educational Aspects of Therapy

A key finding of this research was the participants' view of the importance of education in counselling sessions for clients with disordered eating.

Discussions about regular eating and nutrition, the physiological effects of eating and not eating and about different types of food were identified by therapists in this study as a significant part of working with clients experiencing disordered eating. This finding supports the view of authors (Hanh & Cheung, 2011; Jacob, 2001) who highlight the importance of

helping clients to understand effects of food and the effects that regulation and deregulation of eating have on the body. Topics relating to food such as portion sizes, nutrition, carbohydrates, proteins, fats, fibre and sugars; topics relating to physiology such as cravings, set point, metabolism, energy levels, sleep, concentration and memory; and other topics such as effects of dieting, and basic cooking were all described by therapists in this study as helpful discussions for some clients experiencing disordered eating.

Another central and integral finding in this present study was the importance that therapists placed on discussing the mixed messages that abound in society about body image, food and eating, including the normalisation of these ideals and messages in society. Numerous authors presented supporting perspectives (Bays, 2009; Jacob, 2001; Orbach, 2006; Pereira & Alvarenga, 2007) about societal messages and the translation of these messages into developing issues with food, eating and body image. Participants highlighted that discussing messages in media and society such as body size and shape, cosmetic surgery, health and fitness, messages from food companies and restaurants and highlighting in counselling that these are contradictory messages, rather than truths can be helpful to clients with disordered eating to challenge their own thoughts around these messages. Furthermore, one participant highlighted the effect of societal values on influencing the loss of self, particularly for women. This is consistent with literature where Orbach (2006) highlights inequality between men and women and social roles and expectations of women as a basis to developing issues with food and eating for many women.

Implications for Practice

The specific focus of this research was to investigate counsellors' perspectives of the methods and approaches they use in counselling sessions with clients with disordered eating. The findings have identified a number of factors that could be helpful for other counsellors and professionals working with clients with these issues.

This research provides unique insight into the nature and etiology of disordered eating from the professional perspective of counsellors with experience in working with clients with disordered eating. This perspective brings value to the counselling field and research on disordered eating through enhanced awareness and further knowledge of the value of gentle, flexible and integrative or pluralistic approaches to this work. This could be helpful for current programmes offering professional services to people struggling with disordered relationships with food and could enhance current counselling practice for independent clinicians also working with clients with these difficulties.

This research also presents new insight into helping people who are struggling with disordered relationships with food and eating that do not fall specifically within diagnosed eating disorders categories but fall anywhere on the spectrum of disordered eating. While much of the literature on counselling clients with disordered relationships with food focuses on working with eating disorders, this research has attempted to add to the literature by providing a perspective that focuses on the full disordered eating spectrum. This has potential to further enhance counselling and other professional services that assist people who present with difficulties that fall at any point along this spectrum.

Strengths and Limitations to this Study

There are a number of strengths and limitations to this current research.

A key strength is that this research provides a perspective for working with disordered eating that differs from that provided by the majority of current literature. It also addresses a gap in the literature by its focus on clinician's perspectives and their clinical experiences. Each of the participants had current and relevant experience working in this field and this provided a clear and specific perspective of what current and up to date work with disordered eating entails. Working with a qualitative methodology provides opportunity for participants' voices to be heard and this provides a valuable insight into understanding from a personal, experienced and professional viewpoint, adding strength to the research findings. It is hoped that this perspective helps to enhance understanding, develop knowledge and add valuable insight into working therapeutically with clients experiencing disordered eating.

An additional strength of this study is that while this research focus has been on *counselling* clients with disordered eating, the findings provide a unique insight for other professionals into the difficulties that clients experiencing disordered eating struggle with. This knowledge has potential to be helpful to other professionals for example medical personnel and professionals in social services agencies who work with clients with these difficulties by providing a perspective into the complex and sensitive issues that are part of disordered eating for many people. It also provides opportunity for other professionals to modify their own methods or approaches with working with these clients with this insight in mind.

A further strength of this current research is the use of qualitative methodology, in particular the Interpretative Phenomenological Analysis (IPA) method of data analysis that was employed, as outlined in the methods section. The data were collected by semi-structured interviews and then analysed within the structured analysis system of IPA. This method enabled open and broad discussion from the participants in this study around the research question, resulting in the collection of rich and detailed data that could be analysed within the structured framework of IPA. This structured system of analysis helps to provide rigour to the findings.

There were also limitations in conducting the current research. A limitation which turned out to be a strength was the initial confusion with terminology. My search for a term that identified what it was I was interested in studying meant that I used a number of different descriptions in my literature search and in my search for research participants (Appendix B, C, D and E). However, qualitative research methodology allows a researcher to change some aspects of the research when new findings emerge. When I began this research I thought I was exploring the work of counsellors who work with clients who struggle with 'weight management'. After encountering confusion from potential research participants, I further changed the term I used to 'struggles with food and eating'. Later, I discovered that 'disordered eating' was a more appropriate term. Given that counselling is all about meanings and meaning-making, this change is most appropriate.

A further limitation could be considered sample size. However, as previously discussed in the methods chapter of this research, in IPA studies, this sample size was considered appropriate. While sample size in qualitative research is important, so too, is depth of data and I found the quality of the interviews conducted provided rich and detailed data for analysis.

Recommendations for Further Research

The findings from this current study can provide a guide from which further research into working therapeutically with clients experiencing disordered eating can develop. With the focus of this research being the perspectives of counsellors working with clients with disordered eating, these perspectives might not reflect in a true sense, the actual experiences of clients themselves who are receiving counselling. Of specific interest therefore, for further research would be the perspectives of clients themselves who have received counselling for their difficulties with disordered eating. The findings of this study have therefore generated further research opportunities that would add to enhancing knowledge and understanding of working with these issues.

Qualitative research on the integration of solution-focused therapy into therapeutic approaches used in work with clients experiencing disordered eating could be an additional area for further research to explore. Research with a focus on integrative approaches incorporating solution-focused techniques might be of particular interest given the findings in this present research that integrative and flexible models and approaches are favoured by therapists in their work with clients with disordered eating. Research in this area could add value and potential new perspectives to the findings in this current study and to current literature on therapeutic approaches and their effectiveness for clients with disordered eating.

Further research into better understanding the benefits or limitations in using a pluralistic framework for exploring and understanding working therapeutically with disordered eating would also be valuable. While it was found that this framework fits well with the findings from this current study, it has generated further potential enquiry about the applicability of this framework in a more in depth analysis with these issues.

Research into the male perspective of disordered eating provides a further potential avenue for research both from a therapist's perspective and a client perspective. It might have been interesting to have had a male counsellor participate in this study for a perspective that may or may not have differed from those accounts given from the three female participants who took part. The findings from this research have identified that disordered eating and difficulties with food and eating often have a relevance and significance with feminist issues. As noted in literature, in some cases there is a connection between sexual abuse and disordered eating, and it is recognised that many female clients prefer to disclose historical abuse to female therapists, highlighting the differing perspectives that gender offer in the therapy room (Wooley, 1994). While it was noted by all participants in this research that increasingly men are seeking help around disordered eating, it would be interesting to have had the perspective of a male counsellor on these dilemmas. Further research into the male perspective would add valuable and additional knowledge into working therapeutically with clients with disordered eating.

Conclusion

The findings from this current study provide unique insight into counsellors' perspectives of the myriad of difficulties that clients with disordered eating struggle with and highlight various methods and approaches counsellors employ in their work with these clients. These findings suggest that the gentle, sensitive and careful approach from counsellors working with these clients is imperative along with a preference for flexible, integrative and client directed models of therapy. An acknowledgement of the complex, personal and individual nature of difficulties experienced by people with disordered eating and the value in adding education into therapy sessions was also identified in the findings as important aspects to this work. In

summary, the broad themes identified in this research indicate the complex and sensitive nature of counselling work with people who struggle with disordered eating. This provides a basis from which both future research and enhanced understanding and developing knowledge in working therapeutically with these issues can develop.

References

American Psychiatric Association (2006). *Practice guideline for the treatment of patients with eating disorders* (3rd ed.). Retrieved from http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Publishing.

Arnow, B. (1996). Cognitive-behavioural therapy for bulimia nervosa. In J. Werne & I.D. Yalom (Eds.), *Treating Eating Disorders* (pp. 101-141). San Francisco, CA: Jossey-Bass.

Bays, J. C. (2009). *Mindful Eating*. Boston, MA: Shambhala.

Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative Research for Education. An Introduction to Theory and Methods* (5th ed.). Boston, MA: Pearson.

Caldwell, K. L., Baime, M. J. & Wolever, R. Q. (2012). Mindfulness based approaches to obesity and weight loss maintenance. *Journal of Mental Health Counseling 34*(3), 269-282. Retrieved from Psychology and Behavioral Sciences Collection database.

Cooper, M. & McLeod, J. (2011). *Pluralistic Counselling and Psychotherapy.* London, United Kingdom: Sage.

Cooper, Z., Fairburn, C. G., & Hawker, D. M. (2003). *Cognitive-Behavioral Treatment of Obesity*. New York, NY: Guilford.

Creswell, J. W., (2013). *Qualitative Inquiry & Research Design* (3rd ed.). Thousand Oaks, CA: Sage.

Crisp, A. H. (1996). Anorexia nervosa in a young male. In J. Werne & I.D. Yalom (Eds.), *Treating Eating Disorders* (pp. 1-30). San Francisco, CA: Jossey-Bass.

Eating Disorders Victoria. (2011). *Disordered Eating and Dieting.* Retrieved January 24, 2015 from http://www.eatingdisorders.org.au/eating-disorders/disordered-eating-a-dieting.

Eatough, V. & Smith, J. A. (2008). Interpretative phenomonological analysis. In C. Willig & W. Stainton-Rogers, *The Sage Handbook of Qualitative Research in Psychology* (pp. 179-195). doi:http://dx.doi.org.ezproxy.canterbury.ac.nz/10.4135/9781848607927

Fishman, H. C. (1996). Structural family therapy. In J. Werne & I.D. Yalom (Eds.), *Treating Eating Disorders* (pp. 187-215). San Francisco, CA: Jossey-Bass.

Glesne, C. (1999). *Becoming Qualitative Researchers: An Introduction* (2nd ed.). New York, NY: Longman.

Hanh, T. N., & Cheung, L. (2011). *Mindful Eating, Mindful Life*. London, United Kingdom: Hay House.

Jacob, F. (2001). *Solution Focused Recovery from Eating Distress*. London, United Kingdom: BT Press.

Jones-Smith, E. (2012). *Theories of Counseling and Psychotherapy: An Integrative Approach.* Thousand Oaks, CA: Sage.

Lambert, M. J. (1989). The individual therapist's contribution to psychotherapy process and outcome. *Clinical Psychology Review, 9*, 469-485. doi:10.1016/0272-7358(89)90004-4

Lowe, M. R., Bunnell, D. W., Neeren, A. M., Chernyak, Y., Greberman, L. (2011). Evaluating the real-world effectiveness of cognitive-behavior therapy efficacy research on eating disorders: A case study from a community-based clinical setting. *International Journal of Eating Disorders 44*(1), 9-18. doi:10.1002/eat.20782

McFarland, B. (1995). *Brief Therapy and Eating Disorders*. San Francisco, CA: Jossey-Bass.

Moustakas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks, CA: Sage.

McLeod, J. (1999). *Practitioner Research in Counselling*. London, United Kingdom: Sage.

McLeod, J. (2007). *Qualitative Research in Counselling and Psychotherapy*. London, United Kingdom: Sage.

McLeod, J. (2013). The counselling relationship. In J. McLeod, *An introduction to counselling* (5th ed.), (pp. 400-430). Retrieved from http://www.eblib.com

Mearns, D., & Thorne, B. (2007). *Person-centred counselling in action* (3rd ed.). London, United Kingdom: Sage.

Morgan, A. (2000). *What is narrative therapy? An easy-to-read introduction.* Adelaide, South Australia, Australia: Dulwich Centre.

New Zealand Association of Counsellors. (2012). *Code of Ethics*. Retrieved from http://www.nzac.org.nz/code_of_ethics.cfm

Ogden, J. (2010). *The psychology of eating: From healthy to disordered behavior* (2nd ed.). Retrieved from http://www.eblib.com.

Orbach, S. (2006). *Fat is a Feminist Issue*. London, United Kingdom: Arrow

Pereira, R.F. & Alvarenga, M. (2007). Disordered eating: Identifying, treating, preventing, and differentiating it from eating disorders. *Diabetes Spectrum 20*(3), 141-148. Retrieved from ProQuest Health & Medical Complete database.

Pike, K.M. & Striegel-Moore, R.H. (1997). Disordered Eating and Eating Disorders. In S. J. Gallant, G. P. Keita, R. Royak-Schaler (Eds.), *Health care for women: Psychological, social, and behavioural influences* (pp. 97-114). Washington, DC: American Psychological Association.

Protinsky, H., & Marek, L. I. (1997). Insights into the treatment of eating disorders: A qualitative approach. *Family Therapy, 24*(2), 63-69. Retrieved from SocINDEX database.

Ramey, H. L., Tarulli, D., Frijters, J.C., & Fisher, L. (2009). A sequential analysis of externalising in narrative therapy with children. *Contemporary Family Therapy, 31*(4), 262-279. doi:10.1007/s10591-009-9095-5

Santos, K (2014). *Disordered eating and eating disorders from a therapist's perspective* (Doctoral dissertation, preview, pp. i-11). Retrieved from ProQuest Dissertations and Theses database.

Scott, N., Hanstock, T. L., Patterson-Kane, L. (2013). Using narrative therapy to treat eating disorder not otherwise specified. *Clinical Case Studies, 12*(4), 307-321. doi:10.1177/1534650113486184

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis Theory, Method and Research*. London, United Kingdom: Sage.

Smith, J. A. & Osborn, M (2003). Interpretative phenomenological analysis. In J. A Smith (Ed.) *Qualitative psychology: A practical guide to research methods* (pp. 51-80). London, United Kingdom: Sage.

Snape, D., & Spencer, L. (2003). The foundations of qualitative research. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice. A guide for social science students and researchers* (pp. 1-23). London, United Kingdom: Sage.

Treadgold, R., Treadgold, A., & Treadgold, D. (2009). Rediscovering a daughter. In H. Malson & M. Burns (Eds.), *Critical Feminist Approaches to Eating Dis/orders* (pp. 233-244). East Sussex, United Kingdom: Routledge.

von Ranson, K. M., Robinson, K. E. (2006). Who is providing what type of psychotherapy to eating disorder clients? A survey. *International Journal of Eating Disorders, 39*(1), 27-34. doi:10.1002/eat.20201

Werne, J. (1996). Introduction. In J Werne & I. D. Yalom (Eds.), *Treating Eating Disorders* (pp. xiii – xxxix). San Francisco, CA: Jossey-Bass.

Willig, C. (2012). *Qualitative Interpretation and Analysis in Psychology*. Retrieved from http://www.eblib.com.

Wooley, S. C. (1994). Sexual abuse and eating disorders: The concealed debate. In P. Fallon, M. A. Katzman, & S. C. Wooley (Eds.), *Feminist perspectives on eating disorders* (pp. 171-211). New York, NY: Guilford Press.

Appendices

Appendix A – Human Ethics Committee Approval

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2014/56

14 July 2014

Tiffany Parish
School of Health Sciences
UNIVERSITY OF CANTERBURY

Dear Tiffany

The Human Ethics Committee advises that your research proposal "Counselling weight management: a qualitative study from the therapists' perspective" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 11 July 2014.

Best wishes for your project.

Yours sincerely

Lindsey MacDonald
Chair
University of Canterbury Human Ethics Committee

Appendix B – Participant Information Sheet (first version)

School of Health Sciences
Ph: 03 343 7737
Email: tiffany.parish@pg.canterbury.ac.nz
Researcher Ph: (Phone number provided on original)

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

4 September 2014

Participant Information Sheet

Project title: Counselling weight management: a qualitative study from the therapist's perspective

I am Tiffany Parish, the researcher for this project and a student at the University of Canterbury, completing a Master of Counselling. This research project constitutes part of the requirements for this degree in the form of completing a thesis.

The purpose of this research is to discover methods and approaches that are used by therapists working with clients who seek counselling or therapy for weight management issues.

As a participant, your involvement in this project will take the form of a semi-structured interview where I will ask you a number of open ended questions about your work with clients who seek counselling for weight management issues. Our interview will take approximately 1 hour and will be at a location mutually agreed upon between ourselves, either in a University of Canterbury library conference room or office space, or in a private location at your place of work. The interview will be audio recorded on my mobile phone or a dictaphone.

I will ask you at the interview stage for permission to contact you post interview if there were to be any further questions that arise after the interview has taken place. I can be contacted on the mobile phone or email address above if you have any further questions or need to contact me about the study.

In the process of interviewing, I anticipate there to be no risks.

I will ask you, as a participant in this study whether you would like to view the transcript of our interview to ensure that you are happy with it. Should you wish to do this, I will provide a copy for you.

You may receive a copy of the summary of results at the conclusion of the project by marking the box on the consent form indicating that you would like to receive this.

Participation is voluntary and you have the right to withdraw from this study at any stage without penalty. If you withdraw, I will remove information relating to you that is practically achievable and identifiable as data collected from you prior to draft submission stage.

The results of the project will be published, but you may be assured of the complete confidentiality of data gathered in this investigation: your identity will not be made public without your prior consent. To ensure anonymity and confidentiality, I will use pseudonyms or generic labelling (for example, participant A, participant B, participant C) when transcribing our interview, during data analysis stage and in any final writing up of the data. It is important that in talking of your experiences as a counsellor or therapist, working with clients seeking counsel around weight management issues, that any identifying information about clients is removed from conversation. All information referring to specific cases must be discussed in general terms to protect the anonymity and confidentiality of your clients.

Data can be accessed only by myself and my academic supervisor, Shanee Barraclough (contact details below). Data will be stored in password protected electronic form and/or in securely locked locations and will be destroyed after a period of 5 years post completion of thesis. A thesis is a public document and will be available publicly through the UC library.

The project is being carried out as a requirement for a Master of Counselling by Tiffany Parish, principal researcher, under the academic supervision of Shanee Barraclough, who can be contacted at shanee.barraclough@canterbury.ac.nz. She would be pleased to discuss any concerns you may have about participation in this project.

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to: The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you have any questions or wish to contact myself prior to signing the consent form, please feel free to do so on (phone number provided in original) or by email to tiffany.parish@pg.canterbury.ac.nz.

If you agree to participate in the study, you are asked to complete the consent form and return to me by Monday 29 September 2014 either by email to tiffany.parish@pg.canterbury.ac.nz or returned in the self-addressed envelope provided.

Thank you.

Tiffany Parish

Appendix C – Participant Information Sheet (second version)

School of Health Sciences
Ph: 03 343 7737
Email: tiffany.parish@pg.canterbury.ac.nz
Researcher Ph: (Phone number provided on original)

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

8 October 2014

Participant Information Sheet

Project title: Counselling struggles with food and eating: a qualitative study from the therapist's perspective

I am Tiffany Parish, the researcher for this project and a student at the University of Canterbury, completing a Master of Counselling. This research project constitutes part of the requirements for this degree in the form of completing a thesis.

The purpose of this research is to discover methods and approaches that are used by therapists when working with clients who seek counselling or therapy for difficulties with food, eating and weight management issues.

As a participant, your involvement in this project will take the form of a semi-structured interview where I will ask you a number of open ended questions about your work with clients who seek counselling for these issues. Our interview will take approximately 1 hour and will be at a location mutually agreed upon between ourselves, either in a University of Canterbury library conference room or office space, or in a private location at your place of work. The interview will be audio recorded on my mobile phone or a dictaphone.

I will ask you at the interview stage for permission to contact you post interview if there were to be any further questions that arise after the interview has taken place. I can be contacted on the mobile phone or email address above if you have any further questions or need to contact me about the study.

In the process of interviewing, I anticipate there to be no risks.

I will ask you, as a participant in this study whether you would like to view the transcript of our interview to ensure that you are happy with it. Should you wish to do this, I will provide a copy for you.

You may receive a copy of the summary of results at the conclusion of the project by marking the box on the consent form indicating that you would like to receive this.

Participation is voluntary and you have the right to withdraw from this study at any stage without penalty. If you withdraw, I will remove information relating to you that is practically achievable and identifiable as data collected from you prior to draft submission stage.

The results of the project will be published, but you may be assured of the complete confidentiality of data gathered in this investigation: your identity will not be made public without your prior consent. To ensure anonymity and confidentiality, I will use pseudonyms or generic labelling (for example, participant A, participant B, participant C) when transcribing our interview, during data analysis stage and in any final writing up of the data. It is important that in talking of your experiences as a counsellor or therapist, working with clients seeking counsel around these issues, that any identifying information about clients is removed from conversation. All information referring to specific cases must be discussed in general terms to protect the anonymity and confidentiality of your clients.

Data can be accessed only by myself and my academic supervisor, Shanee Barraclough (contact details below). Data will be stored in password protected electronic form and/or in securely locked locations and will be destroyed after a period of 5 years post completion of thesis. A thesis is a public document and will be available publicly through the UC library.

The project is being carried out as a requirement for a Master of Counselling by Tiffany Parish, principal researcher, under the academic supervision of Shanee Barraclough, who can be contacted at shanee.barraclough@canterbury.ac.nz. She would be pleased to discuss any concerns you may have about participation in this project.

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to: The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you have any questions or wish to contact myself prior to signing the consent form, please feel free to do so on (phone number provided on original) or by email to tiffany.parish@pg.canterbury.ac.nz.

If you agree to participate in the study, you are asked to complete the consent form and return to me by Monday 20 October 2014 either by email to tiffany.parish@pg.canterbury.ac.nz or returned in the self-addressed envelope provided.

Thank you.

Tiffany Parish

Appendix D – Consent Form (first version)

School of Health Sciences
Ph: 03 343 7737
Email: tiffany.parish@pg.canterbury.ac.nz
Researcher Ph: (phone number provided on original)

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

4 September 2014

Consent form for participants

Project title: Counselling weight management: a qualitative study from the therapist's perspective

I have been given a full explanation of this project and have had the opportunity to ask questions.

I understand what is required of me if I agree to take part in the research.

I understand that participation in this study is voluntary and I may leave at any time in the project without penalty. Withdrawal of participation will also include the withdrawal of any information I have provided should this remain practically achievable.

I understand that any information or opinions I provide will be kept confidential to the researcher, Tiffany Parish and her academic supervisor, Shanee Barraclough, and that any published or reported results will not identify me or my place of work. I understand that a thesis is a public document and will be available through the UC library.

I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after five years.

I understand that it is anticipated there will be no risks associated with taking part.

I understand that I will be offered a copy of the interview transcript with real names changed. I also understand that I am able to receive a summary of findings of the study by putting my email or postal address in the space provided below.

I understand that I can contact the researcher, Tiffany Parish, ph (phone number provided on original) or tiffany.parish@pg.canterbury.ac.nz, or her academic

supervisor, Shanee Barraclough, ph 364 2987 extn 3839 or shanee.barraclough@canterbury.ac.nz for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

By signing below, I agree to participate in this research project.

Name:

Date:

Signature:

☐ I wish to receive a summary of findings

Email:

Or postal address:

Please return this signed consent form to Tiffany Parish either by email to tiffany.parish@pg.canterbury.ac.nz or in the self-addressed envelope provided by Monday 29 September 2014.

Thank you.

Tiffany Parish

Appendix E – Consent Form (second version)

School of Health Sciences
Ph: 03 343 7737
Email: tiffany.parish@pg.canterbury.ac.nz
Researcher Ph: (phone number provided on original)

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

4 September 2014

Consent form for participants

Project title: Counselling struggles with food and eating: a qualitative study from the therapist's perspective

I have been given a full explanation of this project and have had the opportunity to ask questions.

I understand what is required of me if I agree to take part in the research.

I understand that participation in this study is voluntary and I may leave at any time in the project without penalty. Withdrawal of participation will also include the withdrawal of any information I have provided should this remain practically achievable.

I understand that any information or opinions I provide will be kept confidential to the researcher, Tiffany Parish and her academic supervisor, Shanee Barraclough, and that any published or reported results will not identify me or my place of work. I understand that a thesis is a public document and will be available through the UC library.

I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after five years.

I understand that it is anticipated there will be no risks associated with taking part.

I understand that I will be offered a copy of the interview transcript with real names changed. I also understand that I am able to receive a summary of findings of the study by putting my email or postal address in the space provided below.

I understand that I can contact the researcher, Tiffany Parish, ph (phone number provided on original) or tiffany.parish@pg.canterbury.ac.nz, or her academic

supervisor, Shanee Barraclough, ph 364 2987 extn 3839 or shanee.barraclough@canterbury.ac.nz for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

By signing below, I agree to participate in this research project.

Name:

Date:

Signature:

☐ I wish to receive a summary of findings

Email:

Or postal address:

Please return this signed consent form to Tiffany Parish either by email to tiffany.parish@pg.canterbury.ac.nz or in the self-addressed envelope provided by Monday 20 October 2014.

Thank you.

Tiffany Parish