An Exploration of Women's Experiences of Cognitive-Behaviour Therapy for the Treatment of Bulimia Nervosa

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ABSTRACT

Background: The previous and current NICE guidelines consider cognitive-behaviour therapy (CBT) to be the best psychological intervention for the treatment of bulimia nervosa (BN). This is despite various issues with the studies contributing to this evidence-base. Overall, research has suggested that CBT is associated with the highest levels of symptom reduction, but little is known about what makes the therapy effective. Clients' views regarding the topic have been especially neglected thus far.

Aims: The study aimed to gain a detailed understanding of women's experiences of CBT and its impact on their post-therapy lives. It also sought to provide clinicians and other professionals with helpful insights into how best support individuals with bulimic difficulties.

Methodology: Semi-structured interviews were completed with four women who met the inclusion criteria for the study. The verbatim transcripts were analysed by using Interpretative Phenomenological Analysis (IPA).

Findings: Three master themes and nine subthemes were revealed through the analytical process. The master themes were: Loss of control; Staying on the surface; and Holding onto power.

Conclusions: The findings indicated that the concept of 'control' and concerns regarding its loss and maintenance were central to all four women taking part in the study; these concerns were present in each master theme. Although all participants reported CBT to have helped them to address their disordered eating behaviours, parts of the women's identities associated with these difficulties were left untouched. The implications of the findings to clinical practice, and suggestions for future research will be discussed.

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ABBREVIATIONS

AN	Anorexia nervosa
APA	American Psychiatric Association
BN	Bulimia nervosa
BMI	Body Mass Index
BPS	British Psychological Society
CBT	Cognitive-behaviour therapy
CBT-E	Cognitive-behaviour therapy for eating disorders
CBT-Eb	Cognitive-behaviour therapy for eating disorders (broad)
CBT-Ef	Cognitive-behaviour therapy for eating disorders (focused)
CoP	Counselling psychology
DSM	Diagnostic and Statistical Manual of Mental Disorders
DP	Discursive psychology
ED	Eating disorder
EDE	Eating Disorder Examination
EDNOS	Eating disorder not otherwise specified
FDA	Foucauldian discourse analysis
GT	Grounded theory
HADS	Hospital Anxiety and Depression Scale
HRA	Health Research Authority

ICD	International Classification of Diseases
IIP	Inventory of Interpersonal Problems
IPA	Interpretative Phenomenological Analysis
IPT	Interpersonal psychotherapy
LMU	London Metropolitan University
NHS REC	National Health Service Research Ethics Committee
NICE	National Institute for Health and Care Excellence
PDT	Psychodynamic Therapy
SP	Social phobia
TFCBT	Trauma focused cognitive behaviour therapy
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

1.1 Overview

The current study examined women's experiences of cognitive-behaviour therapy (CBT) for bulimia nervosa (BN), or bulimia, through individual accounts to better understand an under researched topic. This chapter will provide a brief historical overview of the development of the diagnostic criteria, treatment options, and issues associated with prevalence and prognosis data for BN to contextualise this study.

1.2 Diagnosis

Bulimia nervosa was first described as a distinct eating disorder (ED) with its own defining features in 1979 (Russell, 1979) and it was included in a diagnostic manual for the first time a year later (3rd ed.; DSM–III; American Psychiatric Association [APA], 1980). Currently there are two categorisation systems that are used to diagnose the condition: the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (5th ed., DSM-5; APA, 2013) and the 10th revision of the International Classification of Diseases (ICD-10; World Health Organisation [WHO], 1992).

Both systems consider overeating episodes (binges) followed by attempts to counteract the effects of the consumed food (purges) as the defining behavioural features of bulimia. Psychologically, those with bulimic difficulties are likely to be extremely fearful of gaining weight or becoming fat. According to the DSM-5 criteria (APA, 2013), the individual should experience episodes of binges and purges at least once a week, the ICD criteria (WHO, 1992) does not specify a behaviour frequency. However, it has been suggested that for many the key factors relating to the maintenance of the bulimic difficulties do not focus on fear of weight gain, but on problems with coping with challenging emotions (Corstorphine, 2008). The role of distress intolerance and issues with affect regulation are not currently recognised in the diagnostic criteria for any eating issues.

Diagnosing EDs is challenging, as the symptoms as specified by the diagnostic manuals, are associated with temporal changes and those affected may move between diagnoses. The 'catch-all' diagnosis of Eating Disorder Not Otherwise Specified (EDNOS) has been suggested to be the most common diagnosis in outpatient ED settings (Fairburn & Bohn, 2005). Thus, individuals with eating issues often present with features of different EDs, rather than fit neatly into one of the other diagnostic categories. The conditions also have a high comorbidity with difficulties such as depression and anxiety (Fairburn & Harrison,

2003). The rigidity of the diagnostic criteria combined with the changing nature of the illness seems to be a difficult combination, as there appears to be a mismatch between the criteria and the clinical reality, as has been noted by clinicians (e.g. Fairburn & Cooper, 2011). The divisions between EDs by using diagnostic criteria seem somewhat arbitrary. For instance, the main difference between anorexia nervosa (AN) binge-purge subtype and BN is body weight, whereas the lack of purging behaviours following a binge distinguishes binge eating disorder (BED) from BN. Some of the criteria appear rather subjective: one of the key criteria for BN is bingeing, yet the diagnostic criteria do not objectively define a binge. Instead, they rely on subjective judgements and social comparisons, e.g. eating significantly more than people normally would do in a short period of time. Consequently many fall through the cracks and do not meet the criteria, or are placed in the EDNOS category. These factors are likely to influence access to treatment negatively.

Diagnostic labels make positivist assumptions about psychological distress and wellbeing, as one is either considered ill or not ill within this framework. Not meeting the exact diagnostic criteria for a particular disorder often impedes access to treatment, as health service providers, such as the National Health Service (NHS), heavily rely on diagnostic criteria to determine access to their services. Also, diagnoses focus on patterns of 'symptoms', i.e. thought and behaviour patterns that indicate certain psychological illnesses. The aim is then to treat these symptoms, and thus remove or alleviate illness. Considering these patterns as signs of psychological distress and finding out their specific function for the individual could be a more helpful approach in psychological work, as the focus then becomes the individual and their experiences, rather than the psychiatric label. The use of diagnostic labels will be discussed further in Chapter 3.

1.3 Prevalence

Attaining accurate prevalence data is difficult, possibly due to the issues related to diagnosing the condition. However, EDs are relatively common: research has found that approximately 1% of European adolescent and young women have BN compared with 0.3% for AN. These figures have remained stable across the years (Hoek, 1991; Hoek & van Hoeken, 2003). In an older US study, Killen and colleagues (1986) discovered that 13% of adolescent females engaged in purging behaviours at subclinical levels. That is, they engaged in the specified behaviours, but did not meet the full criteria for a specific disorder. A survey completed on the general population in the UK in 2007 found that 6.4% of individuals aged 16 and above screened positive for eating disorders and young women aged 16 to 24 were the most likely group to screen positive. The majority (81%) of all individuals

that screened positive were not receiving any treatment for emotional or psychological issues (Health and Social Care Information Centre [HSCIC], 2009). This echoes previous findings suggesting that individuals experiencing eating difficulties are unlikely to seek support and instead try and hide their symptoms (Judit, Schmidt & Pilling, 2005; Hoek).

Some of the challenges of using strict criteria for ED diagnoses seem to be reflected on the prevalence rates: the large size of the subclinical group indicates that eating issues are common. However, accessing support and specialist services can be very challenging, especially if one does not meet the specific diagnostic criteria for a particular disorder.

1.4 Costs Associated with Eating Disorders

Eating disorders have been linked to numerous costs at individual and societal levels, including financial implications and lowered quality of life. A report commissioned by the ED charity Beat (PriceWaterhouseCoopers LLP, 2015) estimated the annual total cost of EDs in the UK to be between £13.3 billion and £16.7 billion. These figures included direct costs, such as lost university fees and travel costs to treatment, treatment costs in both the NHS and the private sector, and lost income to the economy. Thus, eating difficulties are a considerable problem in many levels and addressing them appropriately could reduce the costs both to the individual, as well as to the wider society.

1.5 Aetiology and Prognosis

It is currently believed that there are a multitude of contributors for the development of EDs. These include sociocultural influences, genetics, neurobiology, and perinatal and childhood risk factors (Schmidt, 2005). Some sociocultural factors, such as perceived pressures to be thin, thin-ideal internalisation and history of dieting have been suggested as specific risk factors for bulimia (Stice, 2002). Lacey, Coker and Birtchnell (1986) suggested that historical issues, such as parental marital conflict, poor relationships with parents and peers, and academic striving could contribute to the development of bulimic difficulties. They also found that events, such as major changes in life circumstances and losing a close relationship through bereavement or estrangement had often taken place in the six months prior to the onset of bulimia. The associations between specific risk factors and particular eating difficulties remain largely unclear.

The prevalence rates suggest that females in adolescence and early adulthood are the most likely group to have issues with food and eating. These life stages are associated with various biological and social changes, for example. Relationships are likely to transform or

be impacted as a result of increased independence from the family, developing romantic relationships, moving away for university and starting a career. Although these changes could be positive, they can also cause stress and overwhelm, especially if the individual does not have adequate coping strategies to deal with the changes. Thus, they may turn to a strategy that is readily available to them: food and its manipulation. Over time food can become a method to regulate challenging and unpleasant emotions and thus contribute to the maintenance of the bulimic difficulties (Lacey et al., 1986).

Eating disorders have been linked to multiple problems, including poor prognosis regarding physical and mental health and high relapse rates. Bulimia has been described as an incapacitating condition that is likely to become chronic. Individuals often continue to experience residual symptoms relating to body image problems, psychosomatic symptoms, anxiety and low self-esteem even after they have stopped engaging in ED behaviours (Keski-Rahkonen et al., 2009). Those who have recovered are likely to experience problems with employment, relationships and fertility (HSCIC, 2009).

1.6 Treatment

The treatment of bulimia includes interventions, such as medication, dietary advice and more recently, invasive and non-invasive brain stimulation treatments. Brain stimulation interventions have been found to produce good results for those with persistent and severe difficulties (e.g. Lipsman & Lozano, 2014; Downar et al. 2013). However, brain stimulation is not widely available and requires further research regarding its risks and effectiveness. Psychological therapies are considered the main form of treatment for bulimic difficulties.

The previous guidelines provided by the National Institute for Health and Care Excellence (NICE, 2004) considered CBT as the best treatment for adults with bulimia followed by interpersonal psychotherapy (IPT). The updated NICE guidance (2017) also favour cognitive-behavioural approaches for the treatment of bulimia, as they state that guided cognitive-behavioural self-help programmes and individual eating-disorder-focused cognitive-behavioural therapy (CBT-ED) should be offered to treat those with bulimic difficulties. Although a wide range of other psychological therapies with an emerging evidence base have been utilised to treat eating difficulties, the guidelines omit any mention of these alternatives; the options focus on a single-model approach. The limitations of this will be discussed in the consequent chapters. Some examples of other therapies include cognitive analytic therapy (CAT; e.g. Newell, 2012), dialectical behaviour therapy (DBT; e.g. Palmer & Birchall, 2003) and compassion-focused therapy for eating disorders (CFT-E;

e.g. Goss & Allan, 2012). CFT-E is a specific version of CFT developed to treat eating difficulties.

1.7 CBT Formulation for Bulimia Nervosa

The first recorded psychological intervention specifically developed to treat bulimia was created in 1981. CBT-BN was a form of CBT that focused on the cognitions linked to the binge-purge cycle (Fairburn, 1981). The most recent version of CBT for EDs is a transdiagnostic model titled CBT-E (Fairburn, 2008) with an increasing evidence base supporting its efficacy.

Broadly, CBT for bulimia emphasises the importance of targeting the cognitions that reinforce the individual's problematic affect states and/or behaviours and how these may interact. The CBT model for bulimia (Figure 1) by Fairburn (2008) suggests that the core maintaining factor for the condition is the individual's dysfunctional belief system regarding their self-evaluation. Most other elements of the model are considered to directly originate from this belief system. Examples of these include the dietary restraint (pathway a), other types of weight-control behaviour, body checking and avoidance. Cognitively they are likely to be preoccupied with shape, weight and eating. Binge eating is seen to be a consequence of the dietary restraint rather than the core self-evaluations. According to the model, the individual tries to follow demanding and specific rules about their diet, which usually leads to a rule violation. This, combined with the individual's tendency to react in a strongly negative manner to any violations, is what leads to binge eating (pathway b). Binges maintain the core self-evaluations by increasing the concern about shape and weight (pathway c) and encourage further dietary restraint (pathway d), which increases the risk of future binges.

Fairburn (2008) argues that the individual is likely to violate their dietary rules as a result of a negative response to daily events and negative moods (pathway e). The reasons for this are two-fold: following the strict and rigid rules under these circumstances is difficult and engaging in binge eating temporarily alleviates the negative mood state and distracts the individual from their difficult internal experiences. Binge eating is also maintained by compensatory purging behaviours (pathway f), as individuals engaging in these believe that purging minimises weight gain, which will then reduce the likelihood of the individual avoiding binge eating for the fear of gaining weight.
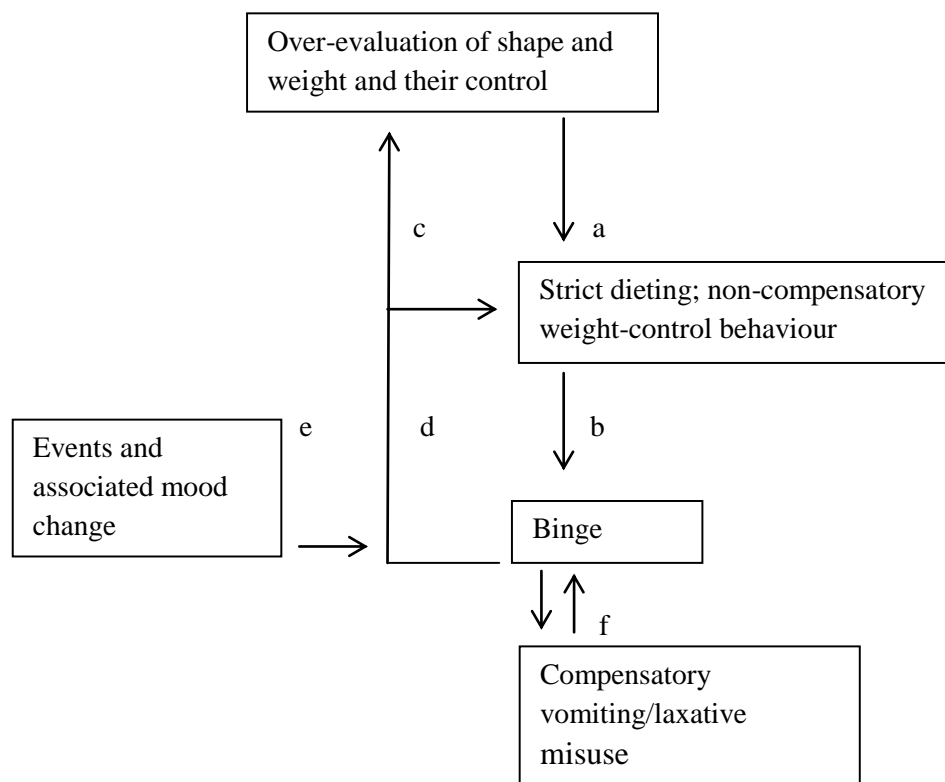
Figure 1. CBT Formulation for Bulimia Nervosa (Source: Fairburn, 2008).

The only difference between the transdiagnostic formulation, CBT-E, and the CBT formulation for bulimia is an addition of significantly low weight as an outcome of strict dieting to the pathway b. This is because, Fairburn concludes, the transdiagnostic model is a combination of CBT formulations for bulimia and anorexia. According to him, all EDs share similar core pathologies. Although the model may go some way in explaining the maintenance of eating difficulties, it does not account for any factors that may have contributed to the development of these difficulties and their potential role in the maintenance of the difficulties.

CBT-E is usually delivered over 20 sessions in 20 weeks. The broad version of CBT-E (CBT-Eb) consists of 40 sessions and is usually delivered to those who have a body mass index (BMI) below 17.5. In addition to targeting ED symptoms CBT-Eb also includes modules on mood intolerance, low self-esteem, interpersonal difficulties and clinical perfectionism. Fairburn (2008) asserts that the shorter version is suitable for 80% of clients accessing CBT-E. The 20-week version is divided into four distinct stages. Stage 1 involves twice-weekly appointments for four weeks. The focus is on introducing the client to two CBT-E procedures: in-session weighing and regular eating. During Stages 2 and 3, the appointment frequency is reduced to once-weekly. Stage 2 lasts for two weeks focusing on

reviewing progress and identifying any obstacles to therapeutic change. Stage 3, which is delivered over eight weeks, focuses on addressing any maintenance factors in ways that are most beneficial to each individual client. Stage 4 consists of three sessions over six weeks. This final stage concentrates on planning for the future to maximise the likelihood of maintaining changes and minimising the risks of relapse. The therapy should be delivered by one therapist, although access to other professionals, such as dieticians should be ensured. According to Fairburn, it is acceptable to end therapy with clients, who may still be engaging in dieting behaviours, occasionally bingeing and purging and/or have residual concerns about their shape and weight. However, he asserts that CBT-E should always be delivered according to the protocol, as the different interventions are not designed to be used independently.

1.8 Counselling Psychology Relevance to This Research

As eating difficulties are relatively common, Counselling Psychologists are likely to come across individuals with these issues in their clinical practice and other professional contexts. Currently Counselling Psychologists and the discipline of Counselling Psychology (CoP) have very little presence in the literature and research concerning this client group. A partial explanation to this could be that many individuals with eating difficulties seek help for the physical health problems that have been potentially caused or aggravated by their eating issues so their first point of professional contact may be a general practitioner (GP) or other medical professional. Thus, many previous studies have adopted a medical stance to investigating eating difficulties. The ways in which eating difficulties are constructed, treated and understood in our society are heavily influenced by the medical model whereby the focus is on clinical diagnosis and medical intervention, and health is defined as absence of illness.

Counselling Psychology could add value and further insights into the existing literature and research due to its pluralistic stance to knowledge and practice. In CoP, this means that a number of models or theories explaining psychological distress and change can be 'true' and that these models can co-exist simultaneously (Cooper & McLeod, 2007). In practice this could mean not relying on one specific type of treatment for particular manifestations of psychological distress or focusing exclusively on symptom reduction, but understanding difficulties within context and approaching wellbeing holistically. McLeod (2013) argues that adopting a pluralistic stance means valuing clients' hypotheses of the potential causes and cures for their difficulties throughout the therapy process. He suggests that our clients

should be seen as active participants, whose knowledge and views are likely to change during the process and thus should be responded to in a flexible manner.

Values associated with the humanistic tradition have been very influential to the discipline of CoP and are central to our practice. Cooper (2009) argues that these values not only form the base of the discipline, but the application of them is in its essence thus permeating all that we do. He proposes two ways to demonstrate our values in our practice. Firstly, we should aim to understand our clients as beings beyond any diagnosis or categorical labels. Secondly, we should seek to find ways in which we could enhance our responsiveness to our clients' needs. Hence, the values from the CoP perspective serve to support wellbeing in individuals rather than on categorising and pathologising psychological difficulties.

It could be argued that there is considerable tension between the values of CoP and the use of protocol-driven therapies, including CBT-E. For instance, frameworks such as CBT locate the presenting difficulty within the individual, as difficulties are viewed as results of thinking biases and dysfunctional behaviour. Thus, the wider contextual factors, such as social systems and societal contributors are not given much consideration. Diagnostic manuals and treatment protocols both rely on nomothetic data concerning patterns of 'symptoms' rather than seeking to understand the individual and the unique functions of these signs of distress. Also, although NICE (2004; 2017) asserts that CBT has the most robust evidence-base for treating bulimia, single-model approaches in formulation and treatment may be limited in their ability to conceptualise and address complex difficulties. In the case of CBT-E, the focus is on reducing specific symptoms relating to eating issues.

Counselling Psychology takes a different approach to examining, understanding and addressing psychological health needs. As opposed to heavily relying on the diagnosis and the criteria to explain and understand psychological difficulties, any diagnostic label is considered to be just one factor of interest, amongst many. The overall aims are to move beyond the labels, to understand psychological distress as experienced by each individual and to consider the individual within their unique contexts. This may involve an exploration of relevant wider societal, political and economic factors, for example, in addition to the influences of immediate systems, such as families, workplaces and social groups. Overall, the focus is on the uniqueness of each individual therapy client in clinical practice and research participant in research.

There also are tensions between the existing research and the values and practice of CoP. Most previous research studies regarding eating difficulties reflect the principles of medical

model, as the effectiveness of therapy has been examined by focusing on reduction in specific symptoms associated with a particular disorder. This is in contrast with Cooper's (2009) suggestions regarding the demonstration of the values of CoP. Research acknowledging the values of CoP should move beyond diagnostic labels and attempt to find ways to better respond to our clients' needs. It should not be driven by specific theoretical frameworks when interpreting study data, but for example remain open-minded and explore various explanations for why change may happen.

This research study developed from the thought of providing a voice to a client group that is not often heard, and understanding their experiences as closely as possible without pre-constructed ideas. The study specifically aims to gain a more nuanced understanding of the therapy experiences of these clients and what may be experienced as the helpful and unhelpful aspects of CBT for bulimia. Approaching the topic from a CoP perspective will enable the participants to explore and reflect on their experiences without predetermined measures or hypotheses and thus enable them to provide and focus on the material that bears particular relevance to each of them. Thus, it is argued that this study seeks to demonstrate the values of CoP throughout the research process.

1.9 Pre-study Reflexivity

I was drawn to the topic of EDs for various reasons. When working in an inpatient ED service, I noticed that it was very common for patients to return to the ward fairly soon after being discharged. This was despite them receiving outpatient support after discharge. I was also aware that many professionals considered eating difficulties to be very challenging to treat due to poor engagement in treatment and high relapse rates. I was interested in finding out more about how patients with these difficulties were supported from a psychological point of view, and why many seemed 'treatment resistant'. The topic also had a personal layer for me, as in my tumultuous teenage years I developed a range of strategies relating to my eating to manage the stresses that I was experiencing. At the time, I could not understand why I was engaging in these behaviours, nor did I talk to anyone about them. I was only able to talk about the behaviours more explicitly, even with my therapists, once most of them had stopped and I felt that I had gained some distance to them. Overall, the process of change was very subtle. I am still not entirely sure about what made the biggest difference along the way, but I am positive that without the psychological support that I received, I would not have been able to make the changes that I did.

To begin with I had rather strong views about the usefulness of CBT for eating issues, as I was not convinced that the diagnostic categories for EDs were particularly robust. In my past professional experience, many clients seemed to utilise food and behaviours, such as bingeing and purging, as ways of dealing with emotions and in response to poor self-concepts, rather than being overly concerned about weight gain. For instance, many had grown up in extremely abusive environments where food had been used as one form of abuse. As adults they seemed to utilise food as a way of punishing themselves and consequently engaged in behaviours such as eating rotten food in secret and making self sick after eating proper food. But the diagnostic criteria did not consider this. I was dubious about using a protocol-driven therapy that focuses explicitly on bingeing and purging, as well as on cognitive processes regarding dieting and weigh gain, to work with such complex issues. In addition, very early into the research process I realised that the treatment guidelines promoted CBT as the most effective therapy based on very limited evidence. They relied on a few research studies that had various issues with validity and attrition rates. I found this surprising as I had expected more from a resource that was widely utilised to make treatment decisions and advise clients about the most suitable interventions. I was curious about this and also wondered about why so many seemed to disengage from this therapy. However, as the treatment seemed to benefit some I wanted to know what had enabled them to make use of the intervention. I was conscious of the favourable bias that CBT seemed to have regarding measuring treatment effectiveness as the therapy specifically focused on the behaviours and cognitions that the diagnostic manuals list as symptoms for EDs. Also, the measures used to assess treatment effectiveness focused on these specific symptoms. In my opinion CBT stood a good chance of seeming effective because of this bias on the specific cognitions and behaviours both in the diagnostic criteri, and in the measures.

Existing research seemed to centre around clinician-derived constructs and clients seemed to be objects rather than subjects in these projects. This was in contrast with my emerging awareness of the values of CoP, which focus on valuing the views of service users and holding different viewpoints as equally true and valid. Also, having my personal and professional experiences of psychological interventions and eating difficulties, I was sceptical about the benefits of protocol-driven treatments and the research evidence that relied so heavily on specific diagnostic labels. Although I was mindful of the potential influence of my personal and professional experiences on my research process, suspending my own reservations and experiences was perhaps not entirely possible. Even though I approached the topic from a professional viewpoint, I could not completely divorce from my

personal views and experiences. Thus, supervision and discussions with others were vital in trying to remain reflective and reflexive throughout the process.

CHAPTER 2: CRITICAL LITERATURE REVIEW

2.1 Overview

This chapter will present and critically evaluate research studies examining the use of CBT for bulimia and other psychological difficulties. It will begin by briefly considering quantitative research considering CBT and bulimia, and then move onto qualitative studies on clients' experiences of CBT.

2.2 Retrieval and Selection of Studies for This Review

Various methods were employed to locate and select studies. Initially the NICE guidelines (2004) were checked for secondary references. Online resources, such as Google Scholar and London Metropolitan University library search tool MetCat were used to access online databases and journals. Key terms, such as *bulimia nervosa, bulimia, eating disorder, treatment* and *cognitive-behaviour therapy* were utilised. The search then focused on recent studies, particularly on qualitative research examining clients' experiences of therapy or treatment.

Most of the studies selected for this critical review focus on the treatment of bulimia. However, as research focusing solely on single conditions is currently limited, it was deemed necessary to utilise studies that examined a broader range of EDs, especially as research has shown that temporal changes in the symptom patterns and moving from one diagnosis to another is common. Due to the scarcity of qualitative research considering the treatment experiences of those receiving CBT, especially for eating difficulties, the review also considers studies regarding CBT for other psychological difficulties.

2.3 Quantitative Efficacy Studies on CBT for Bulimia Nervosa

As CBT is considered the most effective treatment for bulimia in the NICE guidelines (2004; 2017) the review will begin by considering the evidence-base for this suggestion. Treatment effectiveness in CBT is commonly determined by its impact on symptom frequency. Studies presented here have also assessed effectiveness by using one or more of the following indicators: meeting the current DSM criteria for the condition, ED psychopathology in comparison to the general population, and the rates of recovery and remission.

Early comparative studies found CBT to be a superior in reducing bulimic symptoms when compared to behaviour therapy (BT) and IPT (e.g. Fairburn et al. 1991; 1995; Fairburn,

Jones, Peveler, Hope & O'Connor, 1993) and to anti-depressant medication (Whittal, Agras & Gould, 1999). More recently the superiority of CBT to other treatments has been supported by a number of larger scale studies. For example, Agras, Walsh, Fairburn, Wilson and Kraemer (2000) compared the effectiveness of CBT and IPT for women with bulimia. The study investigated the number of recovered patients, the proportion of patients in remission and the amount of the participants meeting the community level of disordered eating attitudes and behaviours. Recovery was defined as no bingeing or purging for the last 28 days and remission was defined as bingeing and purging less than twice a week in the same time period. The remission group included those in recovery.

The results showed that those receiving CBT improved faster than those receiving IPT. CBT was also more effective regarding the three outcomes than IPT at the end of the treatment period. 29% of those in the CBT group recovered compared to only 6% of the IPT group, while 48% of the clients in the CBT group and 28% in the IPT group were remitted. Similarly to earlier comparative studies, at the follow-up the differences between the two groups had evened out indicating that those in the CBT group had plateaued or were beginning to deteriorate, whereas those in the IPT group were likely to continue improving post-therapy. Although the researchers concluded that CBT should be the preferred psychological therapy, as it produced faster results during treatment, it only appeared to be superior to IPT when the participants were still attending therapy. Interestingly, those in the IPT group rated the treatment to be more suitable and had higher expectations of the treatment. Recently Fairburn and colleagues (2015) found that CBT-E produces significantly better results than IPT when the follow-up data was compared.

When specific forms of CBT-E have been compared, CBT-Eb has been found to result in most symptom reduction when compared with the focused version (CBT-Ef), especially if the clients have severe symptoms and present with a complex psychopathology. Yet overall, the best results could be achieved by appropriately matching the level of complexity to either CBT-Ef or CBT-Eb (Fairburn et al. 2009). Notably, the studies by Fairburn and colleagues (2009; 2015) excluded underweight individuals, but included various other ED presentations. This may have influenced the findings.

The studies presented thus far were conducted in highly controlled environments, as the clinical presentation of clients, clinicians' level of training and the delivery of sessions were closely monitored and managed. However, CBT-E has also been found to be effective in regular outpatient ED services (Byrne, Fursland, Allen & Watson, 2011). Contrary to the recommendations by Fairburn (2008) to follow the CBT-E manual rigidly, drawing from

different CBT manuals for eating difficulties (Fairburn, 2008; Waller et al., 2007) has been found to produce similar results to the studies conducted in controlled environments (Turner, Marshall, Stopa & Waller, 2015). In both studies (Byrne et al; Turner et al.) clients also reported improvements in their social functioning and general psychopathology, such as anxiety and depression. This suggests that flexibility in using CBT interventions may not have a negative impact on the therapy outcomes for those with eating issues. However, the long term effects of these treatments are not known, as no follow-up data was collected.

Although the studies presented thus far support the efficacy of CBT for bulimia and other eating difficulties, the findings should be considered in a wider context of high attrition and relapse rates, and difficulties with engaging these clinical groups to treatment, as described in Chapter 1. In the studies considered here, the non-completion rates varied from approximately 20% to 40%. Potentially those who remained in treatment were motivated to engage in treatment and actively address their eating difficulties. The motivational level of the client potentially impacted on their commitment to engage with the interventions and remain in therapy, thus resulting in better reported outcomes.

In many of the studies the differences regarding the recovery and remission rates between groups reduced during the follow-up period. Thus, the superiority of CBT as a treatment may not be as significant as previously suggested. Also, the measures explicitly focused on ED symptoms, including bingeing and purging, and thoughts regarding food, weight and body shape, for example. These measures lend themselves to CBT very well, as CBT for eating difficulties specifically focuses on modifying behaviours and thoughts relating to the above areas. Therefore, it could be argued that the measures allow a level of favourable bias towards CBT as opposed to treatments that may not explicitly focus on targeting thoughts and behaviours associated with eating difficulties. Hence, the measures may fail to capture changes in quality of life, or changes occurring in other life domains.

2.4 Quantitative Research Concerning Factors Contributing to Treatment Efficacy and Outcomes

Several studies have provided quantitative data on the elements that may relate to the process of change and on the different therapy outcomes for CBT for eating difficulties. Having a good relationship with the therapist (Constantino, Arnow, Blasey & Agras, 2005) and a reduction in symptoms early into therapy (Loeb et al., 2005) have been positively associated with reduction in bulimic behaviours. When the development of the therapy relationship has been investigated, it has been found that client factors, such as their

treatment expectations and interpersonal difficulties both have a positive relationship with the alliance in CBT and IPT for bulimia (Constantino et al.; Constantino & Smith-Hansen, 2008). Interestingly, Constantino and Smith-Hansen found that those receiving IPT reported a strong therapeutic alliance despite the type of interpersonal problems. The alliances seemed to develop quicker and be more able to endure problems as they arose during treatment. This was less the case in the CBT treatment group, which echoes the findings by Waller, Evans and Stringer (2012). Constantino and Smith-Hansen suggested that the differences between the two groups may have emerged due to the differences in formulating and treating bulimia, as IPT understands EDs as a result of interpersonal problems, whereas CBT focuses on eating behaviour and thoughts regarding weight and shape. Thus, IPT's interpersonal focus may contribute something specific to this client group. The findings also indicated that patients from the same clinical population may have differing needs regarding the psychological support that is required. This echoes the suggestions by Norcross and Lambert (2011), as they argued that different clinical groups, or even individuals within groups, require different levels of relational work and the use of manualised treatments.

It is notable that, as suggested by the researchers of this study, although the studies by Constantino and colleagues (2005), and Constantino and Smith-Hansen (2008) used the same data set, their findings were somewhat conflicting due to the differences in statistical methods employed to analyse the data. This raises an interesting point about the ways in which research results and consequent treatment recommendations could be influenced and changed by selecting specific methods for data analysis. Also, the alliances were measured infrequently in both studies, which is rather troublesome since past research on other clinical groups has suggested that the perceived alliance fluctuates greatly within and between sessions (e.g. Crits-Christoph, Connolly Gibbons, Hamilton, Ring-Kurtz & Gallop, 2011). In other research concerning therapy outcomes in CBT and IPT, therapist adherence to treatment protocol has not been found to have a negative impact on the quality of reported alliance and thus impact on the therapy outcomes. Rather, the best predictor of outcome in this study was the treatment assignment, CBT or IPT (Loeb et al., 2005).

Spangler, Baldwin and Agras (2004) studied the relationships between therapist interventions, client mechanisms and symptoms during CBT for bulimia. The findings indicated that utilising different types of interventions in a flexible manner seemed to have stronger associations with recovery than relying on a specific type of intervention. This could have implications for treatment protocols, as they could be enhanced by including

information about when and how to move between or mix the types of interventions during a therapy session.

Research considered so far has focused on the outcomes for treatment completers. However, considering the high rates of early termination of CBT for bulimia due to drop-out and clinical reasons, it is important to briefly examine the factors that have linked to those types of therapy outcomes. High attrition rates are a concern, as bulimia and other eating difficulties have been associated with high relapse rates and a range of comorbid physical and mental health difficulties. Many may leave treatment while still vulnerable. A study conducted in an ED outpatient service found that two specific patient characteristics (the lowest reported weight and the tendency to avoid affect) were significant predictors of drop-out (Carter et al., 2012). Similarly to the study by Byrne and colleagues (2011), longer waiting times were associated with higher attrition rates. Pannekoek, Byrne and Fursland (2015) discovered a significant relationship between therapeutic alliance and acceptance of treatment, and patients dropping out of treatment. In these studies the drop-out rates were considerably high varying from 40% to 45%.

The findings from these studies are important, as there may be more flexibility in modifying a process-based factor, such as the waiting time, when compared to individual patient factors, such as weight history and tendency to avoid affect. They also place some responsibility on service providers and provision, as eating difficulties are often seen as very difficult to treat and clients to be challenging to engage, but the impact of the availability of treatment on this has not always been considered. Increasing resources to reduce waiting times may help to lessen drop-out rates and have a positive impact on treatment outcomes.

Making meaningful comparisons between the different study findings is challenging for several reasons. For instance, both the efficacy studies and the outcome studies presented so far have used various definitions for remission and recovery. Also, drop-out has been inconsistently defined across these studies (e.g. Pannekoek, Byrne & Fursland, 2013). Research concerning drop-out rates has often been considered biased towards researching so-called fixed client factors, such as personality traits or duration of illness (Pannekoek et al., 2015) rather than alternative factors, including access to treatment. Notably, all the studies used quantitative measures to assess the treatment efficacy or other outcomes. This had a significant impact on the type of information that could be gathered, as what does not get asked about does not get reported, and the participants can only respond to the elements specified by each measure.

The research studies discussed thus far have not provided CBT with a particularly robust evidence-base in the treatment of eating difficulties, as discussed above. Notably, the measures used to evaluate its effectiveness may allow cognitive-behavioural treatments a favourable bias towards treatments explicitly addressing the symptoms for bulimia, as specified by diagnostic manuals. Adopting such a narrow focus may be useful in evaluating whether certain behaviour patterns can be modified through CBT, but the findings are limited in terms of considering more holistic changes relating to quality of life, self-image and general functioning over time. Although these findings may go some way in explaining why CBT is the recommended treatment for bulimia (NICE, 2004; 2017), it is unknown whether any important elements relating to the process of therapy have been overlooked. Overall, measuring change in symptom frequency has not provided any insights on symptom functions, i.e. why and how these changes happen, and what internal changes may be reflected on the external changes. It could be argued that qualitative methods may be more suited for that purpose.

2.5 Qualitative Research Concerning Clients' Experiences of CBT

Qualitative studies examining clients' subjective experiences of engaging in CBT are scarce and hardly any studies have examined clients' experiences of CBT for eating difficulties. This is despite the view that asking clients about their therapy experiences is a vital step in the process of understanding how psychological therapies may facilitate change (Hodgetts & Wright, 2007). In light of these limitations, this review will also consider the insights provided by qualitative studies on other clinical groups regarding the experience of receiving CBT. Some qualitative studies on this topic have been carried out by teams involving clinical psychologists (e.g. McManus, Peerbhoy, Larkin & Clark, 2010; Vincent, Jenkins, Larkin & Clohessy, 2013; Onslow, Woodward, Hoefkens & Waddington, 2015). However, there is a distinct lack of research conducted by Counselling Psychologists and few doctoral theses have examined the CBT experiences of clients with specific physical or mental health diagnoses by using qualitative methods (e.g. Cheng, 2014).

A comparative study by Nilsson, Svensson, Sandell and Clinton (2007) adopted a qualitative stance to investigating clients' experiences of either CBT or psychodynamic therapy (PDT). They aimed to explore whether PDT and CBT clients differ regarding how they describe their therapy experiences, changes relating to the therapy, and any unhelpful aspects of therapy. Factors relating to clients' diagnoses and therapists' adherence to a particular therapeutic framework were not controlled. 31 individuals aged from 20 to 65 years took part in the study. The findings indicated that there were considerable differences between the

two groups. Those, who were satisfied with their CBT, felt that goal setting, homework and therapist's explanations had contributed to them making changes. Therapists were seen as experts amongst these participants. Some reported changes related to an increased ability to cope, and retaking control over one's life. In the PDT group, changes were seen as results of talking and reflection, making connections and getting to the root of the issue. As a result, participants reported increases in self-acceptance and self-care, and the ability to take on more responsibility. The therapeutic relationship was described as emotionally supportive and adaptable to the individual needs of the client. Dissatisfaction in both groups was often linked to a mismatch between the participant's expectations of that particular type of therapy, the therapeutic focus of each approach and the therapy relationship. In CBT, some felt the therapist to be intrusive and inflexible in how they used the therapy framework, while some in the PDT group felt that their therapist was aloof and disengaged. Although there were issues in the study design regarding the lack of control over the therapists' training and the participants' psychological issues, the study provided interesting information on how different types of therapies may be experienced by clients and also gives some indications on what may be experienced as problematic or dissatisfying in these therapies.

Clarke, Rees and Hardy (2004) carried out a small grounded theory study with five participants, who had received between 12 and 20 sessions of CBT for depression. Three superordinate categories emerged from the interview data. The first category titled 'The listening therapist' highlighted the role of the therapeutic relationship in supporting the clients through the challenges of therapy, as it appeared to be central to the participants' experiences. The second category 'The big idea' consisted of participants experiences of interventions that are typical to CBT, such as hot-cross buns, formulations and experimenting with skills outside the sessions. The final category 'Feeling more comfortable with self' considered the ways in which the clients felt they had improved as a result of being in therapy.

The findings suggested that both non-specific and CBT-specific factors were important. Quality of the therapeutic relationships had an impact on how the clients grew to trust their therapist and themselves over time, and the therapist demonstrating empathy and a good sense of humour were considered valuable aspects of the relationship. Behavioural tasks and understanding patterns or core beliefs were experienced as CBT-specific, helpful aspects of therapy. Although the findings provide interesting insights into how CBT may be experienced by clients, its explicit focus on helpful aspects of therapy limited the findings

and no information was attained about what may hinder the therapeutic process or clients' ability to make and maintain changes. Also, as the participants received CBT for depression rather than eating difficulties, the applicability of the findings across the groups may be limited.

Messari and Hallam (2003) used a discourse analytic methodology to investigate the experiences of five participants with a diagnosis of paranoid schizophrenia, who had received CBT for psychosis. The length of CBT varied between three and 18 months and the therapy was on-going. Similar to the findings of Clarke and colleagues (2004), the participants in this study considered trust, respect and openness to be important characteristics of therapeutic relationships. CBT was seen as a collaborative and educative project that helped the participants to explore different ways of evaluating their experience. The findings indicated that in an inpatient setting CBT was often seen as a condition for discharge. Despite this, the participants generally spoke about their therapist in positive terms. The study did not identify any specific factors that may influence the therapy process or outcome, but rather focused on the discourses emerging in these contexts.

Social anxiety has also been investigated through qualitative methods. McManus and colleagues (2010) interviewed eight individuals in an IPA study. The participants had completed a standardised cognitive therapy (CT) for social phobia (SP) treatment protocol. The semi-structured interviews explored the following: how the clients came to have CT for SP; what they remembered of their experience and whether there was anything specific that had been helpful or unhelpful about the therapy. The analysis revealed four master themes, each with specific subthemes. The master themes were: Social phobia as a way of being; Learning to challenge social phobia as a way of being: transformative mechanisms of therapy; Challenges in the pursuit of change; and Whole new world: new ways of being. The participants' accounts seemed to focus on the impact of specific skills associated with CBT on their anxiety, rather than, for example, consider alternative reasons for change. Interestingly, some felt that the intervention dealt with the issue superficially and also that they were overwhelmed with information relating to their difficulty. However, all spoke about an increased level of self-acceptance and acceptance of others as a result of learning that others were not as judgemental as they had thought. This had prompted some to share their vulnerabilities with others, thus reducing their sense of isolation.

Vincent and colleagues (2013) examined asylum seekers' experiences of trauma-focused CBT (TFCBT) for post-traumatic stress disorder (PTSD) and interviewed seven individuals, who had received a minimum of two sessions of TFCBT and at least five sessions of

psychological therapy within the last six months. The study findings indicated ambivalence regarding engaging in therapy: the participants wanted to get better, but uncertainties about the future and the intensity of TFCBT hindered their engagement. All participants experienced isolation, but this was mitigated by the therapeutic relationship. Losing and regaining their identity were also evident in the participants' accounts of the therapy process. Although the individuals in this study may be very different from the ones in the current study, the findings provide interesting information about the experiences of those, who may traditionally be viewed as difficult to engage in therapy for different reasons.

A CoP doctoral IPA study by Cheng (2014) explored the CBT experiences of six clients with an acquired brain injury. Three master themes titled Professional relationship; Understanding my struggles; and Acceptance emerged from the data. Overall, the participants felt that the timing of the treatment was crucial: feeling ready to engage in treatment had a direct impact on motivation and engagement in therapy. The therapy relationships and the therapists' qualities also influenced the participants' levels of engagement. Akin to the study by Vincent and colleagues (2013), the participants in Cheng's study also described hitting rock bottom prior to seeking out and engaging in treatment. Cheng noted that there were no CBT guidelines or models regarding emotional difficulties experienced by clients with a brain injury, thus practitioners should approach the clients with a pluralistic view accommodating their unique needs and consider their difficulties in broader social and narrative contexts. In practice this would mean clinicians adopting a client-centred approach to CBT, whereby the adaptations could be made both regarding interventions and factors relating to the therapy process, such as the length of sessions and homework tasks.

Eating disorder specific research has investigated various types of CBT interventions, but overall relevant qualitative studies are few and far between. McClay, Waters, McHale, Schmidt and Williams (2013) examined the use of an online self-help CBT package for the treatment of bulimic difficulties by using a thematic analysis approach. Eight women aged between 28 and 50 years were interviewed after having access to the package for approximately three months. The main themes related to the individuals' conceptualisations of their ED; seeking help; motivation; progress and recovery; and privacy, for example. Many had struggled to access support due to their GPs belittling the scale of the problems, and the lack of access to treatment through the NHS. The theme relating to progress and recovery indicated that the focus of the answers and/or the analysis had been the impact of the intervention on the problematic eating behaviours, rather than on other life domains and

quality of life. The theme titled Privacy and secrecy appeared to be a double-edged sword, as the findings suggested that most participants felt that the online intervention enabled them to maintain privacy over their difficulties, which is what they desired. Thus, they preferred the online intervention over face-to-face appointments. Yet some reported a lack of social support post-intervention, as they felt that they could not share their difficulties with anyone. The overall findings indicated that online interventions may help to engage those, who would struggle to access support due to geographical and service-related restrictions. Those who are not ready disclose their eating issues to others may benefit from this type of intervention, although high levels of secrecy may be problematic due to them potentially increasing isolation and feelings of shame.

Laberg, Tornkvist and Andersson (2001) conducted a grounded theory study on a group intervention delivered to women, who met the DSM-IV criteria for BN. Seven women were interviewed a few months after therapy. They were asked about their perceptions of the treatment, and its impact on their lives post-therapy. It was found that many focused on the interpersonal elements of the group experience. For instance, they were relieved to find that they were not alone with their issues and many developed supporting relationships with the other members. Some struggled to trust others and share interpersonal information, which impacted on the progress they made on addressing issues that potentially contributed to their eating difficulties or affected their psychological wellbeing. Interventions focusing on developing interpersonal skills were highly regarded. Also, the participants reported expecting the therapist to take charge and enforce structure. Interestingly, all women felt that individual sessions would have been an important addition to the group therapy. Overall, the treatment enabled the participants to become less secretive about their difficulties and more assertive in their relationships. They also noted that during the treatment their ED-related goals transformed into goals relating to other life domains, such as education, employment and building social relationships.

A recent IPA study by Onslow and colleagues (2015) explored the subjective experiences of individuals receiving CBT-E for bulimia. This study was unique, as the treatment experiences of this client group through a qualitative lens had not previously been examined. This was a single site study in a Welsh ED service. Participants had completed CBT-E within the last 24 months or so. Eight women aged between 26 and 55 years took part. The study focused on four main areas of enquiry: the process of participants getting into CBT-E for BN; the helpful and unhelpful aspects of therapy; experiences of discharge, and the impact of therapy on their current wellbeing and eating behaviour. The analysis revealed

four master themes: Pre-therapy experience of bulimia; Valuable aspects of therapy; Challenging aspects of therapy, and Valuing and maintaining changes. There was found to be a positive relationship between the perceived levels of therapist expertise in EDs and their empathy towards the client. Understanding the maintenance cycles relating to the disorder and experiential learning were considered as the most helpful elements of therapy. Changing thoughts and behaviours both in the situation and in the long term were reported as the most challenging aspects of therapy.

Several factors could have had impacted on the findings. Firstly, the study included individuals from a wide age range, whose history length of eating difficulties is unknown. Previous literature has suggested that the condition is likely to become chronic, but the potential impact of chronicity was not considered in the study. Secondly, the participants were previous service users of a specific service and they were interviewed by professionals associated with the service. This may have made it difficult to give honest feedback regarding the therapy experience, as the participants could have been concerned about how this may impact on any future support available to them. Alternative sources of support may have been limited in this geographical area. The study provides little information on the service context, such as waiting times and eligibility criteria. It is possible that the findings would have been different in other geographical locations and NHS Trusts, as there are considerable differences in support available between areas. Although this study provides an interesting starting point for investigating the therapy experiences of this client group from a qualitative perspective, it also has a number of weaknesses that should be considered when designing future research studies.

2.6 Research Questions and Aims of the Study

Overall, young women have been found to be the most likely group to experience bulimic difficulties. Having reviewed the existing research concerning CBT for bulimia nervosa, most have focused on women's experiences. Although CBT is the psychological therapy recommended by NICE (2004; 2017), the evidence-base for this recommendation is rather weak. Quantitative studies examining the treatment effectiveness have high attrition rates and in most comparative studies the superiority of CBT seems to dissipate when follow-up data is being examined (e.g. Agras et al., 2000) and many studies have no follow-up data. This research has mostly focused on the changes in ED symptoms, rather than other areas of life and functioning. However, consequent quantitative studies have provided some insight into what may contribute to treatment having positive outcomes, such as the quality of the therapy relationship (e.g. Constantino et al., 2005). Overall, there appear to be challenges in

providing effective therapy to those affected by bulimic difficulties, as evidence-base is currently lacking and engaging individuals with these difficulties in therapy is difficult. Even when treatment completers are examined, the outcomes are moderate at best.

Findings from qualitative research concerning CBT experiences have suggested that the therapeutic relationship is often central to the participants' accounts, irrespective of their diagnosis (e.g. Clarke et al. 2004; Messari & Hallam, 2003; Cheng, 2014). Some have indicated that CBT-specific features can be seen as valuable aspects of therapy (e.g. Onslow et al., 2015), yet others may find CBT as superficial therapy that does not deal with the core of the problem (McManus et al. 2010). A desire for privacy during a psychological intervention (McClay et al., 2013) was a unique finding in research concerning those with bulimic difficulties, although in other research those with bulimia valued the social element of group therapy (Laberg et al. 2001).

These findings have provided interesting and valuable information to clinicians about how to use psychological interventions, such as CBT in a way that is the best suited to these clients' specific needs. They have also highlighted the role of the therapy relationship in enabling change. However, research focusing on individuals with eating issues is lacking and the applicability of the findings from other qualitative studies to the current population unknown. Thus, specific areas of need or relevance to those with bulimia have potentially not been discovered.

Overall, the existing literature, research and treatment guidelines in this particular field provoke questions, such as "How do individuals experience particular treatments, such as CBT?", "CBT seems to reduce symptoms rapidly in some individuals, but why and how does this happen?" and "What could be done to promote better or different treatment outcomes?" To answer these questions, an in-depth study in to clients' experiences is required.

Thus, the current study will aim to explore women's experiences of CBT and its impact on their post-therapy lives. The aim is also to provide clinicians and other professionals helpful insights into how best support individuals with bulimic difficulties. The main research question that the study will seek to address is: how do women experience cognitive-behaviour therapy for the treatment of bulimia nervosa?

CHAPTER 3: METHODOLOGY

3.1 Overview

The study aims to gain an in-depth understanding of how women experienced CBT for the treatment of bulimia. The methodology selected for addressing this question and meeting aims of the study is Interpretative phenomenological analysis (IPA; Smith, Flowers & Larkin, 2009). The chapter will outline the use and impact of this methodology on the collection and analysis of the data.

3.2 Rationale for Selecting a Qualitative Approach

Qualitative research concerning the therapy experiences of specific client groups is currently scarce and little is known about the treatment experience of those, who have accessed CBT for BN. So far research has utilised quantitative methodologies aiming to evaluate the impact of therapy on the severity and number of ED symptoms, as defined by the relevant diagnostic criteria, with the focus on the symptom form rather than function. Only one study to date, in addition to the current one, has examined the CBT experiences of this specific group through a qualitative lens. This study aims to gain a detailed understanding of the process of engaging in CBT and its potential impact on the outcomes for each participant.

Qualitative research aims to understand and represent the lived experience of the participants and remain as close to the participants as possible in this process. This is done by attempting to understand it from the participants' perspective and by acknowledging and managing the researcher's own perspectives and existing knowledge through reflection and 'bracketing' (Elliot, Fischer & Rennie, 1999). Bracketing involves becoming aware of and suspending our individual biases and experiences as far as possible. Qualitative methodologies are particularly well suited for research that have a temporal dimension, such as aiming to understand the process of change (Barbour, 2000), what are the factors that could help and hinder this process, and to uncover the factors relating to the different outcomes of interventions (Starks & Brown Trinidad, 2007).

3.3 Overview of IPA Methodology and Its Philosophical Underpinnings

Interpretative phenomenological analysis was originally developed in the 1990s with the initial focus on health psychology research (Smith, 1996). Since then it has gained presence in various fields. For example, by 2008 nearly 300 IPA papers had been published and the majority of the papers were concerned with physical and mental health (Smith, 2011). IPA

is an inductive approach that aims to examine the human experience in detail and as far as possible without predetermined category systems. The approach focuses on examining how individuals interpret their major life experiences (Smith et al., 2009). Although studies utilising this methodology place great importance on the detailed examination of individual experiences, they can also serve as ways to produce generalised knowledge by moving from idiographic to nomothetic data (Eatough & Smith, 2013).

The roots of the approach are located in the 20th century philosophy. It is heavily influenced by three theoretical perspectives: phenomenology, hermeneutics and idiography (Smith et al., 2009). Phenomenology was founded by Husserl, a German philosopher and it is a philosophical approach to the study of experience and consciousness. It examines how individuals in different contexts and at specific times experience the world (Willig, 2001). In philosophy, 'phenomena' is usually defined as the appearances of things rather than how they really are. Although phenomenologists do not deny the existence of the true or objective reality, they argue that it is, and will, always remain an unknown. This is because our reality is an interpretation. This interpreted reality is an outcome of the interaction or 'inter-relatedness' of the 'raw material' of the world and our mental faculties, such as the psycho-social processes that are shared by individuals and the unique circumstances and experiences of each individual (Spinelli, 2005). Husserl's student Heidegger placed significance on death, as it gives a temporal aspect to our Dasein or being-in-the-world (Smith et al.). Death also provides a limit to our being-in-the-world, which we can utilise in our meaning-making in our Dasein (Sturgess, 2016). Thus, our meaning-making and ways of relating to the world are influenced by our temporal existential location (Smith et al.). Our interpretations are considered to be subjective and impermanent as they are influenced by our unique life experiences, the true reality and our temporal existential location.

'Intentionality' is one of Husserl's key concepts in relation to the process of interpretation. He argued that our consciousness has a directional quality, as we are conscious of *some thing* (Spinelli, 2005). In this context intentionality describes the inevitable interpretation process that occurs when we direct our attention to *some thing* and we respond to it as if it were an object in our consciousness. Intentionality is also a term used to refer to the relationship between us (the 'I') and what we do not experience as part of us (the other, or the 'not-I'). The 'I' and the 'not-I' are considered to be inter-related and interdependent: neither makes sense in isolation, but they require each other to exist. Spinelli suggested that rather than there being a single, permanent 'I', the 'I' is an impermanent construct that

occurs through the combination of intentionality and self-consciousness. Thus, our self-concept also has a temporal dimension and is a result of our interpretation.

The phenomenological concept of 'the self', or the 'I', has specific relevance to the current study. Spinelli (2005) argued that the relationship between 'the self' and its physical body is complex, as what we think of as our bodily self is a result of interpretation rather than what is truly or objectively there. Issues with 'proprioception', i.e. the perception that one has of their body and its movements, illustrate this further. For example, distorted body image and negatively biased beliefs about one's shape and size are common amongst those with eating difficulties. In these cases, the objective shape and size of the body can be in stark contrast with the subjective experience that the individual has of their body. Spinelli suggests that our experience of the 'self' can surpass the physical boundaries of our bodies, as we can have inaccurate beliefs of what our bodies look like and we may also reject parts of our bodies that actually belong to us.

In terms of phenomenological research, Husserl believed that phenomenology should find ways to remove, as far as possible, the interpretational elements added to the stimuli, so that we can acquire more accurate and detailed knowledge about the true reality. He considered bracketing to be essential for this (Spinelli, 2005). He believed bracketing to be a continuous process during which layers of biases are revealed. Contemporary phenomenology believes the true reality to be unattainable and unknowable despite us engaging in this process (Spinelli). Heidegger considered a person to always be a 'person-in-context'. According to Heidegger we are permanently an essential part of a meaningful world and the meaningful world is an essential part of us. Thus, we cannot intermittently choose to engage in a meaning-making process to give meaning to meaningless objects in the world. Consequently, it is impossible to remove ourselves and our meaning systems to discover how the reality and things really are (Larkin, Watts & Clifton, 2006). Despite this, bracketing could be considered a helpful method in becoming more aware of our pre-existing views and biases.

Overall, phenomenological research is interested in the experiential phenomena, rather than the individuals speaking about them. Willig (2012) likens the participants in such research to witnesses, who are able to tell us about the phenomena under investigation. Thus, it is concerned with how something is experienced and interpreted by these witnesses.

Hermeneutics, the theory of interpretation, is concerned with the processes of making sense of experiences. In IPA the researcher engages in double hermeneutics by attempting to

interpret how the participant makes sense of a particular experience. However, this is not seen as a linear process, but rather the researcher engages with the data in a dynamic manner moving from a particular to the whole and back again. Derrida's method of deconstruction is particularly relevant for IPA, as it enables us to move beyond the dominant influences and examine the implicit meanings presented in the material. Derrida argues that texts have multiple, or potentially infinite, meanings as they can be examined for semantic, syntactical, rhetorical and stylistic connotations in addition to their explicit meaning. Similar to Heidegger, Derrida also believes that we cannot reach absolute objectivity, but rather are always attached to different contexts and frames, which influence how we engage with the text (Derrida & Caputo, 1997) or the world around us.

Idiography as a theoretical construct emphasises the importance of the particular. In IPA the analytic process involves an in-depth investigation of the details provided in the material. The attention is also on a specific phenomenon as experienced by specific individuals. Although the approach focuses on individual experiences, it locates the experiences within cultural and socio-historical contexts, which are considered important both at the level of the experience and at the level of the analysis.

3.4 Rationale for Selecting IPA

Interpretative phenomenological analysis is considered to be especially suitable for new or under-researched topics that are multidimensional or ambiguous and where the aim is to understand something about process and change (Smith & Osborn, 2008). The study invited participants to explore their experiences in relation to a particular phenomenon, and the time period preceding and following it. Utilising a methodology that recognises the temporal impact was vital. Although the primary aim of the study is not to challenge, prove or support a specific hypothesis or theory, the findings from an IPA study can be used to dispute or illuminate existing theories (Smith et al. 2009).

IPA and CoP share very similar underpinnings and thus it could be argued that using IPA would be complementary to CoP research. As discussed previously, psychiatric diagnoses can have a reductionist effect on the ways in which individuals' experienced are explored and understood, and much of the previous research has focused on specific symptoms, as identified by quantitative measures. However, it is hoped that using IPA to study the experiences of individuals, who have experienced certain types of eating issues would consider their individual stories in more detail and that this exploration would go beyond the diagnostic criteria associated with bulimia.

Both IPA and CoP consider individuals' subjective experiences valid in their own terms and take a constructionist stance to reality suggesting that different versions of 'truth' can be created at different points of time and in different contexts. Thus, both acknowledge the importance of the temporal dimension and the contexts in which the interaction takes place and is interpreted. CoP seeks to "engage with subjectivity and intersubjetivity, values and beliefs (…) and negotiate between perceptions and world views but not to assume the automatic superiority of any way of experiencing, feeling, valuing and knowing" (British Psychological Society [BPS], 2005, p. 1-2). Like IPA, CoP research often examines areas, such as diversity, underrepresented groups, and activities, such as therapy assessments and interventions (APA, 2016).

The role of an IPA researcher and that of a counselling psychologist are similar, as neither claims to have access to the objective, ultimate 'truth' and therefore be an expert in the relationship with the participant or the therapy client. Rather the emphasis is on understanding and respecting the subjective experience of each individual and considering these experiences equally true and valid.

3.5 Using IPA for Counselling Psychology Research on CBT

As discussed previously, IPA and CoP share many similarities and they complement each other in research activity. However, since the current study examines the experiences of CBT, it is important to consider how IPA, CoP and CBT may fit together.

In terms of the differences between IPA and CBT, there are many. IPA values an idiographic approach to understanding individuals and focuses on the importance of subjectivity. It also considers subjective experiences as equally valid. Thus, different realities and accounts can co-exist and be considered simultaneously. Similar to CoP, IPA aims to understand the individual's experiences holistically and within a wider context. CBT, however, is a therapy framework that has contains various models developed from observations on groups of individuals to explain individual experiences and so it utilises the nomothetic approach. Generally, CBT encourages clients to strive towards objectivity to understand and alleviate their difficulties. This is observable in the terminology used in CBT, such as perceiving certain types of thoughts as faulty and referring to them as 'thinking biases'. Various CBT exercises, such as thought records and behavioural tasks aim to challenge the existing biases so that more objective patterns of behaviour and thinking can be developed. It has also been claimed that CBT perceives its role as ultimately helping the client to readapt to the social norms and behave in ways that are socially and culturally considered normal and acceptable

(van Deurzen, 1998). In addition, the approach locates the problem within the individual rather than holistically considers societal, environmental, financial and other external factors. It is the individual interpretations rather than the events themselves that result in psychological distress. This also seems very similar to how psychiatric diagnoses explain and understand human distress. These points suggest that although CBT is interested in understanding the individual processes of how different events are interpreted and stipulates that therapists should be alongside their clients rather than experts in the therapy relationships (e.g. Westbrook, Kennerley & Kirk, 2011), the therapist is implicitly considered to have specialist knowledge that they can use to rectify the client's problematic thinking and behaviour.

Broadly, CBT conceptualises human functioning in dualistic terms, as mind and body are seen as separate entities that interact and impact on each other. Changing cognitions is thought to impact on behaviours, and vice versa. Thus, the body is seen as a physical agent of change: doing something different with the body (behaviour) is believed to influence how situations are experienced and interpreted (cognition). This is in contrast with mindfulness-based interventions, for example, which suggest that it is the *awareness* of the body that brings upon change (Leitan & Murray, 2014).

According to Boucher (2010), CBT is a framework that exists within a continuum. At one end of the continuum, the approach is heavy on both theory and technique, while the therapist's stance towards the client's presenting difficulties is prescriptive and directive. The therapy relationship is a working alliance in which the client and the therapist work in partnership to address the pathologised issues as manifested by their dysfunctional thoughts and maladaptive behaviours. At the other end of the continuum, however, CBT is less technically-oriented and the therapy process is rooted in the core relational principles of empathy, autonomy and congruence, for example. This approach emphasises 'being with' as opposed to 'doing to' in relation to the client. Hence, the process focuses on the client's unique ways of interpreting events and creating meanings at a given point in time rather than on trying to fit the client into an existing model of pathology. Thus, Boucher, who is also a Counselling Psychologist, argues that the second approach appears to be a good fit to the pluralistic values of CoP, as it recognises and appreciates the uniqueness of each person's interpretation within different contexts. This focus on appreciating the individual ways of relating to the world also resonates with IPA's philosophical stance.

Although CBT has been researched in various studies previously, most of the research has examined the effectiveness of treatment as measured by quantitative, clinician-derived

measures. The focus has been on examining impacts on symptoms, as defined by diagnostic criteria for specific disorders, and changes in thoughts and behaviours relating to the disorder. Thus, the existing research has been rather reductionist in its approach to examining psychological distress manifested in the form of disordered eating. Very few have approached the topic from a CoP perspective utilising principles of humanistic practice, and pluralism. Considering the current study, using IPA to examine a phenomenon relating to CBT could potentially provide data that is very relevant to CoP due to IPA's philosophical underpinnings and views of the individual. Thus, it is also hoped that the use of IPA would move the findings of the study beyond the assumptions of cognitive-behavioural approaches.

3.6 Why not Another Qualitative Approach?

Initially alternative qualitative methodologies were also considered for this study. IPA was selected over grounded theory (GT), as although the two methodologies are currently similar in some respects, they were developed with rather different concerns in mind. GT was originally a sociological approach concerned with identifying social processes in various contexts with the aim of developing a theory to explain these processes. Initially the researcher was viewed as the witness to these social processes and it was their role to uncover these processes as accurately and objectively as possible. Thus, the methodology was initially located closer to the positivist paradigm, although in the more recent years more constructivist approaches to this methodology have been developed (Willig, 2001). Due to the time and resource constraints it would not have been feasible to carry out a GT study following the principles of the full version, whereby great importance is placed on reaching theoretical saturation. An abbreviated version of the study would not have been sufficient in developing a robust and detailed theory on the matter.

Although discursive psychology (DP) also examines social processes and practices, the focus is on the discourses in these contexts. Discourse is considered to be action-oriented and the ways in which individuals use carry out social practices, such as negotiation and persuasion are of primary interest to the researcher and data gathering usually occurs in naturalistic settings (Wiggins & Potter, 2013). The current study was not purely interested in the language use of the individuals, but also in the internal thought processes and the emotional responses in relation to the therapy experience as opposed to the DP's focus on how these processes and responses may be constructed in different discourses. Although DP could provide an interesting angle on the study of eating difficulties, the approach would not have been suitable for this study due to its reliance on naturally occurring language and the consequent practical and ethical issues.

3.7 Ontological and Epistemological Positions

The current study adopts the ontological position of critical realism. Bhaskar (2008), who is a critical realist, argued that there are two sides of knowledge. Some knowledge arises as a result of social activity and depends on humans. However, some is knowledge '*of*' things that exist independent of human activity. Overall, our knowledge of the reality is, and will remain, partial. This formulation of the reality and our knowledge of it is not positivist, but rather considers some of the knowledge to be socially constructed.

With regards to this study, it is vital to acknowledge how the diagnosis of BN was conceptualised throughout the study. BN is a concept created within the medical paradigm for the purposes of assessment, diagnosis and treatment. Within this paradigm BN is conceptualised in positivist terms that can be examined through empiricism to establish rules and to create generalisable knowledge, such as diagnostic criteria. Overall, the medical paradigm is aligned with scientific realism, in which scientific research and theories are seen as the methods to take us as close as possible to true reality. Therefore, the assumption is that the current diagnostic criteria are a true depiction of what bulimia is.

Not everyone agrees with this, however. For instance, Evelyn Fox Keller (as cited in Tashakkori & Teddlie, 1992, p. 151) argued that we can create different representations or theories of reality: "scientific theories neither mirror nor correspond to reality. Like all theories they are models. (…) Such theories, or stories, are invented, crafted or constructed by human subjects, interacting both with human subjects and with non-human subjects/objects". According to Fox Keller, scientific theories are socially constructed, which echoes the notions of Bhaskar (1975). Also, as noted in Chapter 1, clinicians and research to date have suggested that the clinical reality may be more complex than what is captured in the diagnostic manuals, and the lines between health, illness and fitting into specific diagnoses may be blurred. This is very much the view that the researcher takes with the current research study despite the practical reasons for utilising diagnostic labels during the recruitment process. In this study, there was some reliance on theoretical constructs, such as 'bulimia nervosa' and 'CBT'. The study included participants, who self-identified as individuals, who had been diagnosed with the condition in the past, but subjectively were no longer eating disordered. By using these theoretical constructs it was possible to define the sample group and examine a phenomenon that had been observed in mental health services. In line with the social constructionist stance, the data occurring in each interview were seen as different but equally valid representations of reality.

3.8 Methodological Procedures and Data Collection

3.8.1 Sample selection.

Purposive sampling was utilised to remain faithful to the principles of IPA and to sustain an idiographic focus. This ensured that the research sample was relatively homogenous, as recommended by Smith and colleagues (2009), which was reflected in the inclusion and exclusion criteria.

The initial inclusion criteria stipulated that women aged 18 to 25 could take part. They should have undergone individual CBT for BN and ended therapy at least six months prior to taking part in the interview. The timing of the ending should have been mutually agreed upon with the therapist. The exclusion criteria stated that those who were still acutely ill with an ED or other types of mental health issue, such as depression, anxiety or psychosis would not be able to take part in the study.

The rationale for focusing on young females in this study included several reasons. Firstly, statistical information has indicated that young women are the most likely group to experience eating difficulties (HSCIC, 2009). It has also been found that the longer the problems continue the more chronic they become (Keski-Rahkonen et al., 2009). Thus, focusing on individuals, who were young adults, may help to homogenise the sample. Examining this life stage could potentially provide interesting information on how eating issues may interact with the relevant developmental tasks, such as identity development, gaining independence, developing romantic relationships, starting work and going to university, for example. Recent research carried out in the UK has also suggested that young males experience gender-specific issues when seeking and engaging in psychological treatment for eating difficulties (Raisanen & Hunt, 2014). Thus, it was decided that the current study would focus on women's experiences only, as it was hoped that the high incidence of eating issues in this group would make it relatively easy to attract a suitable sample.

The study focuses exclusively on those, who received individual face-to-face psychotherapy, as opposed to engaging in guided self-help or group therapy, for example. The current NICE guidelines (2017) instruct offering individual cognitive-behavioural therapy (CBT-ED), if the client has not benefited from self-help focused interventions or if those are contraindicated. Also, much of the quantitative research considering CBT for eating issues has examined individual psychotherapy experiences (e.g. Agras et al., 2000; Byrne et al.,

2011; Fairburn et al., 2009; 2015), yet these experiences have rarely been examined from a qualitative point of view, as discussed in Chapter 2. Hence, there was deemed to be a sufficient rationale for focusing on individual psychotherapy.

In practical terms, individual psychotherapy experiences may provide interesting insights into the therapy relationship between the client and the therapist. In group therapy, the attention of the therapist is divided between the group members and the therapeutic relationships extent to other members in addition to the therapist, and thus there are multiple interpersonal interactions occurring in each session. Thus, the two groups could not be studied in a single study while remaining in line with the principles of IPA.

After several months of failing to attract any suitable participants, the criteria were extended to include women aged 18 to 35, who had finished therapy at least one month prior to taking part in the interview. There were several reasons for these changes. Although women are most likely to experience eating related issues between the ages of 18 and 25, they may not seek or access support during those years. Some of the organisations involved in the recruitment process gave feedback that the individuals who would meet the rest of the study criteria were considerably older than 25 years. A number of other studies had gathered data from clients in therapy during the therapy or within weeks of them completing therapy. As the contraindications to CBT include psychosis, suicidal ideation and severe depression (NICE, 2004), it was felt that these changes would not increase the risk to participants. An amended ethics form was submitted to the University Ethics Review panel in August 2014.

Several women, who made contact, were deemed unsuitable for the study as they did not meet the inclusion criteria. Those who were still in therapy, but were considered otherwise suitable, were contacted again towards the end of their therapy. None of them wished to take part at that point. One person met with the researcher for the interview, but early into the interview it transpired that she had received group CBT for her bulimia. She was provided with a debrief sheet and her local travel costs were refunded. The consent forms, interview recording and the email correspondence were destroyed.

3.8.2 Sample size.

The study was completed with four participants, which has been deemed acceptable for professional doctorate studies (Smith et al., 2009; Hefferon & Gil-Rodriguez, 2011).

3.8.3 Procedure.

Electronic copies of the research advertisement (Appendix I) were circulated in the organisations that were taking part in the recruitment process. Paper copies were provided for individual practitioners so that they could discuss the study with any potential participants. Anyone expressing an interest in the study was sent a copy of the information sheet (Appendix II). Those individuals, who met the inclusion criteria and wanted to take part in the study, were sent a copy of the Hospital Anxiety and Depression Scale (HADS; Appendix III). An amended version of this form was made available after a request from the National Health Service Research Ethics Committee (NHS REC), but it was not utilised as no participants took part through the NHS. Prior to the interview, prospective participants were also sent copies of the consent forms (Appendix IV; Appendix V). Participants were given a choice of completing the HADS and the consent forms prior to the interview or they could complete them at the start of the interview meeting. On one occasion a prospective participant expressed moderate levels of anxiety on their HADS form and this was discussed with them over the telephone. As the person was deemed to have adequate coping strategies in place, they were able to take part in the study.

The interviews took place in private rooms in public spaces, such as libraries and university buildings. They were conducted by utilising a semi-structured interview schedule (Appendix VI), which was used flexibly to guide the process and to encourage the participants to explore their experiences in detail. The interviews lasted between 67 and 77 minutes and were recorded on a dictaphone. During each interview, the distress protocol (Appendix VII) was observed to manage any participant distress. None of the participants displayed signs of distress beyond appearing a little nervous. At the end of each interview all participants were provided with a copy of the debrief sheet (Appendix VIII) and the opportunity to attain a copy of the summary of findings (Appendix IX) once ready.

3.8.4 Recruitment.

After gaining ethical approval from the London Metropolitan University (LMU) Ethics Review Panel in March 2014 (Appendix X), I contacted local and nationwide organisations and university student support services in the UK with the view of attracting their service users, supporters, students or staff to participate in the research. Various ED and mental health organisations agreed to place research advertisements on the organisations' websites, social media platforms, newsletters and local offices. As no prospective participants fitting the inclusion criteria contacted me for a number of months, I attained permission from the

LMU Panel to continue recruitment with modified participant criteria, as outlined previously. After this, I created a Facebook profile, which I used to post the research advertisement on various ED recovery and mental health support pages, as authorised by the organisations. Overall, I approached over 20 organisations and 15 university student support services and visited two ED support groups outside of London to find potential participants. LMU student services were excluded from this study.

In order to enhance my recruitment potential, I submitted an application to the NHS REC to gain permission to recruit in relevant NHS services in November 2014 and attained ethical approval in April 2015 (Appendix XI) after making the amendments to the relevant documents, as requested by the Committee (see Appendix XII for modified documents). Consequently, I applied for local approval through an NHS Trust, which I gained in August 2015 (Appendix XIII). While waiting to gain permission from this NHS Trust, I approached another Trust and gained permission to start recruiting through their ED service in November 2015 (Appendix XIV). Despite regular contact with both services, visiting one of the services twice and extending the period of access with NHS REC, I was unable to find participants through either. As I had identified only four participants by then, I looked into recruiting through an additional Trust. At this point, the Health Research Authority (HRA) had taken over as the party dealing with ethics applications. I was informed that HRA was overwhelmed with applications even for studies that had already gained NHS REC approval. I discussed these constraints with my supervisor and we agreed that I would stop recruiting as I had been looking for participants for approximately two years at that point.

3.8.5 Participants.

The aim was to recruit six participants for the study, but due to the difficulties with the recruitment, the study was completed with four participants. Finding these participants took approximately 18 months. The organisational structures in the NHS and the bureaucracy involved in getting ethical approval were considerable obstacles in the process, but they may not be wholly accountable for the level of difficulties. Several women with bulimic difficulties contacted me via non-NHS organisations wishing to participate. Yet, only a small number were in recovery and had not left therapy prematurely. This could be indicative of several things: for instance, individuals in recovery may not wish to revisit this potentially distressing period of their life and those, who were unhappy with their therapy experience, might be more willing to discuss it. Also, research has shown that EDs are related to high levels of shame and stigma and thus, this may have made it difficult for participants to come forward.

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The sample consisted of women, who met the inclusion criteria. Two were recruited through the ED charity Beat, one via a student mental health organisation and one was recruited through an ED support group. All participants had received CBT in the UK. They will be referred to by their pseudonyms to protect their anonymity. See Table 1 for participant characteristics.

Table 1. Participant Characteristics

Name (pseudonym)	Age (at interview)	Approx. Age of Onset for Eating Disorder Symptoms	Approx. Age of Starting CBT for BN	Practitioners Directly Relating to the Delivery of CBT Only
Emma	24	16	21	Female practitioner for assessment and treatment
Laura	26	13-14	24	Female practitioner for assessment and treatment
Sarah	34	11-12	18-19	Female practitioner for assessment; another female practitioner for treatment
Amber	18	10-11	16-17	Female practitioner for assessment and six months of therapy; male practitioner for the remaining six months of therapy

3.8.6 Interview schedule.

The interview schedule was developed based on the guidance of Smith and colleagues (2009) with the overall aim of being able to use it as a flexible guide, rather than a step-by-step list of questions. The main focus of the interview was to explore women's overall experience of the therapy and its impact. The key questions approached the therapy experience with a temporal stance, as the questions guided the interview from the time before seeking help through to being in therapy, and finally to the outcomes of therapy and their meanings for the participants. Additional probing questions were utilised as appropriate

to explore how the participants experienced different components of therapy. All questions were used flexibly during the interview so that the unique material brought by each participant could be attended to in detail.

The initial version of the interview schedule (Appendix XV) was piloted on colleagues at the university research group. Based on their feedback and the discussions with the supervisor, the schedule was revised to ensure that the questions were not leading, but flexible enough to allow the material arising in each interview to guide the interviews. The research supervisor was consulted during this process to spot any biases or other weaknesses in the schedule. This schedule was also piloted on colleagues to get a sense of how the questions may be experienced by interviewees. Feedback from these individuals was positive. There were no pilot interviews on potential participants, as finding participants was very challenging. Smith et al. (2009) suggest that pilot interviews with colleagues and peers can help the researcher to familiarise themselves with the schedule, but they do not make other recommendations regarding pilot interviews.

3.8.7 Data analysis.

The data was analysed in line with the guidelines by Smith and colleagues (2009). First the interviews were transcribed. After this the transcripts were re-read while listening to the interview recordings and any initial impressions were noted in separate notes. Transcripts were also re-read several times without the recordings. During the initial coding process, the transcripts were annotated for descriptive, linguistic and conceptual comments in the right hand margin. After this, the left hand margin was used to record emergent themes. The emergent themes were then recorded on sticky notes. The sticky notes were examined for any connections and those were deemed to share similar features were clustered together and consequently organised into tables containing master themes and relevant subthemes. This step took a considerable amount of time, as during the analytical process some of the themes moved from subthemes into master themes and vice versa. This process was first carried out on individual transcripts. Once a satisfactory theme structure had been established for each transcript, the theme tables were brought together in order to check for patterns across cases. Again, themes were interrogated until a satisfactory theme structure was established. Overall, the analytical process from developing emergent themes onwards was done twice, before and after a formal discussion with colleagues, as the initial themes were considered descriptive and the consequent analysis lacked evidence of interpretative work.

3.8.8 Ensuring quality in qualitative research.

In line with the guidelines provided by Elliot and colleagues (1999) for good quality research, the current study was explicit in its aims to carry out a scientific research study that contributes to the existing knowledge on the topic under study. Specifically, it was a qualitative study that acknowledged the role and impact of the researcher on the various stages as well as on the end product of the research project.

Credibility checks were carried out by discussing the findings with the research supervisor, presenting the initial themes and transcript of their interview to one of the participants and discussing the themes and analysis in detail with a fellow research student. Findings were also presented to a small audience in an IPA meeting, which was followed by a group discussion. These discussions helped me to identify that perhaps a part of me felt quite protective of the participants, as I was concerned that my interpretations would be experienced as judgemental or exposing by the women that took part in the study. In response to these, I engaged in further reflection on the justification for specific themes and interpretations. However, this was very difficult, as I felt quite trapped by my own concerns. Thus, it was necessary for me to continue revisiting these concerns in supervision.

Following a more formal discussion with professional peers, who were experienced in phenomenological research, and consequently discussing the feedback with my supervisor, I returned to the transcripts to ensure that the resulting analysis would shift from descriptive to a more conceptual, interpretative position. In practice, this meant revisiting each step of the analytic process from the development of emergent themes to compiling the master themes for all four participants. For instance, the original structure contained themes that presented a linear time line of the therapy experience with very CBT-focused content, whereas the revised themes appeared to move closer to the participants' experiences with less emphasis on existing theoretical assumptions about therapy and CBT. I feel that the space, time and support given by various individuals to revise the analysis enabled me to address my identified need to protect, and its impact on the analysis.

3.9 Ethical Considerations

This research study gained ethical approval from the LMU Ethics Review Panel and an NHS REC. It was also approved by Beat. I was then able to recruit participants through Beat's website and volunteer database.

3.9.1 Right to withdraw.

The research advertisement and the participant information sheet explained that participants could withdraw their consent at any point up to or during the interview and that after the interview they would have four weeks to withdraw their consent. Debriefing took place at the end of each interview to ensure that the participants had understood their rights regarding withdrawing from the study.

3.9.2 Confidentiality.

In line with the recommendations by the BPS (2009), participants' right to confidentiality were respected throughout the study. Participants were informed of their rights both verbally before the interview commenced and in writing on the participant information sheet. This included reassuring participants that their anonymity was protected in any verbal or written reports or presentations from the project, including any direct quotations from the interview. This was done by removing any identifying data from the transcripts and providing each participant with a pseudonym. The original interview data were kept securely in accordance with the Data Protection Act 1998 and any forms containing personal information, interview recordings and transcripts were held separately from each other in locked filing cabinets.

3.9.3 Potential distress.

The topic of this research study was considered sensitive under the guidance of the BPS guidelines on human research (2014), as it was likely to involve more than a minimal degree of risk to participants due to potentially causing discomfort, stress or psychological harm to the participants. This was also in line with the recommendations provided by the NHS REC applications telephone support service. A distress protocol was utilised to ensure that any participant discomfort or distress was addressed appropriately.

CHAPTER 4: ANALYSIS

4.1 Overview

This chapter presents the findings of this study in detail. The results were derived from four semi-structured interviews. Three master themes and nine subordinate themes were identified. They are presented in Table 2. All four master themes and seven of the subordinate themes were present in each interview. These are presented in Table 2. The themes will be expanded into narrative form in the chapter. The original transcript for Sarah (Participant 3) is located in Appendix XVI, a sample of the analysed transcript in Appendix XVII, and the individual themes in Appendix XVIII.

The themes and the narrative offer one possible account of how women experience CBT for bulimia and it is recognised that the account is subjective to the researcher. There were considerable similarities and differences between the participants' accounts and these are reflected in the material presented in each theme.

Short utterance, such as 'um' were removed from the transcripts unless they were considered to be important to the process of interpretation. Empty square brackets indicate that some material of the original transcript has been omitted. Square brackets containing a description refer to non-verbal gestures and communications. Three dots signify a brief pause.

The concept of 'control' and concerns regarding its loss and maintenance were central to all the women taking part in the study. They occurred at various points of the interview and the analysis in relation to other people, their eating difficulties and the therapy experience, for example. Temporally these concerns seemed to have a consistent presence in these women's lives from the early beginnings of their difficulties until the present day. During the analytical process, and arranging and rearranging of the themes, the concept of control was broken into smaller segments: master themes and consequent subthemes. Although not all themes explicitly discuss and name control, it is notable that the shadow of the concept was present throughout the process. The analysis begins by presenting 'Loss of control' as the first master theme. The latter themes, namely 'Staying on the surface' and 'Holding onto power' relate to the various actions that the women seemed to take to avoid losing control, and the impact of this on them.

Table 2: Master Themes and Subthemes with Quotes

Master Theme	Subordinate Theme	Quote	Frequency of Subtheme
Loss of Control	Reaching a Crisis Point	*"And he said, he said "You've got to, you've got to go." I told him I was being sick and that was when he said "If you don't tell someone, I will.""* (Amber, 27-28)	All participants
	Rejection	*"And 'cause they were saying "Well, you don't meet the criteria, you don't have an eating disorder, because you might be making yourself sick ten times a day, but you're not, like, you're not whatever size.""* (Laura, 80-82)	All participants
	Exposure	*"As soon as she saw that I was allowing myself to be more relaxed or exposed, she would like bore into the whole, like tear it open [participant laughs] to try and get me to be less kind of constructed and less kind of whole, I suppose, and more kind of fluid in my approach to the sessions, 'cause I think I'm quite like business-like about therapy, 'cause it's very intimidating."* (Emma, 1000-1006)	All participants
Staying on the Surface	Rational Therapy	*"It wouldn't require me to talk about... like my childhood or you know, she made it sound very practical. And that it deals kind of really with what you're doing right now and how to stop it, I guess. As opposed to... you know, looking back and kind of why I'd got here. I think, y-y-you know, she explained there would be certain amount of that, but not to the extent that the psychotherapy. And that had freaked me out."* (Sarah, 284-289)	All participants
	Keeping Others Happy	*"I was just worried that the treatment would stop and I wouldn't have support anymore, because I knew how hard it was to get support in the first place. So I was just worried that it would come across that I was non-compliant and I would get discharged."* (Laura, 584-586)	Laura, Sarah, Amber
	The Core Remains Untouched	*"I'm always scared to lose weight, because I'm scared to get obsessed again. [ ]I've been on hundreds of diets over the years, properly done Slimming World, Weight Watchers, that kind of stuff. But the problem is I get fully obsessed and I, I get, I get competitive, [ ] and I, I know it's just under surface. You know, it's like it's just like scratching the surface."* (Sarah, 660-664)	Emma, Laura, Sarah

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Holding onto Power	Hiding	"Neither to my GP, nor to my psychiatrist, nor to my therapist did I ever mention food. But I knew that I wasn't mentioning it. It wasn't a kind of a, it wasn't an issue and therefore it didn't come up. I, I decided it was something that I didn't want to have to. And I think that was part of the, I really didn't wanna have to have an eating disorder." (Emma, 615-621)	All participants
	Letting Others in – The Therapy Relationship	"The lady, she was younger, so she was closer to my age so more kind of relatable as well. [ ] She, she was more like a friend, whereas the second one had a much more kind of dominant… position over me. [ ] Like a sort of teacher or parent sort of thing. Whereas my first one, she was like sitting with a friend and telling her about it." (Amber, 439-443)	All participants
	Loss of a Safe Place, Struggling to Hold on	"I found it quite terrifying at the time, to be honest. Just because I wasn't expecting it, I guess. And she said that you know, I mean we'd been thinking about things anyway and I felt as though I hadn't had that conversation with her. Like I hadn't been thinking about ending things with her, like I hadn't been thinking that things were gonna end, because we hadn't spoken about things been going to end." (Laura, 744-748)	All participants

4.2 Master Theme 1: Loss of Control

The first master theme consists of three subordinate themes, all of which were present in each participant's account. The theme covers the time period from the critical incidents relating to seeking help to the participants having engaged in therapy for some time. Notably all accounts were similar in that losing control related to their eating issues, relationships with others and their experience of the therapy. The accounts were characterised by a sense of chaos, isolation and feeling unable to cope.

4.2.1 Reaching a crisis point.

Each participant spoke in detail about the time period leading up to them getting help for eating difficulties. All women had reached a crisis point, where the issues became increasingly chaotic and difficult to hide. Emma and Laura reported being very active in seeking help during this time. However, Sarah and Amber were forced to seek support by their families. The impact of the difference in this initial phase of entering treatment is also

observable in other parts of the analysis and will be discussed further in relation to relevant themes.

"But at this point I had the process of me starting uni, my eating getting really bad and then me leaving uni and seeking help, all happened within about a three month period. And it'd been so bad and so intense in that time that six months seemed like a very dangerous possibility. I mean, even with the seeking help, I did it and then take an overdose sort of thing." (Emma, 576-582)

Emma had been teetering on the brink of needing and seeking help for some time, but the issues intensified during life transitions in the form of starting university and moving away from home. Here she speaks about the relatively short period of deterioration that culminated in her taking an overdose. There appears to be a sense of chaos in her account with rapid changes feeling increasingly unmanageable and dangerous. During the interview she repeated several times how she had rejected her eating issues for several years prior to deciding to seek help. Being placed on a six-month waiting list when life felt chaotic seems to have felt unbearable. She perhaps felt that she could not trust herself to get through it. Thus, the overdose could be seen as an attempt to reduce this discomfort and tension.

"Whereas when I was bulimic, it was more. Like, I was feeling guilty all the time, that I was making myself sick. And it was like the opposite. I had hundreds of emotions. It was like emotional like out flow all the time and just like that was the sort of feelings of like desperation and stuff like that would sort of come up more then." (Laura, 157-160)

Laura also describes the chaos that ensued when she was experiencing bulimic difficulties. Laura's eating issues started with weight loss and restriction, but later developed into bulimia. Eventually these two "phases", as she called them, cycled in rapid successions. In the interview she contrasted the phases in a way that was rather split. When restricting, she felt invincible and did not think that there was a problem that needed attention. Yet during the bulimic phases everything felt out of control. Here she describes difficult emotions flooding her, which were reinforced by her purging. There also seems to be a strong sense of being trapped and overwhelmed in her account.

"I went to A&E... my friend, again in the nurses' home found me and took me to A&E. And I was, you know, I was really young. This time they phoned my parents and they came."   *(Sarah, 118-120)*

Similarly to Laura, Sarah also restricted her diet in the early stages of her eating issues. This lead to her physical health deteriorating and eventually she took an overdose due to feeling totally powerless to change her situation. Here she begins by demonstrating agency in relation to seeking help. However, this quickly fades away and the agency completely shifts to others around her: her flatmate, the hospital staff and her parents. Sarah had not perceived her eating to be an issue and had managed to avoid on-going interventions from others until this point. It is interesting how Sarah's denial and others' concerns interact in the quote, as her friend discovering her physical body after the overdose meant that her problems were no longer hidden and that others could already see what she refused to acknowledge. In addition to her feeling powerless regarding her issues, she was also very vulnerable due to her age and the overdose. Others stepping in meant that she was less able to maintain control, as after this hospitalisation Sarah moved back home and her family forced her into treatment.

"And he said, he said "You've got to, you've got to go." I told him I was being sick and that was when he said "If you don't tell someone, I will."" *(Amber, 27-28)*

Amber's account is somewhat different, as she had not felt out of control with her eating issues. However, she had been concerned that her behaviours, such as using diet apps on her phone at such young age were indicative of a problem. Here she describes sharing her concerns with her then-boyfriend. This meant that what had once been a private experience for Amber was suddenly something that she was no longer in complete control of, as the boyfriend threatened to share the concerns independent of Amber's permission. Later in the interview Amber described how this had escalated into her mother sharing these issues with others. Also, since she was underage, her mother had taken her to their GP. Throughout the interview Amber communicated a consistent lack of agency regarding her seeking and receiving support.

4.2.2 Rejection.

This subtheme relates to the pervasive sense of rejection that all participants experienced regarding others' perceptions of them and their eating issues. Overall, physical and mental health seemed to be considered rather separate by professionals and family members. It appeared that the lack of understanding presented by others was an important contributor to

the sense of rejection reported by all four women. The quotes selected for this subtheme illustrate the variation between the accounts, as feeling misunderstood, judged and isolated were some of the elements that were visible in relation to the central premise of rejection.

"I was just like "Yeah, I'd actually like to be treated, please" and he was just like "Yeah, that's fine, but you're not like about to die, so if you have the means to go private, I really recommend that that's what you do, because with bulimia in particular, especially if you're not really manifesting any really adverse health side-effects, it's gonna be difficult for you to get seen."" (Emma, 133-140)

Emma describes approaching her doctor in a very direct manner that indicates her being in control of the process. However, as she was turned away she no longer had the agency she perhaps expected to have in relation to accessing help. Interestingly "adverse health side-effects" is used to refer to physical health only, which perhaps highlights the unequal position between physical and mental health presented in the quote. Had Emma been in physical danger, she would have been provided with more support. Fortunately for her, she was able to follow her doctor's advice and access support privately.

"And 'cause they were saying "Well, you don't meet the criteria, you don't have an eating disorder, because you might be making yourself sick ten times a day, but you're not, like, you're not whatever size."" (Laura, 80-82)

Laura also discovered that her physical health was the main priority when she seeking help for her eating issues. Laura appears to have experienced her doctor's response as very dismissive because of her weight, as the NHS criteria meant that her weight was not low enough to get support. It took Laura several years and different doctors to get help. Even then she did not meet the criteria for specialist services, but was seen in a psychological therapies service. In this excerpt her use of the word "they" to describe those blocking her access to support could indicate her experiencing the whole health care system as rejecting of her difficulties. It seems that she felt discriminated against due to the type of difficulties she experienced. Elsewhere in the interview Laura described how these rejections contributed to her mental health deteriorating further. The impact of being turned away by professionals at this stage also seemed to impact on her consequent engagement in therapy, which will be discussed later.

"You know, people just really didn't get it. It was just like "For god's sake, you're thin, just stop. You know. Why are you getting yourself like this?" So yeah, it was just very lonely, really." (Sarah, 745-747)

As Sarah was severely underweight when she went into health services, she did not experience difficulties with getting help, but in her relationships with family and friends. Sarah's account communicates frustration and simple solutions offered by others. It also illustrates how isolating having the difficulties was. This may go some way in explaining why and how participants hid their issues from others: being rejected when feeling vulnerable may have been very painful and made it less likely for the participants to open up. Problems with family and friends were also consistently reported by other participants, as they were often experienced as rejecting due to not understanding the challenges of having an eating disorder.

"Like I said to him one time "I've cut myself as well" and he said "Oh, did you need stiches? Did you have to go to hospital?" And I was like "Oh, no. It wasn't, it was just cutting." And it made me feel like "I didn't do it bad enough." Like it wasn't, I'd never, I was never ill enough… for him…"   (Amber, 522-525)

During the interview, Amber spoke about her struggle to relate to her second therapist, who was a much older male. She seemed to have experienced him as a distant figure, who was intimidating and misunderstood her regularly. Here she describes attempting disclosure and indicating that it is not just food that is a problem. Although her therapist may have been checking for severity of Amber's self-harm to assess the level of intervention required, she appears to have experienced it as a somewhat blunt response. She often spoke about being highly sensitive to other people's judgement and constantly worrying about them rejecting her somehow. Not being considered ill enough was very central to Amber's experience of her issues, as she was very focused on her healthy body weight being the main barrier to her difficulties being understood and taken seriously by others.

4.2.3 Exposure.

All participants spoke about feeling very exposed during the therapy process. The exposure evoked difficult emotions, such as distress due to being unable to maintain own boundaries and lacking a sense of control over the situation.

"As soon as she saw that I was allowing myself to be more relaxed or exposed, she would like bore into the whole, like tear it open [participant laughs] to try and get me to be less kind of constructed and less kind of whole, I suppose, and more kind of fluid in my approach to the sessions, 'cause I think I'm quite like business-like about therapy, 'cause it's very intimidating." (Emma, 1000-1006)

Emma describes her therapy experience as a violent attack on her. She is using rather physical imagery to reflect on her therapist's actions. This could indicate discomfort and pain on both psychological and physical levels. Interestingly, this attack seems to have occurred when she was allowing herself to be more vulnerable. I wonder, if her laughter midway through was her deflecting the impact of the recollection, as she laughed several times during the interview when she was talking about difficult personal experiences. It also seemed to be in contrast with her general way of speaking. Emma attempts to provide an explanation for the therapist's intervention: it was done to challenge Emma's rigidity and so it was for her own good. Overall Emma appears to be displaying insight into her own patterns and why the therapist felt necessary to use brutal force to address them.

What was also typical to Emma's account was her framing her therapy as a medical intervention or a business affair. This implicates distance and power imbalance between her and her therapist. Also, her being "business-like" could indicate her being careful to manage her boundaries to protect her vulnerability, and keeping her cards close to her chest to win the best deal.

"I would find that during the sessions I was more scared about what she was thinking about what I had eaten, than actually being able to move forward. Because I was just so focused on that. [ ] I was so like "Oh my god, what does she think of this?" and "What does she think of that?" and "I can't have her having that food diary. Oh my god, she's taken it off me."" (Laura, 495-499)

Laura appeared to experience certain CBT interventions as very exposing. It seems that food diaries were a physical object symbolising handing over one's vulnerability. Her description has a sense of time stopping in these moments in the therapy room, as she became preoccupied with her therapist thinking of her unfavourably due to what she had written on the diary sheets. Letting go of control in therapy appears to have been extremely difficult for Laura and eventually she asked to stop with the diary sheets. It is interesting that this dynamic was not explicitly addressed in therapy, as fear of judgement was very central to Laura's experience in and out of therapy.

"I remember my dad kind of saying "It's like seeing you daughter being a drug addict, because", he said, "I feel like you're doing this to yourself and you're killing yourself and you don't realise that you're killing yourself." And he just said "You feel powerless to stop it, you just..." And I just remember thinking "What? You know. How can you see it as that, it's not even that bad." And I, but it really kind of, it was like a punch in the stomach."
(Sarah, 330-335)

Here Sarah speaks about her parents coming to the hospital after her overdose. Until then she had been able to hide the extent of her difficulties from her family. Sarah's account of exposure also has a physical dimension. She describes it as a punch in the stomach; it is a painful and violent attack on the body that is inflicted on her by an external force. There appears to be a tension in Sarah's account: on one hand a blind spot seems to have been uncovered, yet she is holding onto a state of denial. Her father's words suggest confusion regarding agency: is it Sarah or the illness that is in charge? He appears very frustrated with Sarah "doing this" to herself while being unaware of its impact.

"But I remember with him I had to do things like food diaries. So it was a very different. You know with her it was like… all that stuff… With him it was like "Write your calorie intake." And that was, oh it was just horrible. Horrible thing to have to do."
(Amber, 211-214)

Akin to Laura, Amber also struggled with food diaries. Her recollection provides further evidence regarding the lack of agency that she experienced regarding her therapy ("I had to…"). Here she contrasts her two therapists, which seems to split her therapy into two very distinct phases. She experienced the male therapist as a dominating character, who gave orders rather than negotiated in partnership. Amber's repeated use of the word "horrible" appears to underline her distress even when recalling her experience.

4.3 Master Theme 2: Staying on the Surface

The second master theme consists of three subthemes. It seemed that there was a general desire to avoid going too deep in therapy, which was supported by the therapeutic approach, as well as the participants' own ways of managing the process. Each participant considered CBT to have given them rationality and objectivity that they could use to address their eating issues. Most also spoke about focusing on appeasing others while they were in therapy, which was reflected on their engagement with the therapy process. Consequently, many felt that the core of their issues remained unchanged.

4.3.1 Rational therapy.

Each participant described their therapy as an experience that emphasised a rational and objective approach to their eating issues. In most cases there seemed to be a distinct lack of interventions addressing emotional experiences and in some cases the participants explicitly preferred this to a therapy delving deeper into the reasons for the difficulties.

"I mean like my therapist for bulimia making me do the diaries and different writing exercises and then reviewing those afterwards in order to understand how I think about stuff and why that might be and how I might be able to think about things differently." (Emma, 812-816)

Throughout Emma's account the process of recording and evaluating her thoughts seemed to be led by her therapist, who was perhaps allocated an expert role. The therapy process appears to have focused on practical tasks: writing thoughts down in order to be able to evaluate them objectively, and then rationally consider how to change the thought patterns. This approach suggests that our difficulties can be understood and dealt with rather simply by rationalising them and learning new ways of thinking.

Elsewhere in the interview Emma also spoke about gaining insight to the emotions accompanying these experiences. She presented a fair understanding of what her eating issues were really about. For instance, she was able to uncover deeper meanings, such as being an anxious person and her ED was a way to manage this anxiety. Yet the therapy seemed to have fallen short in dealing with these deeper and perhaps more pervasive issues.

"I feel as though it gave me what I needed in terms of a structure. [ ] I think with eating disorders you just feel so out of control. And I think the argument for this like structure like "Okay, I can do this or I can do this" or "When I'm feeling like this, I can do this." And that kind of appeals to... my sort of brain." (Laura, 632-636)

For Laura, therapy brought structure into the chaos that she had associated with bulimic difficulties. Being "out of control" seems to have caused discomfort for her, especially as she also described her anorexia as an exhilarating experience of being in control, even if this was just an illusion. Also, it is implicated that regaining a sense of control by having a structured and rational approach felt like a relief. There are multiple clues in the excerpt that communicate her being rather happy with the approach. For example, she describes the rationale, or "argument" for having structure as having available alternatives that focused on doing something to the emotional discomfort. Therefore the focus was possibly on moving

away from uncomfortable experiences rather than tolerating or exploring them. She also mentions how this approach suited her "sort of brain". Thus, the focus was on a body part associated with rationality and logic, as opposed to referring to the approach being a good fit to her as a person. Although this rationalising approach perhaps provided her with different methods that she could use to gain emotional relief, it seems to have had a limited impact on her, as discussed in the consequent subthemes.

"It wouldn't require me to talk about... like my childhood or you know, she made it sound very practical. And that it deals kind of really with what you're doing right now and how to stop it, I guess. As opposed to... you know, looking back and kind of why I'd got here. I think, y-y-you know, she explained there would be certain amount of that, but not to the extent that the psychotherapy. And that had freaked me out." (Sarah, 284-289)

For Sarah, CBT was presented as a practical therapy that would not require her to go too deep into the reasons why she developed the issues. Thus, her personal preference appeared to have been to avoid depth and to stay on the surface. The excerpt suggests that CBT was seen as a simple method that could be applied to problematic situations and it would not examine sensitive and challenging areas in as much detail as psychotherapy had done. During the interview Sarah also noted that she would not have been able to stay in therapy, had there been an expectation on her to examiner her early life experiences. However, retrospectively she felt that a deeper, more challenging approach may have resulted in more fundamental changes in her.

"Like two really different approaches to, to the... counselling... The first woman, she would like we'd do drawing up stuff and she'd tell me about, how like the brain works and things like that. Like activities. And then the second one was like very intense talking..." (Amber, 124-127)

Amber's two therapy experiences were in stark contrast and here she describes how her preferred therapist had focused on sharing information with her and used different methods, such as drawing, to take the focus of Amber. Overall it seemed that the therapist's aim had been to enable Amber to think about her issues with rationality and logic. The male therapist, however, expected her to engage in "very intense talking", which she found distressing to the extent of feeling paralysed in sessions. Thus, similarly to all other respondents, Amber enjoyed the practicality of the CBT, as practised by her first therapist.

4.3.2 Keeping others happy.

Three of the participants spoke about being very externally focused regarding their therapy experience: it had been very important to appease others and appear compliant. This was often done to mitigate feelings of guilt or for the fear of early discharge from therapy.

"I was just worried that the treatment would stop and I wouldn't have support anymore, because I knew how hard it was to get support in the first place. So I was just worried that it would come across that I was non-compliant and I would get discharged." (Laura, 584-586)

For Laura, some of the central concepts of her interview were her struggle to get help and her consequent concerns regarding her eligibility for care. Here she describes how she experienced pressure to appear compliant and unquestioning, as care and support were viewed as conditional on her being a good client. This indicates that not meeting the expectations of her therapist, she would have been abandoned and left with no support. This is an example of how some of the experiences preluding therapy may impact on the consequent therapy dynamics. This was also evident in Amber's account. However, Laura was able to address her concerns by seeking additional support from the eating disorder support group and then gained more confidence to bring up any struggles with her therapist.

"I don't think it was ever about how it affected me. I'd never thought that was that important. I was just like "Well, I just want to be thin, you know, and that's it." But when I understood more about how it affected other people… that helped me. [ ] I think I just felt such tremendous amount of guilt that it, it was like "I can't do this to other people.""(Sarah, 618-622)

This excerpt illustrates well how Sarah made sense of her treatment experience and need for support in the interview. There was considerable tension between her own wishes (i.e. wanting to be thin) and wanting to please others. She believed this tension to be a great contributor to her unhappiness. These two appeared to be closely intertwined, as she thought that becoming thin would mean becoming loveable, which in turn would mean that others would be happy with her. Here Sarah explains how being very externally focused and seeking validation from others contributed to her engaging in therapy and ultimately not acting out her desires for thinness.

Overall, her drive to please others seemed to be a rather complex construct. Firstly, it meant her self-worth remained bound to external events and thus it was vulnerable to any changes in her environment, yet it helped her to stay in therapy. It could also be suggested that it

enabled her to hold onto a sense of control, as she did not need to look inwards and examine why she devalued herself so much, but she could try and attain a sense of achievement by influencing how others respond to her because of her actions. Perhaps all this felt safer than moving closer to the core of her issues.

"You felt like you could have like nothing just in case he's like thinking he's wasting his time on you." (Amber, 300-301)

Amber also appears to have been very externally focused in her therapy. For example, her feeling guilty regarding the impact of her difficulties on her loved ones was one of the reasons for her wanting to recover. However, similarly to Laura, Amber also found completing food diaries very distressing, not least because she felt undeserving of the support she was given. Having "nothing" to eat felt like the only way to prove that she was in distress and needed help. Appeasing the therapist was a big part of the dynamic between her and the male therapist, whom she felt intimidated by. Unfortunately she did not seem to be able to address this with the therapist, but her therapeutic experience remained focused on her concerns regarding his judgement.

4.3.3 The core remains untouched.

Three of the women spoke about a central part of them and their eating issues not being addressed in therapy and thus, it has remained unchanged. They described how they are now able to manage this part better as a result of their therapy, yet it continues to have a constant presence in their lives.

"I'm very, um, I still am, it's probably I mean, if obviously there are certain ways of thinking that stay with me and I think that um... I suppose the main thing that I've learned is how not to... let my kind of... certain patterns of thinking lead me in to really negative cyclical things that will like deteriorate into destructive patterns of behaviour and just kind of learning to." (Emma, 276-282)

Elsewhere in the interview Emma spoke about being very controlled about how she speaks. This was also something that came across during our meeting, as she spoke clearly and eloquently for the most part. Thus this excerpt stands out, as there is considerable hesitation at the beginning. I feel that this relates to her struggle to articulate any criticisms of her therapy experience, which came up regularly during the interview. It may be that voicing her thoughts regarding therapy changes and any limitations regarding them was uncomfortable for her, as perhaps this would mean that the effort put into therapy was in vain, or that the

part that she originally rejected is actually part of her identity. For instance, she seems to begin by indicating something about her way of being, but then shifts the focus to different ways of thinking. This is potentially done to distance herself from the limitations by framing it in a safer, less disappointing way: although the troublesome thoughts have not gone away, she has learned to manage them more effectively and less destructively. It may also indicate a need to have some agency regarding the matter: rather than stating "I have not changed", she can hold onto a sense of mastery by doing the above.

"I think it's one of those things, like, it'll probably always be in my head, I guess, like, but it's just kind of controlling it. Control is probably the wrong word, but [participant laughs] you know, like, it's just kind of staying on top of it now, so I still go to… it feels, I don't feel as though it affects my life now." (Laura, 63-66)

Laura's account is very similar to that of Emma: although she acknowledges that there is a part of her that has remained unchanged, she has seems to have learned to control it. By stating that it will "always be in my head" she seems to be referring to her thought processes, rather than her as a whole, but also somehow accept it as something that will remain with her forever. Her laughter in the middle of the account is perhaps indicative of discomfort, as she becomes aware of her choice of words, since 'control' is a concept that is regularly brought up in relation to eating disorders. The quote also shows juxtaposition in the way Laura conceptualises her eating disorder: these difficulties will always be with her and require attention to be managed, yet she denies it having any impact on her.

"I'm always scared to lose weight, because I'm scared to get obsessed again. [ ]I've been on hundreds of diets over the years, properly done Slimming World, Weight Watchers, that kind of stuff. But the problem is I get fully obsessed and I, I get, I get competitive, [ ] and I, I know it's just under surface. You know, it's like it's just like scratching the surface." (Sarah, 660-664)

Sarah also spoke about there being something that had been left untouched by therapy. Here she describes her eating issues being right under the surface and even just a scratch could unleash it. Her account paints a picture of her ED being contained within her, yet the boundary is not very strong, but things could get very easily get out of control for her. Interestingly managing her weight is a big part of her managing her eating related issues. This also seems to fit in with her conceptualising her eating disorder as an addiction.

Dieting seems to have an important role in her present life, as it is something that she has engaged in repeatedly. During the interview she described how her current weight protects

her from becoming ill again and also manages others' perceptions of her, as others are surprised if they hear that she has had an eating disorder before.

4.4 Master Theme 3: Holding onto Power

The final master theme examines the internal mechanisms that all participants seemed to utilise to hold onto a sense of power and control before, during and after their therapy. Importantly, these factors did not appear to be borne out of therapy experiences, but rather appeared to be something that was characteristic to the participants. All three subthemes were present in each participant's account.

4.4.1 Hiding.

All four women spoke about hiding their eating issues both from their families and professionals working with them. In some cases they also seemed to be trying to hide the extent of the issues even from themselves. Hiding the issues appeared to serve multiple purposes, such as maintaining an acceptable social role and not having to address something that was perhaps experienced as part of their identity.

"Neither to my GP, nor to my psychiatrist, nor to my therapist did I ever mention food. But I knew that I wasn't mentioning it. It wasn't a kind of a, it wasn't an issue and therefore it didn't come up. I, I decided it was something that I didn't want to have to. And I think that was part of the, I really didn't wanna have to have an eating disorder." (Emma, 615-621)

Emma's quote relates to the time prior to her seeking help for her eating difficulties. It is interesting that she was able to try and get support for other mental health issues, but made a conscious effort to keep her eating issues hidden. Overall Emma rejected her eating difficulties for a long time before they deteriorated to the point where she was unable to continue with her day-to-day life as before. I believe that the hiding she is describing here was related to this rejection: by not addressing the difficulties she was denying their existence and thus she attempted to hide them from herself, as well as from others.

Although Emma's explanation focuses on her hiding the eating issues because she did not want the disorder, I wonder if not addressing the issues was partially about her reluctance to get rid of them. This hypothesis is supported by Emma conceptualising her eating issues as one manifestation of her personality as an anxious person, who likes to be in control. Thus, interfering with the core sense of herself perhaps felt too intimidating for her.

"So, I was always very, sort of, smiley and happy and apparently, to the outside world like that. And I managed to keep that up for quite some time and I also was like, if I was feeling really rubbish, like, I would just, I would say that it was my stomach. [ ] "I have to go home, because I've got all these problems with my stomach." And I guess everyone just kind of bought into that." (Laura, 235-240)

Laura describes a contrast between what is shown in public and what she kept private. Through this split she was able to maintain a happy public persona, as she knew that she was able to engage in bulimic behaviours once she got home. It seems that she was able to hide her eating issues inside physical health difficulties very effectively, as during the interview she told me that her eating issues had caused her to develop irritable bowel syndrome (IBS). Thus, she was regularly having stomach problems. It seems that considering her issues as physical health problems was acceptable to others and perhaps to herself also. Yet I also feel that she is highlighting here how physical health issues were so much easier to communicate, as they were received with acceptance and even with sympathy. Similarly to many other participants, Laura was also very sensitive to others' perceptions of her and thus this perhaps strengthened her need to hide what may have been deemed unacceptable.

"You know you can read kind of... they'd go "Oh you shouldn't have, you know, that was too many. Ten, maybe you should've taken eight. And next week try that." And I'd pick up on those little things really... [ ] And then next week I would. I wouldn't necessarily change, but I would write down that I'd done that." (Sarah, 693-699)

At the beginning of the excerpt Sarah seems to be confiding in me about the covert ways in which she was trying to manage the therapy process. She describes how she used to carefully "read" professionals' responses to her disclosures to be able to give the type of answer that would appease them. Sarah was overusing laxatives and she was meant to be working on this in therapy. However, although she may have appeared compliant on the surface, she continued with her old behaviours in private. This secretiveness allowed her to be able to continue with what she is doing without having to challenge herself to change, and to avoid judgement. Sarah was the only participant, who discussed deception in therapy in such an explicit way.

"'Cause I started to dislike the things that I was writing, when I looked back at them... And then I couldn't do them, because I didn't like having it there as a physical thing, it was awkward, so I had to stop doing that... in case someone got hold of it and... saw it."
(Amber, 840-844)

Amber also spoke about using written records as an example of her hiding her issues. She told me that she used to prepare to her sessions by writing down the things that she wanted to discuss, as she felt paralysed once she was sat in the room with her therapist. This was due to her feeling that her therapist expected her to discuss "deep" topics in the sessions. However, she was unable to make use of these records. This was partially due to her feeling that they were irrelevant when she then went into her therapy sessions and also because she was worried that the therapist would judge her on the basis of what she had written.

In addition, she describes how seeing her thoughts written down was very uncomfortable for her. Although she is concerned about others seeing the records and thus finding out more details about her issues, I am also wondering whether having them written down felt as a reminder of these thoughts and concerns. Thus, they would have been more difficult to dismiss, but rather they may have challenged Amber and her way of being.

4.4.2 Letting others in – the therapy relationship.

All participants spoke about their perceptions of their therapists. Overall each struggled to share their difficulties with anyone due to the reasons considered previously. This struggle was also at times reflected on the therapy relationship, as isolation, difficulties with opening up, and needing to be in control possibly made it very difficult. Despite these issues, all participants seemed to have created an alliance with their therapist, although the general sense of the accounts was that it was important for them to have a sense of control or power in these relationships.

"I think she was the head of the eating disorders unit or something quite formidable. [ ] But I think that they were very keen to get me in a room with somebody who would be quite... I guess quite assertive with me quite soon after that." (Emma, 744-751)

Here Emma describes how after her overdose she was very quickly assigned a therapist. She seems to be highlighting the powerful position that her therapist had in the service, and perhaps also in relation to Emma and her ED. Having a "formidable" therapist may have been intimidating and thus there is a distinct lack of any criticism or acknowledging of any shortfalls of the therapy experience throughout Emma's account of her therapy. I also

wonder if Emma felt rather powerful and important due to the therapist's position at the service, as in other parts of the interview she appeared quite happy with being noticed by others after her overdose.

At the end of the excerpt she appears to be indicating needing someone confident and firm to work with her, which may have been partially due to Emma considering herself to be a strong character, who would not benefit from having a gentler, and perhaps in her eyes a lesser therapist. However, having a robust therapist may have provided her with a sense of safety that she needed amidst the chaos of her illness that she was desperate to get rid of.

"I think that's a really useful thing because a counsellor or a therapist can't necessarily tell you that. Like you can't say "I've been there." I mean, it's a very one-way thing with counselling and therapy, whereas the group's a very two-way thing." (Laura, 1032-1034)

Accessing an eating disorders support group before, during and after her CBT was central to Laura's experience. Throughout the interview she described a sense of gratefulness in terms of how much attending the group had benefited her and how she is now able to support others that are working on their difficulties. Although she felt that therapy had been helpful for her overall, it had one major flaw: it was a "one-way thing" despite being described as a partnership to her. However, the group provided her with empathic understanding that made it feel like she was an equal.

In this excerpt she states "Like you can't say…" which seems to indicate that I was also viewed as a professional, who could not understand her experience as closely as a peer could, and neither could I share my story with her as a peer could. As Laura often felt misunderstood in her relationships with others due to her eating issues, I believe that this dynamic was also repeated in her therapy relationship at least partially and perhaps contributed to her guarding her boundaries closely. In contrast, in the support group she could open up and share the different elements of her journey.

"She was probably about my size actually. Like now. And I, but I just couldn't, couldn't do it. Just couldn't. It was really weird. And she was really lovely, but… just couldn't. And the way I, the girl that I ended up doing all the work with was quite young. And she was slim. And I think it just, it was fine in my head." (Sarah, 511-514)

Sarah was initially assessed by a female practitioner, whose size alarmed Sarah immediately. She was not able to address the issue with the assessor or the consequent psychologist, but took it up with her GP instead. Interestingly, despite previously reporting a very low

motivation for engaging in therapy, she chose to return to her GP in order to continue with the support. Perhaps there was a part of her that recognised the need to address her issues.

The assessor's size could have made Sarah question her ability to work on eating issues, as she may have thought that the professional also had issues with food. Elsewhere in the interview Sarah spoke about previously not being able to respect people, who were not thin, as thinness was her ultimate goal. In light of this, I am wondering how she experiences the current similarities between her own current size and the size of someone that she had rejected because of their weight. There is quite a contrast in the way she seems to have related to the two professionals, as her psychologist was a newly qualified, young and slim "girl". Perhaps Sarah felt that she needed a therapist, whose characteristics she could admire, such as her weight and possibly her intelligence, while sharing some characteristics, such as her gender and age.

"The lady, she was younger, so she was closer to my age so more kind of relatable as well. [ ] She, she was more like a friend, whereas the second one had a much more kind of dominant… position over me. [ ] Like a sort of teacher or parent sort of thing. Whereas my first one, she was like sitting with a friend and telling her about it." (Amber, 439-443)

Amber's perception of the relationship with each therapist appears to have been very much influenced by the therapists' age, appearance and gender. Possibly she perceived her female therapist as an equal, where the therapy sessions felt like opening up to a friend, while the male therapist was an authority figure, who she could not really talk to. Her use of words "position over" to describe the dynamic between her and the male therapist could indicate Amber feeling intimidated in the relationship. Interestingly, she uses the word "lady" about her female therapist, whereas elsewhere in the interview she refers to the male therapist as "the bloke". This may provide further support to the stark contrast she experienced between her therapists: elevating the female therapist and dismissing the ability of the male therapist to work with her.

4.4.3 Loss of a safe place, struggling to hold on.

All participants spoke about the sense of loss that they experienced when their therapy came to an end. In Amber's case, her therapy took place in two rather distinct halves, whereby she felt abandoned by her first therapist, but conceptualised the actual ending of her therapy very differently. The rest of the participants described feeling lost, and concerned about their ability to cope post-therapy, yet none of these concerns resulted in a deterioration regarding the eating issues for which they had initially received support.

"I was just like "Wow, now I have to do this for myself" and it felt, it did feel to a certain extent like the, all of the responsibility was being put back upon me in a way that was quite scary. But I dealt with it, so she was obviously right to an extent that I was ready to do that. But that was a very, that was sort of similarly destabilising as having to do the whole thing in the first place."   *(Emma, 1124-1130)*

Emma's response to her therapist discussing the ending appears to have related to her concerns about being able to manage responsibility on her own. Emma may have felt that the therapist had been shouldering some, if not most, of the responsibility, as she had been a robust professional guiding her through therapy. The way in which the responsibility was returned to Emma was "scary", perhaps because it felt so sudden for her and she had not yet had time to process it. Similarly to before, Emma describes her therapist being right "to an extent" with the timing of the discharge, but perhaps there was something that she had missed and Emma had not been able to communicate to her. Overall, Emma's description of the impact of ending therapy gives a sense that maintaining balance was like walking a tightrope and changes threatened the stability that she had worked so hard to sustain. Laura seems to have shared Emma's concerns about the therapy coming to an end.

"I found it quite terrifying at the time, to be honest. Just because I wasn't expecting it, I guess. And she said that you know, I mean we'd been thinking about things anyway and I felt as though I hadn't had that conversation with her. Like I hadn't been thinking about ending things with her, like I hadn't been thinking that things were gonna end, because we hadn't spoken about things been going to end." *(Laura, 744-748)*

Although therapy had largely been a positive experience for Laura, the discharge process was a disappointment, as it was so unexpected. It seems that the therapist and Laura had different understandings of the extent to which the discharge had been planned. Laura also indicates a reluctance to think about her therapy ending. Not thinking about it could have felt like it would not become reality. On the other hand, she possibly expected the therapist to take the lead in approaching the subject and making it more explicit.

"'Cause I guess it was a safe space for me to go every week. And talk about things and you know, it, it was a nice area, I guess. So I was scared coming up to the end, because I was like "Well, what am I gonna do now?"" (Sarah, 782-785)

It appears that the therapy appointments provided Sarah with a sense of safety, even if she was not able to be completely honest or open. Just as others, Sarah was also worried about managing the ending and seems to have felt rather vulnerable at this point. She told me that she had been able to identify someone in her private life that she could approach, as necessary. Interestingly, this person was a professional that had been a youth worker in a centre that she had attended. Thus, Sarah seems to have felt most at ease with professionals rather than exposing herself to family and friends.

"But it was, when I left, I remember the day I left. It felt like a bit of weight off the shoulders… because I felt like officially not being there meant that I didn't have it." (Amber, 938-940)

Out of all four interviewees, Amber had ended her therapy most recently prior to taking part in the research interview. For her, the ending of therapy was mainly associated with a sense of relief. Interestingly, she uses the phrase "weight off the shoulders" here, as although it probably referred to the sense of freedom she experienced, her body weight had been very much on her mind throughout therapy, as discussed previously.

The relief that she is describing may have been due to her struggling to work with the male therapist, as her ending therapy with the female therapist had been tainted with feelings of abandonment. As she continued to work with the male therapist for six months after this, the extra time could have allowed her to move further along her journey of addressing her difficulties. Thus she may have felt less vulnerable. However, her quote suggests simplicity in how she conceptualised her illness and recovery: the ending of therapy also signified the official end of her illness. Since her therapy had ended fairly recently, it may be that she had not yet faced many situations where she had to evaluate her conceptualisations of illness and recovery, as others' accounts reflected more complex processes regarding both.

CHAPTER 5: DISCUSSION

5.1 Overview

This chapter brings together the information presented in the thesis thus far and evaluates the findings of the current study in relation to existing research and literature. This study sought to answer the following research question: how do women experience CBT for the treatment of bulimia? The interview schedule encouraged the participants to reflect on their experiences regarding from seeking to receiving therapy, and its overall impact.

5.2 Summary of Findings

Three master themes were identified in this study: Loss of control; Staying on the surface; and Holding onto power. Each master theme had three consequent subthemes. Overall, all three master themes were found to be underpinned by the concept of 'control', as concerns regarding its maintenance, loss and regain seemed to be central to all four women. These concerns seemed to have a long-lasting presence in relation to the women's relationships with others, their eating difficulties and the CBT experience.

'Loss of control' related to the participants experiences of losing control and its impact on their help-seeking, as well as their relationships with others and the therapy process. The women's accounts shared a sense of chaos, isolation and feeling unable to cope. It seemed that there was a general desire to avoid going too deep in therapy, which was discussed in more detail in the second master theme 'Staying on the surface'. The therapeutic approach appeared to lend itself well to this desire and also support the participants' individual ways of managing this process. Consequently, many felt that the core of their issues remained unchanged. The final master theme, 'Holding on', considered how the women tried to hold onto a sense of power and control before, during and after their therapy. These factors seemed to be something that was characteristic to the participants rather than a response to the therapy experience.

The results from the study may not be generalisable beyond this study due to the small sample size and the nature of IPA research. However, as noted previously, some of the findings are in line with various studies carried out on larger groups, while others are novel to this research and have not been previously examined.

5.3 Master Theme 1: Loss of Control

5.3.1 Reaching a crisis point.

All participants in the current study described critical incidents preceding them seeking support and entering therapy. There was a distinct difference between those, who seemed ready to address their issues and those, who appeared to be externally focused in their help-seeking: Emma and Laura reported feeling desperate to address their difficulties due to the issues interfering with their lives and wellbeing, and as a result they persisted with help-seeking despite challenging encounters with support services. However, Sarah and Amber appeared to be somewhat in denial regarding their eating issues, and others forced them to seek help. All four had a shared sense of losing control over their lives and difficulties at this point.

Previous research regarding clients' experiences of CBT has suggested that hitting rock bottom prior to seeking and receiving help is a theme that appears across different psychological difficulties (Vincent et al., 2010; Cheng, 2014). Broadly, help-seeking for eating issues has been associated with various challenges. For example, many are unlikely to seek treatment, but try and hide their symptoms (HSCIC, 2009; Judit, Schmidt & Pilling, 2005; Hoek, 1991). A recent systematic review regarding help-seeking in EDs included quantitative, qualitative and mixed-methods studies (n=13) discovered that stigma and shame, as well as fear of losing control and fear of change, were common barriers to seeking help (Ali et al., 2017). Troop, Allan, Serpell and Treasure (2008) also noted that bulimic difficulties have been associated with internal shame (feeling ashamed) especially in women (Troop, Allan, Serpell & Treasure, 2008).Thus, the current findings were very similar to previous ones.

5.3.2 Rejection.

All four women reported a widespread sense of rejection regarding others' perceptions of them and their difficulties. This included friends, family and health care professionals. Feeling dismissed by others appeared to be a long-standing issue, and it intensified when the women were trying to address their difficulties. It also seemed to be a somewhat dynamic construct, whereby the women reported being very sensitive to other people's judgements, but also had experienced dismissive attitudes and comments from others regarding the nature of their difficulties. All participants appeared rather powerless and defeated in the

face of such responses and consequently spoke about the impact of this on their help-seeking and on opening up to others.

Similarly to the findings by McClay and colleagues (2003), many in the current study struggled to access support due to their GPs being unsupportive and the participants not meeting the strict criteria for ED services as stipulated by the NHS. The challenges in attaining treatment for eating difficulties have been discussed in the media over the recent years. It has been argued that health services determining the level of need based BMI can put people's lives at risk, as under-weight patients are prioritised due to physical risk. Thus, those with bulimic difficulties or BED are likely to wait for treatment for excessive amounts of time (Campbell, 2015) or they may even be refused care (McCubbin, 2016). The participants in the current study spoke about the impact of the long waiting time on their mental health, while they were still trying to get into treatment. For instance, depression, deteriorating eating issues and overdoses were described as responses to the lack of available support. The difficulties in attaining treatment also seemed to have an impact on their therapy engagement and relationship with the therapist.

Delays in seeking and receiving help for disordered eating are problematic, as previous research has suggested that bulimic difficulties often go undetected in health care services and are likely to become chronic if not detected early. Also, residual symptoms relating to body image, psychosomatic symptoms, anxiety and low self-esteem often continue even after the individual is no longer engaging in ED behaviours (Keski-Rahkonen et al., 2009). Problems with employment, relationships and fertility are also likely amongst this group (HSCIC, 2009). As mentioned in Section 5.3.1, many do not seek help for their eating issues due to various barriers, including shame. The struggle in obtaining support due to service-based issues, as well as difficult emotions associated with the condition, is likely to cause a delay in receiving appropriate support, which in turn has been associated with an increased risk in therapy drop-out (Byrne et al., 2011; Carter et al., 2012).

5.3.3 Exposure.

All participants described experiencing unexpected exposures regarding their difficulties. In most cases, these took place in the therapy room with the therapist, while Sarah felt this way about her father's words prior to her engaging in therapy. Broadly, feeling exposed was in stark contrast with the apparent need to be in control, and thus understandably evoked challenging emotions. Two of the women used physically violent imagery to relay their experience of exposure, which suggested that the boundary violation experienced in relation

to the incidents was both a physical and a psychological struggle. With all, there appeared to be a sense of shock associated with the exposing incident.

The interventions that focused on eating behaviours, such as food diaries and records of binges and purges, were experienced as exposing and shaming. Interventions that related to weight, such as regular weighing, often triggered thoughts about not being worthy of treatment. However, no previous research has examined the aspects of therapy that may be especially challenging or unhelpful for clients undergoing CBT for eating issues. Interestingly, Nilsson and colleagues (2007) found that those, who spoke about their CBT experiences favourably, considered being forced to confront their fears as a necessary step in facilitating change, although the quality of the therapy relationship was important in this process. The differences between the findings in the current study and those of Nilsson and colleagues may be partially explained by dissimilar study samples. In this study, the participants reported high levels of shame in relation to the challenging interventions and they seemed to have internalised the narratives offered by those around them, such as medical professionals. This was absent in the study by Nilsson and colleagues. The experience of shame in relation to bulimic issues was also discussed in Section 5.3.1.

5.4 Master Theme 2: Staying on the Surface

     5.4.1 Rational therapy.

CBT aims to enable the client to become their own therapist through developing sufficient skills and insights to monitor and modify problematic beliefs, thoughts and behaviours. In CBT-E, this should be done in a limited time frame, and the therapy process should involve behavioural experiments and cognitive restructuring.

In the current study all participants felt that their CBT approached the eating issues in a rational and objective manner. The examples of interventions that were discussed in this context included meal plans, thought diaries and psychoeducation. Therefore, interventions that were typical to CBT were considered. Many participants described also using their skills post-therapy. These findings are somewhat similar to several studies examining clients' experiences of CBT (Messari & Hallam, 2003; Clarke et al., 2004; Nilsson et al., 2007; McManus et al., 2010; Onslow et al., 2015). However, the participants in the current study did not respond positively to all CBT interventions, such as food diaries, unlike those taking part in the other studies mentioned here. Interestingly, Nilsson and colleagues noted that individuals, who had undergone PDT mostly spoke about increased self-understanding, self-acceptance and changes in how they related to others. Thus, the broader focus of PDT

seemed to evoke changes that related to the participants way of being, rather than attempted to fix a specific issue with interventions targeting the symptoms specifically.

In this study, interventions examining the emotional experiences of the participants seemed to be largely absent. Some explicitly preferred a rational approach to any alternatives that may have examined the origins of their difficulties in detail. Only one participant described gaining deeper insights regarding herself as a person and the role of her eating issues in protecting her from experiencing unwanted parts of herself. Alternative approaches to CBT suggest more explicit ways of working with emotional experiences amongst those with disordered eating, especially when the core of the issues appears to relate to affect regulation and consequent maladaptive coping strategies, such as bingeing or self-harm, rather than on weight and shape concerns as proposed by CBT-E (Fairburn, 2008). For instance, Corstorphine (2008) describes interventions based on schema therapy (Young et al., 2003), which would be especially useful with emotionally avoidant clients that utilise food and the function of eating to cut off from or manage challenging emotional experiences. Notably, Corstorphine argues that addressing the underlying issues with affect regulation would lessen the likelihood of the client substituting problematic eating behaviours with another method, such as self-harm. Dialectical behaviour therapy (DBT; Linehan, 1993) may also allow clients to develop ways to relate to their emotional experiences in ways that lessen the need to utilise food, or other unhelpful methods, to manipulate overwhelming emotions.

5.4.2 Keeping others happy

Three women spoke about being externally focused regarding their therapy experience. For them, it had been vital to appear compliant and ensure that others were happy with them. This was especially the case with those, who were forced into treatment by family members and remained there to avoid feeling guilty for concerning others. For Laura, this was somewhat different, as she was driven to get better, yet she seemed to view the therapist as the gatekeeper, who could discharge her if she was deemed to be non-compliant. Emma's account did not consider the impact of her actions on her therapist or others, although this could be explained by her being very compliant and appearing reluctant to evaluate or discuss the therapy relationship during the interview. Thus, she did not feature in this subtheme. Broadly, the participants employed different methods to appease others. For instance, Sarah utilised covert techniques to avoid being disapproved of. This suggests that even if clients continue to engage with interventions on the surface due to the demand from the therapist or their own internal pressures, they may manage the emotional discomfort by utilising covert methods.

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Interestingly, those attending a group treatment for eating issues have reported increased self-confidence, and an enhanced ability to maintain boundaries and be assertive with others (Laberg et al., 2001). Laura also spoke about being able to assert her views better due to the support she received from the ED support group. This suggests that clients may benefit from the support of their peers in similar situations to increase their ability to maintain and express their views. The power imbalance in one-to-one therapy may make this difficult, especially as many seem to struggle with self-esteem and confidence issues. Being aware of the clients' potential desire to please their therapist could enable clinicians to be more mindful of the therapy relationship, as well as use relational interventions to help the clinician and the client to address this dynamic in therapy. However, Waller (2009) and Fairburn (2008) assert that clinicians must not diverge from the manual and utilise the interventions flexibly. Research concerning the therapy relationships in individual therapy may help to illuminate the issue further and will be discussed in more detail in Section 5.5.2.

5.4.3 The core remains untouched.

Although all participants felt that they no longer had an ED, many suggested that parts of the psychopathology relating to their ED had been left unattended in therapy. Most described feeling more able to manage the unchanged part as a result of their therapy. This part appeared to be a central and stable feature to their experiences of themselves, as well as of their eating issues. Amber was the only participant, who considered the end of her psychotherapy to signify the end of her disorder without much further reflection. Thus, she does not feature in this subtheme. Sarah separated the thinking and acting parts of bulimia and considered herself to still be "thinking like a bulimic". Overall, the findings suggest that although changes on a behavioural level benefited the clients in terms of enabling them to re-engage with other parts of their life, the therapeutic changes seemed to lack depth.

Previous research has indicated that those, who were dissatisfied with their CBT experience, felt that it lacked depth and dealt with issues superficially (McManus et al., 2010). Clients with CBT-E experiences have also reported similar concerns (Onslow et al., 2015) despite Fairburn (2008) asserting that the improved version of CBT for eating issues (CBT-E) would address the underlying emotional components. As suggested by the findings of Onslow and colleagues, CBT perhaps enables change at a surface level focusing on those elements of the illness that are easily available. Consequently, the fundamental components of these types of difficulties seem to be left unaddressed and residual difficulties with core perception of self persist. Interestingly, Nilsson and colleagues (2007) discovered that those with an experience of PDT felt that their therapy got to the core of the problem. Also, there was an

increase in reported insight and positive changes in how they related to themselves and others.

The findings in the study are not surprising, as eating issues have been understood to be egosyntonic and CBT-E does not consider questions regarding the person's identity and its development, for example. All four women described their difficulties beginning when they were young adolescents, and felt unhappy, but powerless to change their circumstances. The difficulties seemed to have escalated in association to major life transitions, such as parental breakups, changing schools and starting university. Erikson's psychosocial development theory (Gray, 2002) suggests that our developmental tasks in adolescence and early adulthood relate to forming our own identity and developing intimate relationships with romantic partners. The stage theory heavily draws on psychodynamic ideas, but also focuses on the role of social relationships. Difficulties during these two stages are likely to result in the person feeling confused about who they are (their identity) and feeling excluded from experiences, such as exploring and developing romantic relationships. In both cases, the individual is likely to feel isolated and rejected, much like the participants in the current study described feeling. Notably, all women attended psychotherapy in their adolescence and/or early adulthood. There are various reasons for why undergoing therapy during these life stages could have been very beneficial to them. For instance, the therapist could have potentially supported them to negotiate the developmental crises associated with the stages, as per Erikson's theory. Also, the therapy process could have served as a platform for self-discovery and exploring the emerging identity.

Within the existential framework, identity difficulties could be a result of a 'split'. Spinelli (2005) suggests that within the existential framework such isolation could be understood to be a result of a 'split'. That is, the individual experiences a sense of internal split, or fragmentation within the self. There is a distinct separation between those aspects of self that are accepted by the individual, and the aspects that are unacceptable and the individual tries to keep them at bay and rejects them

Identity issues have also been examined from a cognitive perspective. For example, it has been suggested that difficulties in identity development can contribute to the development and maintenance of eating issues through negative self-schemas, i.e. the knowledge and beliefs held about the self (Stein & Corte, 2007). Stein and Corte discovered that those with anorexia or bulimia reported more negative self-schemas and less positive self-schemas than those in the control group. The researchers also examined the presence of the body-weight schema, and discovered that those with bulimia were especially likely to select adjectives

that related to being fat. Thus, their self-schemas were biased towards seeing self in a negative light and considering self to be fat, independent of the actual body weight and size. The researchers argued that individuals with negative self-schemas are less likely to be able to engage in behaviour change, for example. Consequently, the usefulness of CBT focus on working with thoughts and behaviours relating to weight was questioned: They argued that interventions, such as food diaries, may heighten the presence of the fat schema, while also failing to take into account the presence of 'identity impairment' (i.e. highly negatively biased views of the self). Thus, interventions should focus on developing more positive self-schemas.

Thus, although CBT may be quite effective in targeting specific cognitions and behaviours associated with eating issues, the approach may fall short in contributing to a more fundamental change involving moving beyond the obvious and addressing issues behind the observable manifestations of psychological difficulty. Clinical implications for clinicians working with identity concerns, while adopting a multi-theoretical approach will be discussed in more detail in Section 5.7.

5.5 Master Theme 3: Holding onto Power

5.5.1 Hiding.

In the current study, each participant spoke about attempting to hide their eating issues from professionals, peers, family members and even themselves. Secretiveness regarding the difficulties seemed to have multiple functions: it was a way to maintain a sense of control, to avoid feelings of shame and to reject the issues as part of the self, for example. Maintaining privacy over the issues seemed to be a process that permeated participants' lives in various ways. For example, there seemed to be a split between their public and private personas. Having access to the problematic coping strategies in private, i.e. behaviours relating to food, enabled some of the participants to maintain a public persona that felt acceptable to them.

Thus, similarly to McClay and colleagues (2013), all participants thrived to protect their privacy by hiding and engaging in secretive behaviours. In the current study, most women openly reported feeling incredibly lonely and isolated as a result of hiding themselves and their issues from others for the fear of being judged. In both studies secrecy and hiding seemed to provide the participants with a sense of safety, but it was also a trap leading individuals isolated and without support. Spinelli (2005) suggests that within the existential

framework such isolation could be understood to be a result of a 'split'. That is, the individual experiences a sense of internal split, or fragmentation within the self. This internal split thus has implications for the individual's experience of their identity, concept that was discussed in more detail in Section 5.4.3. Spinelli proposes that there is a distinct separation between those aspects of self that are accepted by the individual and the aspects that are unacceptable and the individual tries to keep them at bay and rejects them. Also, a similar separation is experienced in relation to self and others. Others are perceived as risk to the individual's self-autonomy. In this case, the individual avoids contact with others to maintain a sense of safety. In the current study, this withdrawal seemed to occur to maintain a sense of control, and thus safety. Revealing self to others was risky, and being found out felt even violent, as discussed in Section 5.3.3.

5.5.2 Letting others in – the therapy relationship.

Each participant in the study struggled to share their issues with others for the reasons discussed previously. The struggle was also present in the therapy relationship. Isolation, fear of rejection, and needing to be in control seemed to make these relationships challenging. Overall, the relationships and personal boundaries appeared to be carefully managed by the women, for example by rejecting therapists, who did not feel safe or were deemed too demanding.

Some were explicit about how the therapist's characteristics may have impacted on their relationship, while for others the impact seemed to be more subtle. For example, those with external motivation for engaging in therapy seemed to focus on the external characteristics of the therapist, such as weight, age and gender. Fairburn (2008) suggested that the therapist's gender does indeed matter in CBT-E, as the therapist could act as a role model for the client. In the current study, all participants spoke positively of their female therapists and in some cases their descriptions were somewhat admiring of the therapist's appearance and perceived intellect and experience. Amber was the only participant with the experience of working with a male therapist and considered this relationship very challenging, mostly because of the observed differences in terms of age and gender. Fairburn proposed that therapist's size and weight would not be relevant, unless the therapist was of a similar age. Only Sarah commented upon the size of one professional, as she had deemed the assessor to be too big to be able to work with her. The rest of the participants did not comment on this aspect of their therapist's appearance.

Studies regarding clients' CBT experiences have placed great importance on the therapy relationship, which is similar to the findings from the current study. In quantitative research, having a good relationship with the therapist has been positively associated with reduction in bulimic behaviours (Constantino et al., 2005). When the therapy relationship in non-ED populations has been examined qualitatively, trust, respect and openness have been highlighted as its important characteristics (Messari & Hallam, 2003). More specific factors, such as the therapist's position in the organisation and their perceived level of experience in working with eating difficulties has been found to be positively linked with the extent of perceived empathy. Empathy and a non-judgemental stance enabled open and trusting relationships and were valued by the clients (Onslow et al., 2015). This was somewhat echoed by the current findings: for some, the therapist's perceived level of experience seemed to evoke admiration and intimidation, whereas others appeared somewhat indifferent.

Interestingly, Nilsson and colleagues (2007) found that CBT therapists specifically were viewed as experts, when the experiences of CBT and PDT were examined. Those reporting positively on the therapy experience felt that CBT therapists were actively present by structuring exercises and providing explanations. PDT therapists, however, were described as understanding, integrating and having a presence, even when they were silent. Those, who were dissatisfied with their therapy perceived their CBT therapists to be intrusive and rigid, whereas PDT therapists were considered aloof and unavailable. Broadly, the evaluations of CBT therapists echo the findings of the current study, as all participants appeared to position the therapist as an expert that was difficult to challenge or question. There also appeared to be a power imbalance in the relationships. The women tried to manage this in various ways, such as by withholding information, appeasing the therapist and so on. Spinelli (2005) suggested that positioning the therapist as the law-maker and meaning-constructor is an attempt to fend off existential anxieties, such as concerns regarding one's identity and whole existence. Thus, it acts as a barrier to gaining a deeper understanding of the 'symptoms'. In the current study, there appeared to be a strong desire to remain safe and in control, as discussed above. Thus, in the context, positioning the therapist in this way perhaps served as another way of avoid going too deep in therapy.

Although the current study focused on individual therapy experiences, research on CBT for EDs in group settings has suggested that encountering others, who are struggling and addressing their eating issues can provide relief to the sense of isolation reported by many (Laberg et al., 2001). For Laura, this was very much the case and she valued the input from

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her peers perhaps above that of her therapist. However, in other clinical populations one-to-one therapy has been found to reduce isolation directly (Clarke et al., 2004; Vincent et al., 2013) and indirectly through increased acceptance of self and others, and thus being able to share more with others (McManus et al., 2010).

5.5.3 Loss of a safe place, struggling to hold on.

All participants described a sense of loss regarding the end of their therapy. In Amber's case, her therapy took place in two rather distinct halves, whereby she felt abandoned by her first therapist, but conceptualised the actual ending of her therapy very differently. The rest of the participants described feeling lost and concerned about their ability to cope post-therapy. Overall, none of the women reported relapsing after being discharged from therapy, although two mentioned experiencing 'blips' over the years.

Although previous research findings indicate that after many report signs of relapse at follow-up (e.g. Agras et al., 2000; Fairburn et al., 2015), the discharge process and its impact on the clients have not been examined much within this client group. In the current study, all participants described feeling anxious regarding their discharge from therapy. For some the process had been managed in the way that was experienced as helpful. Their therapists had discussed the discharge and considered the available support in case of post-therapy crisis several weeks prior to ending the therapy ending. For others the ending had been sprung on them unexpectedly, which felt overwhelming. Fairburn (2008) suggested that the ending of therapy should be carefully managed to minimise risk of relapse. Also, he recommended framing therapy as a step towards overcoming eating issues, rather than as the end of the process. Laura especially felt that this would have been helpful. Since her therapist did not discuss this explicitly with her, she was left feeling as though her issues were not going to improve any further. Amber was the only client, who experienced two endings of a therapy relationship in her CBT. She was also the only one, whose discharge seemed to be encouraged by her turning 18 soon and thus not being eligible for the care within children and adolescent services.

The findings highlight clients' sense of vulnerability at the end of therapy. This vulnerability could increase the risk of relapse, for example, especially if there is no alternative support available and if the individual had previously relied on their ED to manage difficult emotions and experiences. Thus, creating end of therapy plans and relapse prevention plans together with the client could serve as a valuable intervention on many levels. Although some of clinicians use workbooks for this purpose, reviewing the therapy process and

planning for the future can also be done verbally. This could help the client to recognise any changes, even those that would not be captured by outcome measures focusing on specific symptoms. It could also help to highlight any areas that the client may wish to continue working on, for example, in future psychotherapy or through self-help methods.

5.6 General Observations Regarding the Findings

Interestingly, the physical body was not central to the women's reflective accounts, although all mentioned being dissatisfied with their appearance and this contributing to them developing eating issues. Also, Laura considered her IBS, a condition impacting on the gut and digestion, to be a result of her disordered eating. Emma, however, spoke about how her partner seeing her body enabled her to challenge her "body dysmorphia". Yet, there was minimal discussion regarding the impact of therapy on the participants' body image. Only Sarah spoke about her body image and overvaluing thinness remaining unchanged post-therapy.

The impact of identity difficulties caused by unsatisfactory resolution of developmental crises as described by Erikson's psychosocial developmental theory (Gray, 2002) and the existing negative perceptions of the self (Stein & Corte, 2007) was briefly discussed in relation to the subtheme 'The core remains untouched'. Considering the development of eating issues in relation to early experiences may provide an additional viewpoint on the matter. For instance, bulimia has been suggested to be a disorder of the self that arises as a result of developmental deficit between childhood and adolescence. The deficit refers to something amiss in the relationship between the caregiver and the developing child (Leach, 2006). Leach suggested that problematic early experiences with the care giver may result in the infant, and potentially the future client, developing 'body self distortions'. For instance, a caregiver, who is unable to support the infant to become their own individual and struggles to separate their own emotional experiences from those of the infant, may contribute to the infant developing problematic ways to use body and/or the function of eating to try and define their body boundaries. Thus, the infant may later seek to define their boundary through physical pain, such as deliberate self-harm, or engage in excessive exercise to develop a muscular frame. They may also learn to use food and overeating (bingeing) to experience the physical boundaries of their body. Although Lacey and colleagues (1986) shed some light into how food may become a maladaptive coping strategy to deal with life stage transitions, any potential reasons for why the individual may lack more adaptive strategies were not discussed. Leach's explanation seems to provide some insight into this.

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Overall, the narratives in the current study focused on the changes in behaviours and thoughts that had been identified as problematic and relevant to the eating issues. All women appeared to maintain the acting (behaviour) and thinking aspects of the self as two rather separate entities. This is in line with the dualistic view of human functioning that is observable in CBT, as discussed in Chapter 3. Spinelli's (2005) thoughts regarding the phenomenology of the 'I' seem particularly relevant regarding the apparent disconnect between the 'I' and the bodily self. Issues with 'proprioception' seemed to fuel the participants' eating issues even prior to them becoming diagnosable eating disorders. In all cases participants described rejecting their bodies in the early days of their difficulties, and consequently began to utilise methods to manipulate their physical body to make it fit their beliefs of what an acceptable body would be like. These occurred in the context of the participants believing that they were somehow faulty individuals that lacked something and thus becoming physically something else would also transform who they were internally. The CBT experience did not seem to address this disconnect beyond interventions focusing on rationality, such as weighing, meal plans and food diaries. I wonder whether this approach allowed the women to maintain a status quo regarding the disconnection within them, or fragmentation through splitting, as suggested by Spinelli. The therapy allowed them to engage with their experiences through rationality rather than invited them to incorporate the unwanted parts of the self in their self-concept, or the 'I'.

Although absent in literature concerning bulimia, this disconnection between the 'I' and the bodily self has been considered in literature concerning binge eating and obesity. For instance, Meana and Ricciardi (2008) interviewed individuals, who had undergone bariatric surgery. They discovered that before surgery, some of the interviewees held self-concepts that excluded a physical image of the self. The researchers considered this to be a way of coping with their weight. Interestingly, this self-concept also persisted post-surgery and after the consequent transformation of the physical body. These findings are fascinating and possibly also relate in some ways to the current study. Meana and Ricciardi wondered whether this exclusion of the physical body was perhaps a way to manage the painful emotions experienced in relation to having a large body. Similarly, perhaps the women in the current study felt so negatively about their physical being that it was persistently excluded from their experience of the self.

In addition, the participants in the current study seemed to construct the concept of recovery in different ways. For example, although all agreed that they were no longer actively eating disordered, some of them felt that there was further work to do regarding their eating

difficulties, and how they related to themselves and food. Notably, there is no pre-existing clear definition for recovery in EDs and individual studies have used different methods to define it, such as using quantitative measures to assess whether the individual meets the particular diagnostic criteria for a specific disorder.

Research including various ED diagnoses has suggested that a holistic change in physical, behavioural and psychological domains should be considered (e.g. Bardone-Cone et al., 2010; Keski-Rahkonen & Tozzi, 2005). Bardone-Cone and colleagues argued that individuals with physical and behavioural changes only are considered to be in partial recovery, as elements of their self-concept, such as self-esteem and self-efficacy, were found to be similar to those with an active ED. Thus, individuals may appear free of eating issues on the surface and to others around them, while their self-concepts, or identities, remain largely unchanged. Consequently, they asserted that an improved self-concept may be an essential part of full ED recovery. This also relates to Spinelli's (2005) thoughts about the 'self' and the physical body that were discussed in more detail in Chapter 3, as well as the problems in this relationship as outlined by Leach (2006), and Meana and Ricciardi (2008). As discussed in Chapter 3, CBT as an approach seems to hold a dualistic view of human beings, which consequently appears to encourage the separation between the physical and psychological, as well as the rational and emotional aspects of the self. Thus, the fragmentation of the self, as described by Spinelli, due to the individual rejecting some, while accepting other parts does not seem to be addressed in CBT, specifically in CBT-E.

Reviewing the research literature presented in Chapter 2 with this in mind may produce findings that are in contrast with the researchers' conclusions, as many studies (e.g. Agras et al., 2000; Byrne et al., 2011; Fairburn et al., 2015) argued that not meeting specific behavioural criteria indicated that the individual was recovered, or at least in remission. The inconsistencies in defining recovery may explain some of the findings of the current study, as the participants did not seem to share similar views on what constitutes recovery. For instance, some considered their recovery to be an on-going journey, while others took the end of therapy to signify the end of this process.

These inconsistencies may also explain the observation by Keski-Rahkonen and colleagues (2009) regarding there being residual symptoms amongst individuals, who would be considered recovered. The findings raise questions about what happens to the difficulties that were previously manifested through eating difficulties, when the core psychology of the problem has not been dealt with. As discussed in Chapter 1, using diagnostic criteria to

determine illness and health is problematic, although this practice is common place in various health services, including the NHS.

5.7 Clinical Implications

The study provided useful and novel insights into how this group of women experienced CBT for the treatment of bulimia nervosa. For instance, concerns regarding losing and regaining control seemed to be central to all participants' reflections. These concerns seemed to impact on help-seeking, therapy engagement and the relationship with the therapist. Also, all women described a pervasive sense of isolation regarding their eating issues due to internalised stigma and/or experiences of being turned away by others for their eating difficulties. Feelings of shame and loneliness seemed to common experiences shared by all. Previous research has indicated that although CBT can help some clients to make and maintain positive behavioural changes regarding eating difficulties, it may not make long-lasting and fundamental changes to the person's identity. Since eating issues seem to become egosyntonic over time, exploring and working with identity concerns may help practitioners to encourage therapeutic changes that relate to the person's way of being, rather than just focus on reducing specific behaviours and thought patterns concerning food and weight. This may be particularly important when working with adolescents and young adults, whose identities are still developing. For instance, working to strengthen the role of different life domains, such as education and relationships, while enhancing the individuals' self-understanding may help to build more positive self-concepts and reduce the grip of eating issues. Alternative theoretical and therapeutic frameworks may provide helpful viewpoints to understanding and working with these difficulties, thus enhancing the treatment experience and outcomes.

Clinicians, including Counselling Psychologists, who are trained in multiple psychological and psychotherapy models are potentially very well placed to work with these concerns. Alongside this knowledge and clinical experiences, CoP values of recognising each individual's unique needs and circumstances, and thriving to provide a service that would meet these requirements should mean that each person is provided with the support that is most appropriate to them. For example, developing and utilising individual formulations drawing from relevant theories and therapy approaches, jointly negotiating therapeutic goals and tailoring interventions to address the individual needs of each client are some of the ways in which the training, knowledge and CoP values could be demonstrated in clinical work.

Solely relying on treatment protocols, such as CBT-E, may mean that the client's complex needs are not met and the therapy further alienates the client. Allowing space and time to explore potential issues relating to early life experiences, emerging identity and struggles associated with the specific life stages, for example, alongside considering the role of food and eating behaviours in the presenting issues could facilitate a more conducive therapeutic environment. In addition, this particular client group seems to be vulnerable to feeling and/or being rejected and misunderstood by others, and due to the shame associated with the issues may isolate themselves or use covert tactics to avoid feeling exposed. These are important points to bear in mind when providing therapy for issues evoking shame and other difficult emotions, as clients may try and minimise their issues and disengage from therapy – implicitly or explicitly. Thus, being aware of and compassionate to the difficulties that treatment may bring up, as well as the emotional challenges of being involved in therapy for eating issues, can help to build rapport and thus positively influence the outcome. Therapy frameworks that incorporate relational interventions and focus on the role of interpersonal factors in understanding and working with psychological distress can also prove invaluable in creating an environment in which the client can be helped to work on their difficulties holistically. For instance, IPT for EDs (IPT-ED; Champion & Power, 2012) already has an evidence-base supporting its effectiveness for the treatment of eating issues. It focuses on understanding the role of interpersonal difficulties in the development and maintenance of these difficulties. The work involves gaining insight into the identified interpersonal problem and what is maintaining it, such as lack of intimacy, interpersonal role disputes, role transitions and/or interpersonal deficits. The interpersonal issue is then addressed by using IPT techniques including role plays and decision analysis. Overall, the relationship between the therapist and the client can be used as a platform for helping the client gain a deeper understanding of their patterns of relating to their internal experiences, as well as individuals around them. For example, the therapist may wish to make interpretations and reflect on the therapy relationship with the client. They can also help the client name and explore their emotional struggles and thus demonstrate that emotional experiences can be worked with, rather than pushed away or dissociated from. A therapeutic environment that is experienced as safe by the client may help to alleviate the sense of isolation and feelings of shame, and allow for these feelings to be worked with during the therapy process. It may also assist the client to consider more fundamental questions relating to their way of being and relating. Thus, existential psychotherapy (Spinelli, 2005) may also be relevant to clients that can and wish to go deeper into their understanding of themselves. In summary, there are various frameworks that could be utilised with psychological difficulties that are expressed through

issues with food and eating, and many of them move beyond the CBT focus on problematic thoughts and behaviours.

It is important to mention that many clinicians, especially those working in the NHS, need to demonstrate commitment to evidence-based practice; many are required to work within frameworks that allow short-term and medium-term work only. In the context of eating issues, such as bulimia, many services now focus on delivering CBT-E in line with Fairburn's (2008) recommendations. Thus, the pressures to limit the breadth and depth of the therapeutic work may be externally imposed upon clinicians. Even if the therapeutic framework is externally stipulated to the clinician, they should remain committed to aiming to provide a therapeutic experience to the clients. In these cases clinical supervision may be a space in which multiple theoretical approaches are utilised to think about the client, even when the clinical work may mainly utilise a particular therapy model or a specific treatment protocol.

Counselling Psychologists can also demonstrate the values of CoP by challenging the stigma associated with eating issues within health care and other services. For instance, adopting an active stance in educating current and future professionals in various contexts to better equip them to respond to individuals displaying signs of disordered eating may help to reduce this stigma. This may also help the professionals to make better informed decisions about signposting and referrals.

As discussed in Chapter 2, as opposed to the assertions by Fairburn (2008), research has indicated that flexibility in using the CBT treatment manuals for bulimic difficulties has not been associated with worse outcomes regarding symptom reduction (Turner et al., 2015). There is also an emerging evidence-base for non-CBT approaches. As noted previously, focusing on changes in the criteria associated with specific diagnoses has limitations in terms of evaluating treatment effectiveness. Considering alternative evidence to the studies highlighted by the treatment guidelines is important, as the current guidelines recommend the use of CBT-E due to the existing evidence-base while neglecting evidence for other approaches and for non-manualised CBT practices.

5.8 Post-study Reflexivity

Reaching the end of the study felt like completing a long and arduous journey that challenged me both personally and professionally. I was curious to find out more about a topic that had not been investigated much before, but yet seemed so relevant in light of the

treatment guidelines and current problems with service provision, as documented in the media. Due to my professional and personal experiences I was also highly sceptical of the benefits of CBT and how it was being used to treat eating difficulties.

The unanticipated level of difficulties that I experienced regarding recruitment had a considerable impact on me and my engagement with the study and the emerging material. The difficulties were in stark contrast with the responses from those working in ED services, as those had been largely positive. Although some professionals had expressed a level of concern regarding how long it may take to gain NHS ethical approval. Overall, the process of attaining permission to recruit felt like an endless maze. Dealing with the ever-changing requirements was extremely stressful, as I was eager to move forward with my project and anxious to catch up with my fellow trainees, whom I perceived to be miles ahead. The effort put in certainly did not seem to correspond with the outcome and spending nearly two years consumed by the need to find suitable interviewees impacted on my confidence; many times I thought I had taken on a task that was beyond my abilities. When it came to analysing the transcripts and writing up the analysis, I felt utterly paralysed. This was very similar to how I ended up feeling with the process of attaining ethics and recruiting participants.

Exploring the parallel processes with my supervisor regarding my relationship to my study and what I had observed when looking for participants was a great aid in pushing me forward and finally being able to let go of the study to write up the research process. As mentioned in Chapter 3, the discussions with my peers, supervisor and other professionals helped me to identify that although I sensed a certain kind of protectiveness that services and clinicians had in relation to this client group, I also seemed to be caught up in a similar dynamic, which had an impact on the analytical and the write-up processes. I was concerned that since the individuals that came forward had felt judged and exposed when dealing with professionals, my analysis would be experienced in a similar way. In hindsight, I believe that perhaps I was also concerned about exposing myself through these processes. Since I had been quite struck by Fairburn's (2008) reservations about those with a history of eating issues providing psychological support to others with similar difficulties, I was hesitant to reveal my own experiences for the fear of being seen as someone, who was perhaps engaging in this research due to their own preoccupation with what Fairburn describes as the core psychopathology of eating disorders. Throughout my struggles, I tried to remain focused on the questions that had initially grabbed my attention regarding what was happening with ED treatments, specifically with CBT.

Similarly, I found discussing my research process with my fellow trainees and other people unrelated to psychological professions extremely helpful, as they helped me to question my motivations for focusing on different aspects of the research literature and the interview transcripts. As mentioned earlier, I was dubious about the evidence-base supporting the use of CBT and possibly initially approached the topic with this pre-judgement in the forefront of my mind. Attending a number of conferences and reflecting on my research with others working in the field helped me to open up my thinking regarding the research topic, as I came across many, who spoke in favour of CBT, as well as those that favoured a different approach or a combination of approaches.

I also experienced my personal therapy as very helpful in terms of untangling the influence of the participants' material from my own processes. As I had adopted a number of roles in relation to the topic, such as those of a researcher, clinician and a private person, it was beneficial to examine how these elements interacted with the research process. More recently I joined a professional working group set up to develop guidelines relating to understanding and treating eating difficulties. This allowed me to further engage in the developments in this field.

I feel that engaging in these activities with others and having honest discussions about the research had an enormous impact on the process, as in order to do this, I had to take risks and expose some of my insecurities regarding the project. Through this I was able to shed some of my initial judgements and attend to the material with a more balanced view. I maintain that the previous and current NICE guidelines seem rather misleading in marketing a treatment that has some considerable limitations, but hearing about the potential benefits of CBT and alternative emerging treatments in the field makes me feel hopeful that those with eating difficulties will be able to access treatments that are better tailored to their needs in the future.

5.9 Evaluation of Current Research and Suggestions for Future Research

The small sample size was a considerable weakness of this study. There may have been a number of reasons for the difficulties with recruitment, but several of the subthemes may help to explain these difficulties. For example, all participants spoke about their experiences of being rejected or not being taken seriously by others, such as professionals. Many also spoke about feeling ashamed about their eating problems and perhaps felt vulnerable in terms of discussing it with me. Previous research has suggested that individuals experiencing difficulties relate to eating disorders likely to try and hide their issues (Judit et al., 2005;

Hoek, 1991), which may have impacted on the recruitment. Overall, there seemed to be a reluctance to self-refer for the study amongst the population that the study was aiming to recruit. Interestingly, many women who made contact were currently bulimic and/or had seen a CBT therapist only once or twice to address their eating difficulties. Although they could not be included in the study, the level of interest from individuals, who had not benefited from therapy could indicate that those with unhelpful therapy experiences may be more willing to share their experiences or possibly the number of individuals in this category exceeds those who met the inclusion criteria.

The recruitment of participants heavily relied on a third party to share information about the study, distribute leaflets and encourage individuals to consider taking part. Although the NHS services were inherently positive about the project and supporting me with the recruitment, I observed clinicians' reluctance to discuss the study with their clients as they had already deemed the clients unsuitable for the study. In many cases this was alleviated by me actively clarifying the research criteria with them, although judging the impact of this is difficult. To me, this process indicated that there was an element of wanting to protect the vulnerable. I am unsure whether it was the clients, who were perceived to require additional gate-keeping or whether the service and the clinicians also felt rather exposed. Statistics show that bulimia is associated with high relapse rates and thus, many clients have to return to services multiple times. It may be that treating such a client group is inherently stressful and also perhaps frustrating. Perhaps maintaining a level of control over the clients by not passing on the information, the clinicians showed their biases towards infantilising the clients by expecting them to make unwise judgements about their ability to take part.

The study also had some considerable strengths. For example, the participants had received treatment in different geographical areas at different points of time. As the study was not connected to any specific organisation, participants may have been able to be more honest in their accounts. This may have contributed to the participants evaluating both strengths and weaknesses of their therapies and therapists during their interviews, and discussing the challenges in relation to accessing and ending treatment. Overall, the study provided novel insights into the area and provided further evidence concerning individuals' therapy experiences. It also gave a platform to the individuals to discuss and think about an experience that perhaps is often associated with shame and other difficult emotions. It is hoped that this acted as a step towards de-stigmatising eating difficulties. Some potential and actual participants expressed a similar hope as their reason for wanting to take part in the study.

The findings highlighted various areas of interest that have not previously been investigated in much detail. For example, deviations from the CBT treatment manuals for bulimia may be helpful, as certain types and levels of divergences could have a positive impact on the therapy relationship and the outcome. Also, the role of social support alongside therapy has not been considered in other research examining ED treatments. In relation to the impact of therapists' physical characteristics on therapy relationships, Fairburn (2008) noted that currently there is very little research concerning this interesting aspect of therapy relationships. Finally, the relationship between CBT or other psychotherapies and identity concerns in eating issues would appear to be an interesting, but also an important area for future research, as it could help to shed more light on the wider reaching impacts of therapy. Also, this type of research would help to evaluate whether therapy interventions focusing on identity concerns would indeed promote positive outcomes to our clients.

Qualitative research studies could discover further information about how clients with eating difficulties engage in therapy. GT would potentially be a useful approach for future studies to be able to build theory frameworks on clients' experiences. The findings could be utilised to evaluate the current match between the availability and necessity of different interventions for this client group to guide policy making and the development of ED service provision.

Studies employing the Foucauldian discourse analysis (FDA) could examine how clinicians and medical professionals, such as GPs may speak about working clients with eating difficulties. The current study indicated that perceived power dynamics in the relationships between the participants and professionals had an impact on the therapy process both directly and indirectly. Many also spoke about resistance to certain elements of treatment. FDA could be utilised to investigate how language is used to resist those perceived to be in power. Negotiating interventions with the therapist and struggling to their assert own concerns when seeking help or attending therapy were interesting narratives that emerged in the current study. Focusing on the power dynamics between the client and the professionals may provide new insights into the barriers to treatment engagement.

Future qualitative research findings could add to the knowledge base and potentially act as a platform for developing quantitative methods to investigate these areas in larger populations and different groups. Current quantitative methods, such as questionnaires often utilise concepts and terminology that are relevant to CBT, whereas developing measures based on the clients' reports may gather different type of data. Also, no research to date has considered the timings of drop-out in ED treatments. The current research study highlighted certain stages of CBT-E that clients may find especially distressing. As the attrition rates are

currently high, investigating the timings of and reasons for drop-out could provide valuable information about the stages that could be considered as high risk.

CHAPTER 6: CONCLUSION

The current study aimed to examine a topic that has thus far received a limited amount of attention. The existing literature and studies concerning the treatment of eating issues, specifically CBT for bulimia nervosa, have focused on assessing treatment effectiveness by using quantitative methods and using clinician-derived measures that focus on the particular diagnostic criteria. The use of diagnostic criteria to determine treatment effectiveness is problematic for various reasons, as discussed in the thesis. For instance, the criteria focus on the cognitions and behaviours associated with the particular diagnosis, and fail to consider the person and their individual context holistically. Very few studies thus far have examined the treatment experiences of this client group through qualitative methods. This is despite there being an increase in involving clients and patients in the shaping of treatments and services. Also, qualitative research could allow new information to emerge without using clinician-derived constructs and to better understand the usefulness and impact of a particular type of therapy.

This qualitative study focused on the subjective experiences of four women, who had undergone CBT for bulimia in the past. Three master themes emerged from the study: Loss of control; Staying on the surface; and Holding onto power. The master themes seemed to be underpinned by the concept of 'control', as concerns regarding its maintenance, loss and regain appeared to be central to all participants. 'Loss of control' related to the participants experiences of losing control regarding their eating issues, and the impact of this on their help-seeking, their relationships with others, and the therapy process. There seemed to be a general desire to avoid going too deep in therapy, which was explored in more detail in the second master theme 'Staying on the surface'. The therapeutic approach appeared to lend itself well to this desire and also supported the participants' individual ways of managing this process. Consequently, many felt that the core of their issues remained unchanged. The final master theme, 'Holding onto power', considered how the women tried to hold onto a sense of power and control before, during and after their therapy. The therapy relationship and the impact of discharge were some of the concerns raised in this master theme.

The study revealed unique information about how women with bulimic difficulties may experience CBT. For instance, they spoke about the discomfort of engaging in particular CBT interventions and how they attempted to manage this discomfort, as well as the impact of the therapists' external characteristics on the therapy process. None of these have been discussed in detail in previous research or literature concerning CBT. Interestingly, the women discussed and defined recovery and the overall impact of therapy in various ways. In

all cases recovery was conceptualised as being better at managing the eating disorder part of the self, rather than understanding the function of this part, and its role within one's identity. Thus, the self-concept appeared to remain somewhat fragmented and the stigma relating to the unacceptable parts of the self seemed to remain mostly unchanged. The CBT framework and the role of the therapist within this framework perhaps allowed the women to maintain this self-concept and did not enable them to bring about a more cohesive and accepting self-identity. Furthermore, CBT was seen as a rational therapy that did not get to the core of the psychological issues, which has also been reported by other studies examining clients' experiences of CBT for various psychological difficulties (e.g. Nilsson et al., 2007; McManus et al., 2010; Onslow et al., 2015).

Future research considering the impact of therapy on identity, and examining the recovery process could provide interesting and important insights into the changes that therapy may evoke in different individuals. Although the current research study uncovered new information, as well as produced some similar findings to that of previous research, the findings may not be generalisable beyond this study due to it focusing on specific individuals and their subjective experiences of CBT. Thus, carrying out further investigations to the areas outlined above may help clinicians and researchers to build a more coherent picture of how various elements of different therapies may impact on clients with eating and food related issues.

Clinicians, such as Counselling Psychologists should have an awareness of the stigma and shame commonly experienced by these clients. Also, as illustrated by the accounts in the current study, many struggle to get help due to lack of resources, personal or otherwise. Thus, engaging in treatment can be very challenging. Although CBT is currently the main psychotherapy recommended for bulimic difficulties, it may be helpful for clinicians to consider each individual's unique needs and circumstances when carrying out assessments and planning for interventions. This may mean drawing from complementary psychotherapy frameworks and utilising various psychological theories throughout the therapy process. Even in circumstances where a particular psychotherapy model takes precedence due to service requirements or the client's own preferences, alternative frameworks and theories could be considered and held in mind during the therapy process.

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APPENDICES

Appendix I
Research advertisement

"An exploration of women's experiences of cognitive-behaviour therapy for the treatment of bulimia nervosa."

I am a Trainee Counselling Psychologist at London Metropolitan University carrying out a research study as part of my doctoral training. The study examines the experiences of receiving cognitive-behaviour therapy (CBT) for bulimia nervosa (BN). My aim is to gain a more detailed understanding of these experiences, as they may help service providers and professionals to improve the ways in which those with the diagnosis are supported.

Participants would be expected to take part in private one-to-one interviews lasting approximately 1 hour. These interviews will take place in a location that is mutually agreed on. Travel expenses will be reimbursed.

The study has received ethical approval from the London Metropolitan University Ethics Panel and an NHS Ethics Committee.

Who can take part?

• Women aged 18 to 35 who:

• Were diagnosed with bulimia nervosa or EDNOS (bulimia subtype) in the past

• Have undergone one-to-one cognitive-behaviour therapy for bulimia nervosa only once in the past

• Are no longer in therapy

• Are able to talk about their experience of receiving this therapy

• Do not currently have a mental health diagnosis, such as eating disorder, psychosis, severe depression or anxiety disorder

• Are able to travel locally for the interview

If you are interested in taking part in this study, would like an information sheet or have any questions, please contact me on kah0557@my.londonmet.ac.uk or 07968 947 981. You can withdraw from the study at any point, up to and during the interview.

Kati Hallikainen (Trainee Counselling Psychologist)

Appendix II
Participant information sheet

"An exploration of women's experiences of cognitive-behaviour therapy for the treatment of bulimia nervosa."

Who am I?

My name is Kati Hallikainen and I am studying for a Professional Doctorate in Counselling Psychology at London Metropolitan University. I am interested in finding out more about how women with bulimia nervosa experienced their cognitive-behaviour therapy treatment.

What is the purpose of this project?

This project seeks to learn more about the individual experiences of having psychological treatment for bulimia nervosa. There are a number of different treatments available, but the current research does not really explain well what the experience of cognitive-behaviour therapy is like even though it is commonly used to treat bulimia nervosa. The findings from the project could be used to improve the services people with eating disorders receive and to help trainees and therapists learn the best way to work with somebody who has difficulties with their eating behaviours. For the purposes of this project I am looking for volunteers to participate who are female and aged 18 to 35.

Who can take part?

• Women aged 18 to 35 who:

• Were diagnosed with bulimia nervosa or EDNOS (bulimia subtype) in the past

• Have undergone one-to-one cognitive-behaviour therapy for bulimia nervosa only once in the past

• Are no longer in therapy

• Are able to talk about their experience of receiving this therapy

• Do not currently have a mental health diagnosis, such as eating disorder, psychosis, severe depression or anxiety disorder

• Are able to travel locally for the interview

What will happen if I take part?

You can contact me via email or telephone to express your interest in taking part. I would then make contact with you over the telephone to ensure that you meet the criteria for this research. Also, you can contact me if you have any questions about the study before you decide whether or not to take part.

I will arrange a suitable date and time to meet with you to interview you about your experiences of cognitive-behaviour therapy. The interview will be audio-taped and is likely to last for approximately 1 hour. Please note that you will be asked to complete a brief questionnaire prior to starting the interview to further assess your suitability for the study. Should there be any concerns over your wellbeing then, I would not be able to interview you.

You will be reimbursed for your travel costs to attend the interview upon production of a valid receipt.

The interviews will be transcribed and analysed and the findings from all the interviews will be written up as a thesis. All information which is collected about you during the course of the project will be kept strictly confidential. However, I would have a legal duty to breach confidentiality if you posed a serious risk to yourself or to others. If this was the case, I would let you know. All data collected will be made anonymous and a pseudonym (made up name) will be used. Your anonymity will be protected in any verbal or written reports or presentations from the project, including any direct quotations from the interview. The original data will be kept securely in accordance with the Data Protection Act, and will only be accessible to me and my supervisors.

If you change your mind about taking part prior to the interview, you can withdraw your consent at any time and you do not have to give a reason. However, if you do participate in the interview process, you have four weeks to withdraw your consent

Are there any risks in taking part?

Thinking and talking about past experiences can provoke difficult emotions. This is quite normal and every step has been taken to minimise the risks involved. However, if you did become upset during the interview, I would try to assist you to identify someone to contact for support. Also, the interview can be stopped, if you wished not to carry on with it.

Are there any benefits to taking part?

By taking part you would be giving information about your experiences of having a psychological treatment for your eating disorder and the things that have helped or hindered that process. This information could be used to inform the experiences of other people who have similar problems to you.

What will happen to the findings of the project?

The findings will be written up as a thesis. I may also present the findings, including direct quotations, through writing research articles in academic and professional journals and through conference presentations. However, all data will be made anonymous so that you will not be able to be identified.

Who is monitoring and reviewing the project?

The project follows the Code of Ethics by British Psychological Society (2010) and has been given ethical approval by the Research Ethics Committee of London Metropolitan University. It is monitored by my supervisor Dr Angela Loulopoulou with whom I meet regularly.

If you have any concerns about the project after you have agreed to take part, you should contact me or one of my supervisors. We will try to address your concerns and answer your questions.

If you would like any further information to help you decide whether or not to take part, please feel free to contact me directly via email (kah0557@my.londonmet.ac.uk) or telephone (07968 947981).

Appendix III
HADScale

Hospital Anxiety and Depression Scale (HADS)

Patients are asked to choose one response from the four given for each interview. They should give an immediate response and be dissuaded from thinking too long about their answers. The questions relating to anxiety are marked "A", and to depression "D". The score for each answer is given in the right column. Instruct the patient to answer how it currently describes their feelings.

A	I feel tense or 'wound up':	
	Most of the time	3
	A lot of the time	2
	From time to time, occasionally	1
	Not at all	0
D	I still enjoy the things I used to enjoy:	
	Definitely as much	0
	Not quite so much	1
	Only a little	2
	Hardly at all	3

A	**I get a sort of frightened feeling as if something awful is about to happen:**	
	Very definitely and quite badly	3
	Yes, but not too badly	2
	A little, but it doesn't worry me	1
	Not at all	0
D	**I can laugh and see the funny side of things:**	
	As much as I always could	0
	Not quite so much now	1
	Definitely not so much now	2
	Not at all	3
A	**Worrying thoughts go through my mind:**	
	A great deal of the time	3
	A lot of the time	2
	From time to time, but not too often	1
	Only occasionally	0

D	**I feel cheerful:**	
	Not at all	3
	Not often	2
	Sometimes	1
	Most of the time	0
A	**I can sit at ease and feel relaxed:**	
	Definitely	0
	Usually	1
	Not Often	2
	Not at all	3
D	**I feel as if I am slowed down:**	
	Nearly all the time	3
	Very often	2
	Sometimes	1
	Not at all	0

A	**I get a sort of frightened feeling like 'butterflies' in the stomach:**	
	Not at all	0
	Occasionally	1
	Quite Often	2
	Very Often	3
D	**I have lost interest in my appearance:**	
	Definitely	3
	I don't take as much care as I should	2
	I may not take quite as much care	1
	I take just as much care as ever	0
A	**I feel restless as I have to be on the move:**	
	Very much indeed	3
	Quite a lot	2
	Not very much	1
	Not at all	0
D	**I look forward with enjoyment to things:**	
	As much as I ever did	0
	Rather less than I used to	1
	Definitely less than I used to	2

	Hardly at all	3
A	**I get sudden feelings of panic:**	
	Very often indeed	3
	Quite often	2
	Not very often	1
	Not at all	0
D	**I can enjoy a good book or radio or TV program:**	
	Often	0
	Sometimes	1
	Not often	2
	Very seldom	3

Scoring (add the As = Anxiety. Add the Ds = Depression). The norms below will give you an idea of the level of Anxiety and Depression.	
0-7 = Normal	
8-10 = Borderline abnormal	
11-21 = Abnormal	

Reference:

Zigmond and Snaith (1983)

Appendix IV
Participant consent form

LONDON
metropolitan
university

Participant Consent Form for Research Participation

Title of research project: "Exploration of the therapy experiences of women who have undergone cognitive-behaviour therapy for the treatment of bulimia nervosa"

Please read the following statements. Tick the box, if you **agree** with the relevant statement.

1. I have read the Participant Information Sheet, or it has been read to me.

2. I have had the opportunity to ask questions about it and the study, and any questions that I have asked have been answered to my satisfaction.

☐

3. I understand that my participation is voluntary and that I have four weeks to withdraw my consent after the interview, if I wish to do so.

☐

Name of Participant: _____ Date: _____

Signature of Participant: _____

Name of Researcher: _____   Date: _____

Signature of Researcher: _____

Appendix V
Consent for audio taping and
interview transcribing

Consent for Audio Taping and Interview Transcribing

Title of the Research Study: "An exploration of women's experiences of cognitive-behaviour therapy for the treatment of bulimia nervosa."

This form is to ask for your permission for the interview to be audio taped.

The tape and the consequent interview transcript will be anonymised so that no identifying information, such as your name will be revealed. The tapes will be stored separately from any written records that contain identifying information, such as your personal details. The tapes will be accessible to the researcher and the supervisors only and their transcription will also be done by the researcher. The tapes will be destroyed once the interview transcripts have been checked for accuracy.

The interview transcript is produced for research purposes and it may be used in consequent reports or presentations.

Please note that you have up to four weeks to withdraw your consent after the interview, as withdrawing at a later stage may not be possible.

Name of Participant: _____   Date: _____

Signature of Participant: _____

Name of Researcher: _____   Date: _____

Signature of Researcher: _____

Appendix VI
Interview schedule

Interview Schedule

1.   Can you tell me a brief history of your eating disorder from where it started to you beginning therapy?

Potential prompts:

a)   What made you choose this particular type of therapy?

b)   How did you decide which therapist you were going to work with?

2.   Could you describe your experience of the therapy itself?

Potential prompts:

a)   What was it like in sessions?

b)   Was there anything that was helpful or useful?

c)   Anything that wasn't helpful or useful?

d)   Did it match your expectations? If so, how? If not, why?

e)   Aside from talking to someone, how did you feel about the specific features of the therapy? e.g. using diagrams or templates, structure of the session, homework tasks?

3.   Could you describe how the therapy might have impacted on you?

4.   What was it like to end the therapy?

Appendix VII
Distress protocol

Distress Protocol

The purpose of this protocol is to ensure the welfare of the participant(s) and the researcher and to minimise any risk to either party in relation to the present research study examining the experiences of cognitive-behaviour therapy for individuals with bulimia nervosa. Such participants would be deemed vulnerable, as they have had a diagnosis of a mental health problem for which they have sought psychological help.

The protocol will outline the potential signs of distress that the researcher will look out for. The protocol also includes guidelines as to what type and level of intervention the researcher should offer. Please note that the list of signs of distress provided is not exhaustive, but the researcher is expected to use their professional judgement to detect any other signs that the participant(s) may display and utilise the most suitable intervention.

Please note: The likelihood of participant experiencing or expressing extreme distress is low, as the researcher must assess the participant's mental state throughout the interview and take suitable action in order to minimise the risk of the participant's mental state deteriorating further.

1. Mild distress:

Possible signs of mild distress may include:

• Verbal indication of discomfort or mild distress, e.g. participant requests a break

• Non-verbal signs, e.g.

• Participant loses concentration

• Participant becomes restless

• Tearfulness

• Voice trembles due to emotion/tearfulness

• Participant finds it difficult to continue speaking

Action to take:

• Ask participant if they would like to continue

• Offer participant a break

• Remind participant that the interview can be paused or stopped at any time if they become too distressed

2. Moderate distress:

Possible signs of moderate distress may include:

• Verbal indication of moderate distress, e.g. participant makes explicit references to wanting to end the interview – possibly combined with non-verbal signs, such as uncontrollable crying

• Non-verbal signs, e.g.

• Uncontrollable crying or sobbing

• Incoherent speech (e.g. due to crying)

• Hyperventilating

• Shaking

• Indication of distressing images or thoughts, such as flashbacks

Action to take:

• End interview

• Offer verbal reassurance e.g. by suggesting relaxation techniques, e.g. breathing exercises

• Ask for them to contact an appropriate provider of care or support, e.g. GP

• Provide contact sheet with support links

• Debrief

• If issues possibly requiring further attention arise during the interview, the researcher will encourage the participant to contact mental health support organisations or mental health professionals for further intervention

3. Extreme distress:

Possible signs of extreme distress may include:

• Verbal or physical aggression

• Threats to self or others

• Signs of participant starting to lose touch with reality e.g. through a psychotic experience

Action to take:

• End the interview immediately

• If there are concerns for the participant's or others' safety, the researcher must inform the participant of their duty to contact existing support or care providers e.g. GP or CPN

• If there are concerns regarding the participant intending to harm themselves or others, the researcher must advise them to attend a local A&E Department

• If the participant is unwilling to seek immediate help and/or becomes violent, the Police will be contacted and asked to use their powers under the Mental Health Act to detain the participant and take them to a place of safety pending psychiatric assessment. Please note that this is an extreme measure and will only be followed through if the participant is presenting an immediate risk and declines to seek help.

Appendix VIII
Debrief sheet

LONDON
metropolitan
university

Dear Participant,

Thank you for taking part in this research study.

Please contact Kati Hallikainen (the researcher), if you are interested in the results of the study or if you have any questions or concerns about this study. You have four weeks to withdraw your consent after the interview has been completed. You can do this by informing the researcher via email.

The researcher's contact details are:

Email: kah0557@my.londonmet.ac.uk

Telephone: 07968 947981

Should you have any concerns or complaints regarding any aspect of the study, you can contact my supervisor Dr Loulopoulou by using the following contact details:

•   Dr Loulopoulou: a.loulopoulou@londonmet.ac.uk; Telephone: 0207 133 2667

If participation has raised any concerns or issues that you wish to discuss further, a number of nationwide and local agencies can provide advice and support in confidence.

•   Beat (nationwide): website: www.b-eat.co.uk; telephone helpline: 0845 634 1414. The helpline is open Mon-Thu 1.30pm - 4.30pm

•   Local support:

•   BODY (Derbyshire): website: www.bodycharity.co.uk; tel. 01332 25 88 33

•   SWEDA (Somerset and Wessex): website: www.swedauk.org; telephone helpline (Thursdays 4pm-7pm): 01458 448600

•   No Bodies Perfect (Scotland): website: www.nbp-eating-disorders.co.uk. No telephone number provided, but you can email No Bodies Perfect on info@nbp-eating-disorders.co.uk or contact them via their website ("Contact Us").

•   Samaritans (nationwide mental health charity): email: jo@samaritans.org; telephone helpline (24h): 08457 90 90 90 (UK).

•   SANE (nationwide mental health telephone support service): telephone helpline (6pm-11pm every day): 08457 67 80 00.

Appendix IX
Study summary

"An Exploration of Women's Experiences of CBT for Bulimia Nervosa"

LONDON METROPOLITAN UNIVERSITY

– Summary of Findings

Background

Treatment guidelines by National Institute for Health and Care Excellence stipulate that individuals with bulimic difficulties should be offered cognitive-behaviour therapy for eating issues (CBT-ED). However, little is known about how individuals may experience this type of treatment, as very few studies thus far have examined the treatment experiences of this client group. Most research has focused on measuring the impact of CBT on particular symptoms associated with bulimia nervosa, rather than examining its wider impact on one's life. Overall, CBT is likely to be the most common form of treatment for bulimia nervosa, as many services are expected to provide 'evidence-based' treatments.

Young women are the most likely group to experience eating difficulties, such as bulimia nervosa. Thus, the current study aimed to explore women's experiences of CBT and its impact on their post-therapy lives. It also aimed also to provide clinicians and other professionals helpful insights into how best support individuals with bulimic difficulties. The main research question that the study sought to address was: how do women experience cognitive-behaviour therapy for the treatment of bulimia nervosa?

Study overview

The current study focused on the subjective experiences of four women, who had undergone CBT for bulimia in the past. Women aged from 18 to 35 years were invited to take part. Four women took part in individual face-to-face interviews, none of whom considered themselves to have an active eating disorder. The women had found out about the study in various ways, such as through the eating disorder charity Beat, an eating disorder support group and a young people's mental health organisation. The interviews were transcribed and analysed by using a research methodology called interpretative phenomenological analysis (IPA) to identify similarities and differences between the women's reflections, and to organise them into themes.

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Study findings

Three main themes were identified from the participants' experiences. These themes were: Loss of control; Staying on the surface; and Holding onto power. The findings indicated that the concept of 'control' and concerns regarding its loss and maintenance were central to all four women taking part in the study. The master themes seemed to be underpinned by the concept of 'control', as concerns regarding its maintenance, loss and regain appeared to be central to all women. 'Loss of control' related to the experiences of losing control regarding their eating issues, and the impact of this on their help-seeking, their relationships with others, and the therapy process. There seemed to be a general desire to avoid going too deep in therapy, which was explored in more detail in the second master theme 'Staying on the surface'. The therapeutic approach (CBT) appeared to lend itself well to this desire and also supported the participants' individual ways of managing this process. Consequently many felt that the core of their issues remained unchanged. The final master theme, 'Holding onto power', considered how the women tried to hold onto a sense of power and control before, during and after their therapy. The therapy relationship and the impact of discharge were some of the topics that arose in relation to the final master theme.

The study revealed unique information about how women with bulimic difficulties may experience CBT. For instance, they spoke about the discomfort of engaging in particular CBT interventions and how they attempted to manage this discomfort, as well as the impact of the therapists' external characteristics on the therapy process. None of these have been discussed in detail in previous research or literature concerning CBT. Interestingly, the women discussed and defined recovery and the overall impact of therapy in various ways. In all cases recovery was conceptualised as being better at managing the eating disorder part of the self, rather than understanding the function of this part, and its role within one's identity. Thus, the self-concept appeared to remain somewhat fragmented and the stigma relating to the unacceptable parts of the self seemed to remain mostly unchanged. The CBT framework and the role of the therapist within this framework perhaps allowed the women to maintain this self-concept and did not enable them to bring about a more cohesive and accepting self-identity. Furthermore, CBT was seen as a rational therapy that did not get to the core of the psychological issues, which has also been reported by other studies examining clients' experiences of CBT for various psychological difficulties.

Summary and conclusions

Future research considering the impact of therapy on identity, and examining the recovery process could provide interesting and important insights into the changes that therapy may evoke in different individuals. Although the current research study uncovered new information, as well as produced some similar findings to that of previous research, the findings may not be generalisable beyond this study due to it focusing on specific individuals and their subjective experiences of CBT. Thus, carrying out further investigations to the areas outlined above may help clinicians and researchers to build a more coherent picture of how various elements of different therapies may impact on clients with eating and food related issues.

Clinicians, such as Counselling Psychologists should have an awareness of the stigma and shame commonly experiences by these clients. Also, as illustrated by the accounts in the current study, many struggle to get help due to lack of resources, personal or otherwise. Thus, engaging in treatment can be very challenging. Although CBT is currently the main psychotherapy recommended for bulimic difficulties, it may be helpful for clinicians to consider each individual's unique needs and circumstances when carrying out assessments and planning for interventions. This may mean drawing from complementary psychotherapy frameworks and utilising various psychological theories throughout the therapy process, or it may be that the service restrictions or clients' own preferences meant that a particular model takes precedence, while other frameworks take on a more implicit role.

The study process and the findings were written up as a doctoral thesis for the qualification of Professional Doctorate in Counselling Psychology.

For more information on the study, please email kah0557@my.londonmet.ac.uk

Researcher: Kati Hallikainen

Appendix X
University ethical
approval

London Metropolitan University,
School of Psychology,
Research Ethics Review Panel

I can confirm that the following project has received ethical approval to
proceed:

Title:	**An IPA study of women's experiences of cognitive-behaviour therapy for the treatment of bulimia nervosa.**
Student:	Kati Hallikainen
Supervisor:	*Dr Angela Loulopoulou*

Ethical clearance to proceed has been granted providing that the study
follows the ethical guidelines used by the School of Psychology and British
Psychological Society, and incorporates any relevant changes required by the
Research Ethics Review Panel. All participating organisations should provide
formal consent allowing the student to collect data from their staff.

The researcher is also responsible for conducting the research in an ethically
acceptable way, and should inform the ethics panel if there are any
substantive changes to the project that could affect its ethical dimensions, and
re-submit the proposal if it is deemed necessary.

Signed:

Date: 03/03/14

Dr Chris Chandler
(Chair - School of Psychology Research Ethics Review Panel)
chandler@staff.londonmet.ac.uk

Appendix XI
NHS REC Favourable opinion

NHS
Health Research Authority
National Research Ethics Service

NRES Committee Northwest – Greater Manchester West

3rd Floor
Barlow House
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7434

16 April 2015

Miss Kati Hallikainen
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London
N7 8DB

Dear Miss Hallikainen

Study title:	**An IPA study of women's experiences of cognitive-behaviour therapy for the treatment of bulimia nervosa**
REC reference:	**14/NW/1414**
Protocol number:	**N/A**
IRAS project ID:	**147323**

Thank you for your submission, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Anna Bannister, nrescommittee.northwest-gmwest@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

<u>Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.</u>

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

<u>Registration of Clinical Trials</u>

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Copies of advertisement materials for research participants	2	15 March 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Insurance]		06 February 2014
Interview schedules or topic guides for participants [Interview Schedule]	V1	01 August 2014
IRAS Checklist XML [Checklist_03112014]		03 November 2014
Other [University Ethical Clearance]		03 March 2014
Other [HADS]	V1	03 November 2014

Other [Distress Protocol]		01 August 2014
Other [Debrief Sheet]	1	01 August 2014
Other [Distress Protocol]	V1	03 November 2014
Other [Email Correspondence]		13 March 2015
Participant consent form	3	16 April 2015
Participant information sheet (PIS)	2	15 March 2015
REC Application Form [REC_Form_27102014]		27 October 2014
Research protocol or project proposal [Research Proposal]	V1	20 October 2014
Response to Request for Further Information		30 March 2015
Response to Request for Further Information		16 April 2015
Summary CV for Chief Investigator (CI) [Summary CV for CI]		
Summary CV for supervisor (student research) [Supervisor CV]		
Validated questionnaire [Pre-Interview Questionnaire]	2	15 March 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments

- Adding new sites and investigators

- Notification of serious breaches of the protocol

- Progress and safety reports

- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely

Dr Lorraine Lighton (Chair)
Chair

Email:nrescommittee.northwest-gmwest@nhs.net

Enclosures: " After ethical review – guidance for researchers"

Copy to: *Dr Angela Loulopoulou*
R&D Manager ████████████████████████
Trust R&D Department

NHS

"An exploration of women's experiences of cognitive-behaviour therapy for the treatment of bulimia nervosa."

I am a Trainee Counselling Psychologist at London Metropolitan University carrying out a research study as part of my doctoral training. The study examines the experiences of receiving cognitive-behaviour therapy (CBT) for bulimia nervosa (BN). My aim is to gain a more detailed understanding of these experiences, as they may help service providers and professionals to improve the ways in which those with the diagnosis are supported.

Participants would be expected to take part in private one-to-one interviews lasting approximately 1 hour. These interviews will take place in a location that is mutually agreed on. Travel expenses will be reimbursed.

The study has received ethical approval from the London Metropolitan University Ethics Panel and an NHS Ethics Committee.

Who can take part?

•   Women aged 18 to 35 who:

•   Were diagnosed with bulimia nervosa or EDNOS (bulimia subtype) in the past

•   Have undergone one-to-one cognitive-behaviour therapy for bulimia nervosa only once in the past

•   Are no longer in therapy

•   Are able to talk about their experience of receiving this therapy

•   Do not currently have a mental health diagnosis, such as eating disorder, psychosis, severe   depression or anxiety disorder

•   Are able to travel locally for the interview

If you are interested in taking part in this study, would like an information sheet or have any questions, please contact me on kah0557@my.londonmet.ac.uk or 07968 947 981. You can withdraw from the study at any point, up to and during the interview.

Kati Hallikainen (Trainee Counselling Psychologist)

"An exploration of women's experiences of cognitive-behaviour therapy for the treatment of bulimia nervosa."

Who am I?

My name is Kati Hallikainen and I am studying for a Professional Doctorate in Counselling Psychology at London Metropolitan University. I am interested in finding out more about how women with bulimia nervosa experienced their cognitive-behaviour therapy treatment.

What is the purpose of this project?

This project seeks to learn more about the individual experiences of having psychological treatment for bulimia nervosa. There are a number of different treatments available, but the current research does not really explain well what the experience of cognitive-behaviour therapy is like even though it is commonly used to treat bulimia nervosa. The findings from the project could be used to improve the services people with eating disorders receive and to help trainees and therapists learn the best way to work with somebody who has difficulties with their eating behaviours. For the purposes of this project I am looking for volunteers to participate who are female and aged 18 to 35.

Who can take part?

•   Women aged 18 to 35 who:

•   Were diagnosed with bulimia nervosa or EDNOS (bulimia subtype) in the past

•   Have undergone one-to-one cognitive-behaviour therapy for bulimia nervosa only once in the past

•   Are no longer in therapy

•   Are able to talk about their experience of receiving this therapy

•   Do not currently have a mental health diagnosis, such as eating disorder, psychosis, severe   depression or anxiety disorder

•   Are able to travel locally for the interview

What will happen if I take part?

You can contact me via email or telephone to express your interest in taking part. I would then make contact with you over the telephone to ensure that you meet the criteria for this research. Also, you can contact me if you have any questions about the study before you decide whether or not to take part.

I will arrange a suitable date and time to meet with you to interview you about your experiences of cognitive-behaviour therapy. The interview will be audio-taped and is likely to last for approximately 1 hour. Please note that you will be asked to complete a brief questionnaire prior to starting the interview to further assess your suitability for the study. Should there be any concerns over your wellbeing then, I would not be able to interview you.

You will be reimbursed for your travel costs to attend the interview upon production of a valid receipt.

The interviews will be transcribed and analysed and the findings from all the interviews will be written up as a thesis. I will ask for your permission to audio tape and transcribe the interview and for the information to be used for the research project. To do this, I will ask you to sign a consent form. The tape and the consequent interview transcript will be anonymised so that no identifying information, such as your name will be revealed. The tapes will be stored separately from any written records that contain identifying information, such as your personal details. The tapes will be accessible to the researcher and the supervisors only and their transcription will also be done by the researcher. The tapes will be destroyed once the interview transcripts have been checked for accuracy.

The interview transcript is produced for research purposes and it may be used in consequent reports or presentations.

All information which is collected about you during the course of the project will be kept strictly confidential. However, I would have a legal duty to breach confidentiality if you posed a serious risk to yourself or to others. If this was the case, I would let you know. All data collected will be made anonymous and a pseudonym (made up name) will be used. Your anonymity will be protected in any verbal or written reports or presentations from the project, including any direct quotations from the interview. The original data will be kept securely in accordance with the Data Protection Act, and will only be accessible to me and my supervisors.

If you change your mind about taking part prior to the interview, you can withdraw your consent at any time and you do not have to give a reason. Please note that you have up to four weeks to withdraw your consent after the interview, as withdrawing at a later stage may not be possible.

Are there any risks in taking part?

Thinking and talking about past experiences can provoke difficult emotions. This is quite normal and every step has been taken to minimise the risks involved. However, if you did become upset during the interview, I would try to assist you to identify someone to contact for support. Also, the interview can be stopped, if you wished not to carry on with it.

Are there any benefits to taking part?

By taking part you would be giving information about your experiences of having a psychological treatment for your eating disorder and the things that have helped or hindered that process. This information could be used to inform the experiences of other people who have similar problems to you.

What will happen to the findings of the project?

The findings will be written up as a thesis. I may also present the findings, including direct quotations, through writing research articles in academic and professional journals and through conference presentations. However, all data will be made anonymous so that you will not be able to be identified.

Who is monitoring and reviewing the project?

The project follows the Code of Ethics by British Psychological Society (2010) and has been given ethical approval by the Research Ethics Committee of London Metropolitan University and an NHS Ethics Committee. It is monitored by my supervisor Dr Angela Loulopoulou with whom I meet regularly.

Should you have any concerns or complaints regarding any aspect of the study, you can contact my supervisor Dr Loulopoulou by using the following contact details:

• Dr Loulopoulou: a.loulopoulou@londonmet.ac.uk; Telephone: 0207 133 2667

If you would like any further information to help you decide whether or not to take part, please feel free to contact me directly via email (kah0557@my.londonmet.ac.uk) or telephone (07968 947981).

Screening questionnaire (HADS) for pre-interview purposes for a research project titled "Exploration of women's experiences of cognitive-behaviour therapy for bulimia."

Please note that returning the questionnaire implies consent to taking part in the next step of the study.

You are asked to choose one response from the four given for each item. You can indicate your choice by ticking the statement that best describes your situation. Try not to overthink your answers, but rather pick the option that seems the most suitable immediately.

After you have completed the questionnaire, please email it to the researcher by using this address: kah0557@my.londonmet.ac.uk.

A	**I feel tense or 'wound up':**	
	Most of the time	3
	A lot of the time	2
	From time to time, occasionally	1
	Not at all	0
D	**I still enjoy the things I used to enjoy:**	
	Definitely as much	0
	Not quite so much	1
	Only a little	2
	Hardly at all	3
A	**I get a sort of frightened feeling as if something awful is about to happen:**	
	Very definitely and quite badly	3
	Yes, but not too badly	2
	A little, but it doesn't worry me	1
	Not at all	0
D	**I can laugh and see the funny side of things:**	
	As much as I always could	0
	Not quite so much now	1
	Definitely not so much now	2
	Not at all	3
A	**Worrying thoughts go through my mind:**	
	A great deal of the time	3
	A lot of the time	2
	From time to time, but not too often	1
	Only occasionally	0

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D	**I feel cheerful:**	
	Not at all	3
	Not often	2
	Sometimes	1
	Most of the time	0
A	**I can sit at ease and feel relaxed:**	
	Definitely	0
	Usually	1
	Not Often	2
	Not at all	3
D	**I feel as if I am slowed down:**	
	Nearly all the time	3
	Very often	2
	Sometimes	1
	Not at all	0
A	**I get a sort of frightened feeling like 'butterflies' in the stomach:**	
	Not at all	0
	Occasionally	1
	Quite Often	2
	Very Often	3
D	**I have lost interest in my appearance:**	
	Definitely	3
	I don't take as much care as I should	2
	I may not take quite as much care	1
	I take just as much care as ever	0
A	**I feel restless as I have to be on the move:**	
	Very much indeed	3
	Quite a lot	2
	Not very much	1
	Not at all	0
D	**I look forward with enjoyment to things:**	
	As much as I ever did	0
	Rather less than I used to	1
	Definitely less than I used to	2
	Hardly at all	3
A	**I get sudden feelings of**	

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	panic:	
	Very often indeed	3
	Quite often	2
	Not very often	1
	Not at all	0
D	**I can enjoy a good book or radio or TV program:**	
	Often	0
	Sometimes	1
	Not often	2
	Very seldom	3

Participant Consent Form for Research Participation

Title of research project: "Exploration of the therapy experiences of women who have undergone cognitive-behaviour therapy for the treatment of bulimia nervosa"

Please read the following statements. Tick the box, if you **agree** with the relevant statement.

4. I have read the Participant Information Sheet, or it has been read to me.

☐

5. I am giving consent to take part in an interview, and for it to be audio taped and transcribed.

☐

6. I have had the opportunity to ask questions about it and the study, and any questions that I have asked have been answered to my satisfaction.

☐

7. I understand that my participation is voluntary and that I have four weeks to withdraw my consent after the interview, if I wish to do so.

☐

8. I understand that the interview transcript is produced for research purposes and it may   be used in consequent reports or presentations.

☐

9. I understand that my medical records may be looked at by authorised individuals from the Sponsor for the study and the UK Regulatory Authority in order to check that the study is being carried out correctly.

☐

Name of Participant: _____ Date: _____

Signature of Participant: _____

Name of Researcher: _____   Date: _____

Signature of Researcher: _____

Debrief Sheet

Dear Participant,

Thank you for taking part in this research study.

Please contact Kati Hallikainen (the researcher), if you are interested in the results of the study or if you have any questions or concerns about this study. You have four weeks to withdraw your consent after the interview has been completed. You can do this by informing the researcher via email.

The researcher's contact details are:

Email: kah0557@my.londonmet.ac.uk

Telephone: 07968 947981

Should you have any concerns or complaints regarding any aspect of the study, you can contact my supervisor Dr Loulopoulou by using the following contact details:

• Dr Loulopoulou: a.loulopoulou@londonmet.ac.uk; Telephone: 0207 133 2667

If participation has raised any concerns or issues that you wish to discuss further, a number of nationwide and local agencies can provide advice and support in confidence.

• Beat (nationwide): website: www.b-eat.co.uk; telephone helpline: 0845 634 1414. The helpline is open Mon-Thu 1.30pm - 4.30pm

• Local support:

• BODY (Derbyshire): website: www.bodycharity.co.uk; tel. 01332 25 88 33

• SWEDA (Somerset and Wessex): website: www.swedauk.org; telephone helpline (Thursdays 4pm-7pm): 01458 448600

• No Bodies Perfect (Scotland): website: www.nbp-eating-disorders.co.uk. No telephone number provided, but you can email No Bodies Perfect on info@nbp-eating-disorders.co.uk or contact them via their website ("Contact Us").

• Samaritans (nationwide mental health charity): email: jo@samaritans.org; telephone helpline (24h): 08457 90 90 90 (UK).

• SANE (nationwide mental health telephone support service): telephone helpline (6pm-11pm every day): 08457 67 80 00.

Appendix XIII
Letter of Access NHS Trust A

NHS

Kati Hallikainen

5th August 2015

Dear Kati

Letter of access for An exploration of Women's experiences of CBT for bulimia

This letter should be presented to each participating site before you commence your research at ▮
▮ **NHS Trust ('the organisation').**

In accepting this letter, ▮ **NHS Trust** confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on 5th August 2015 and ends on 31st December 2015 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving the organisation permission to conduct the research.

The information supplied about your role in research at the organisation has been reviewed and you do not require an honorary research contract with ▮ **NHS Trust.** We are satisfied that such pre-engagement checks as we consider necessary have been carried out. Evidence of checks should be available on request to ▮ @nhs.net.

You are considered to be a legal visitor to ▮ **NHS Trust** premises. You are not entitled to any form of payment or access to other benefits provided by ▮ **NHS Trust** to employees and this letter does not give rise to any other relationship between you and ▮ **NHS Trust** in particular that of an employee.

While undertaking research through the organisation you will remain accountable to your place of study London Metropolitan University but you are required to follow the reasonable instructions of the organisation or those instructions given on their behalf in relation to the terms of this right of access.

Continued...

Chair ▮   *Headquarters* ▮   Acting Chief Executive ▮

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by ███████████████████████████ **NHS Trust** in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the organisation's policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with ███████████████████████████████ **NHS Trust** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on ███ ███████████████████████ **NHS Trust** premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and ████████████████████████ **NHS Trust** prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the organisation's premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation will not accept responsibility for damage to or loss of personal property.

This organisation may revoke this letter and may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your place of study is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

The organisation will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your place of study.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your place of study through their normal procedures. You must also inform your nominated manager and the R&D office in the organisation.

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Yours sincerely

PP ████████████

Resourcing Lead

cc: ████████████
HR department of the substantive employer

Appendix XIV
Letter of Access NHS Trust B

NHS Foundation Trust

Research and Development Office

16/11/15

Dear Kati Hallikainen,

Letter of access for research

This letter confirms your right of access to conduct research through █████████ ███████ NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on 16/11/15 and ends on 29/02/16 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct activities associated with such projects as you have received authorisation confirmed in writing from the Research and Development Director of █████████████████████████████ Please note that you cannot start the research until the Chief Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at ████████████ NHS Foundation Trust has been reviewed and you do not require an honorary research contract with this Trust.

You are considered to be a legal visitor to the ████████████ NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this Trust to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through ████████████ NHS Foundation Trust, you are required to follow the reasonable instructions of ████████████ in this Trust or those given on her behalf in relation to the terms of this right of access.

You must act in accordance with ████████████ NHS Foundation Trust's policies and procedures, which are available to you upon request, and the Research Governance Framework.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

You are required to co-operate with ████████████ NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on ████████████ NHS Foundation Trust premises. You must observe the same standards of care and propriety in dealing with patients,

staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

████████████████████ NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You should ensure that, where you are issued with an identity card, this is returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this Trust accepts no responsibility for damage to or loss of personal property.

If your current role or involvement in research changes, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform your employer through their normal procedures. You must also inform the Research and Development Department and your nominated manager in this Trust.

Yours sincerely

████████████

Acting Research and Development Manager
████████████ NHS Foundation Trust

Appendix XV
Draft interview schedule

1. Can you tell me a brief history of your eating disorder from where it started to you beginning therapy?

2. Could you describe the steps that you took in choosing a therapist?

> Prompts: word-of-mouth, referral, qualification of the therapist

3. Could you describe what happens in therapy, in your own words?

> Prompts: What was it like in sessions? Were you given any homework tasks?

4. What was the focus of the therapy for you?

5. What do you think the focus was for your therapist?

6. Would you be able to describe what the therapy was like for you?

> Prompts: Positive aspects? Negative aspects?

7. How well do you think the therapy matched with the type of support that you wanted?

8. Did you ever think about leaving therapy before agreed time?

> Prompts: What do you think made you feel that way? What stopped you from going?

8. How did therapy affect your everyday life?

> Prompts: Consider time commitment, distance, financial aspects. Did anyone else know that you were in therapy?

Full transcript: Participant 3.

Key:

R = Researcher

P = Participant

R1: So it should be recording. So I'll just pop it somewhere there. Um, so I've got just some… fairly generic questions so I really want you to kind of try and… make them your own in a way. So these are just guidelines, but it's more about what sort of… what you want to talk about. But, sort of, as a starting point, could you tell me a brief history of your eating disorder to the point where you actually went into treatment.

P1: Yup. Um, I think... I started dieting, erm, when I was about 11 or 12. I was never big. Looking back, I was a perfectly kind of, normal sized girl, teenage girl, really. Um, but my mum was always very thin. And my dad placed some sort of emphasis on women being very thin and how women should be. Not in a nasty way. But just, he's quite a typical man's man. And had a very clear "Women should wear skirts and women should be women", you know. And I think I remember him saying to me once, you know, "Should you be eating that" or something along those lines. And it really kind of stuck in my head. And I think I just started… being very aware of what I ate and what I looked like and I was never into sport or anything, so I found that restricting my diet, particularly, my mum was a feeder as well. So, my dad played a lot kind of. She wouldn't eat, but she would feed the family a lot. So I couldn't not eat at home. But at school I'd throw away my sandwiches and things like that, so when she wasn't around I wouldn't eat. So I think by the time I finished school at 16, I was on the thinner side. I was never really low weight, but I was, I was quite thin.

And then I got into a relationship with a man… around the age of 17, who was a bit of a player really. And I think he, he cheated on me a lot and I guess I kind of made sense of that as it being because I was too big. For whatever reason it just. You know I thought if I was thinner, then he would love me and, you know. And certainly, as I lost weight by restricting my food, that became clear that that wasn't the case. You know he hated that I'd lost weight. He didn't find it attractive. But by then it kind of, every time we argued, I would, I would restri (sic), I would starve myself. Um… and then…

R2: (overlapping) Did he ever say anything or any indication that that was, because you were saying something about sort of thinking or the way you understood it was: if I was thinner maybe he would love me more.

P2: (overlapping) He never said anything. And the girls that he would cheat on me with were always bigger.

R3: Right.

P3: They were always bigger. It was really strange and I used to, I used to just analyse it so much and be like "why is he going with these girls, they're fat", as I... But they really weren't, but in my mind it was really kind of, you know, "why doesn't he want me." And that was just him, you know, it wasn't anything to do with me. But it really kind of got into, for some reason, and I think it must have been because of how my, the males in my family were. You know, that thinner women were better. And I think as I lost weight, my family, I'd get a lot of positive reinforcement from that. You know, "oh, you look great, cause you're thin" and, you know. So I think it was kind of, it was a real mix, because he would certainly go "what are you do (sic), you need to eat something", you know. "What's wrong with you?"

And then my family would be like "You look great." So, that kind of went on for quite a while and I think when my boyfriend, erm… when we went out, he would make up, he would make me eat. You know, he would be like "We're going out to eat, you're gonna eat. You need to eat." Erm and so I did. And then I'd worry, because you know, I've eaten and I felt horri (sic), I hated that, that full feeling. And so... I started being sick. Erm... probably around, I think I was around 17 or 18 then... erm, coming up to 18 was when I started being sick. Err… And I, but I'm a really noisy sick person (slight laughter) and so people would always hear me being sick. I could never master the whole being sick quietly thing. Erm so I stopped being sick and started taking laxatives. Erm, so that was, I started taking… err, kind of just the normal amount, but then obviously it stopped working so you have to just keep increasing it.

Erm, interestingly that's when I, I decided that I wanted to be a mental health nurse. Erm, and I wasn't really aware that what I was doing was wrong at that time. I just thought I was just getting thinner. And all my friends, we were all at it to a certain extent. You know, everyone, we'd all sit there and go "Have you tried diuretics? Have you taken this? Have you..." You know. And we'd all do it. And um... I decided I wanted to go into nursing and I was accepted and I moved out of home for the first time when I was 18. I moved to XXX (place - town) to go to do my nurse training there... and moved into the nurses' home. And I think really that's when it escalated, because I had freedom. You know, I was on my own.

So no one was monitoring what I was eating. No one was monitoring what I was doing. Erm, you know, I could buy as many laxatives as I wanted. No one was going through my drawers or. You know, it was my first term away from home and I think, erm… That's when I started getting really thin. So I think by that stage I was down to about seven stone, which for me, is tiny for me. Erm, and I absolutely loved it.

You know, I'd, I um. I wasn't somebody with an eating disorder, who... I wasn't really aware at that time that it was an eating disorder, um... But I loved being thin, I felt very, very good being that thin. But by that point I think I was taking kind of fifty laxatives a day and I'd started taking diuretics. Um,

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I still wasn't eating much and I was trying to do clinical placements and things. Erm, and I remember a nurse on one of the wards just being like... um, "You never eat and you, you're ever so thin." And I think because I was so little and young as well, they all kind of mothered me a little bit and they were quite worried. And that's when I started thinking "God, you know, that's a bit weird." And I started getting ever so cold, um, so all my fingers and my toes were always cold and... so I started wearing more jumpers and things to stop people worrying.

Erm, and then, this one day I er, um… I had a big do at the weekend, we were going out, I was still with my boyfriend at this time. Umm, so we were doing like a long distance relationship and we were... okay, but it was still difficult. And we were going out at the weekend and I remember it being a Thursday and I'd gone to placement and I'd taken about a hundred, I think it was about a hundred laxatives, erm, it was the X-lax, the chocolate ones, 'cause I used to love, I used to love chocolate. So it was, it was great for me. Great big blocks of it.

Erm, and I'd, I was so dizzy, I hadn't eaten. I'd taken diuretics, I'd taken about a hundred. And I remember it was during the day, I'd gone to the toilet on placement. And I just collapsed on the toilet. And um, somebody came looking for me, found me and I got taken to hospital. And um, all my potassium levels and everything had just, where I'd gone to the toilet so much, I'd, it, I was, it was really dan (sic), they had to put me on a drip and all this kind of stuff.

And I remember just, in hospital, they, they knew what I'd done, I think. I denied it, I said that I'd had a bug. I was like "Oh, I've had a bug." Erm, and they were like, you could see that they, they knew that I'd...

R4: (overlapping) What did they do?

P4: They, they were just kind of like, you know "If you need to talk to someone, umm, you know, you're clearly, you've clearly got things on your mind." And I was like "No, don't be silly." They were like "Do you want us to phone your parents or something?" "No. Definitely don't phone my parents." And 'cause the A&E in XXXX (place - town) was opposite the nurses' home. And they were like, they were so lovely and they, you know. "If you ever want to talk to someone, just come over." And I was like "Umm, I'm fine, I'm fine." I just kept thinking "I just want to get into this dress", you know, I didn't really care. Um, and I think I was in overnight and then I just walked back over to the nurses' home and didn't really think... anything of it. Um, but I felt, I was, by then I was feeling quite bad and um, the girl in the room next to me, she was a really nice girl. I think she kind of knew what I was up to. She was doing mental health nursing as well. And she made me go to the doctor's and just kind of say "Look, you know, um, there's something going on with my friend." And I think he weighed me and err, was just like "You're really underweight. I want to refer you... somewhere."

So... err, they referred me to a place called XXXX (name – treatment centre) in XXXX (place - town), which is specialist eating disorders. Um, and before I had my first appointment... I took a massive overdose. So, what had happened was the weekend of the party, I'd had a massive argument with my boyfriend, really bad. And then I'd gone home and I'd argued with my parents about... erm, seeing him and all this. They hated him and he hated them and it was all a big... And I just remember going back to uni, so back to XXXX (place - town) on the Sunday night and just thinking that I can't, I can't make anybody happy. I'm miserable, they're miserable, everyone hates me. And just taking a big paracetamol, erm, overdose.

But they'd also, the GP had started me on Prozac… Erm, so I took loads of them as well not knowing then that you can't overdose on Prozac. So it probably saved my life, because apparently the amount of paracetamol that I'd taken would, could have killed me. But the Prozac made me so sick... that I, I brought it all up, so I'd, I went to A&E, erm… my friend, again in the nurses' home found me and took me to A&E. And I was, you know, I was really young. This time they phoned my parents and they came.

R5: How long after the initial, when you went to, or when you were taken to the hospital after you collapsed in the toilets and then saw the GP...

P5: (overlapping) It was about a week.

R6: A week later?

P6: Yeah. So it was all very, very close together really.

R7: Do you remember how long the wait would have been for your first appointment?

P7: It would've been about 12 weeks, I think.

R8: (overlapping) Okay.

R8: Yeah, it was quite a long, it was quite a long wait. Erm... But yeah, I was in hospital for a little while. The psychiatrist, the duty psychiatrist came around to assess me. I think I was so underweight at that time that they were probably considering an inpatient... admission. Erm, but I, I just pretended that everything was okay, really. I kind of, because I'd had, knew that the appointment at the XXXX (treatment centre) was coming up, they were reassured by that, I guess. And I'd said that I'd go back with my parents. And so I left uni… I quit and I went back home, basically. And then we started at the XXXX (treatment centre). Erm, but I didn't have my CBT there. That came afterwards, so... I'll get to that. (laughter) But the, the XXXX (treatment centre), I went and first of all they offered a, kind of like a family, it was more like a psychotherapy type approach. It was a, it was great, it was a really great centre. They offered me individual therapy, but also, I guess it was quite clear that there was a lot of family... dynamics and so they offered us a time to, to go.

Err, and we only actually had one in the end, because, because I left the catchment area to go home, so I couldn't stay at the XXXX (treatment centre), which was a real shame. Erm, but we had one family therapy session and I think that's kind of where I talked to my dad a lot about kind of where this thin thing, and he was heart, you know, he was absolutely heartbroken that, you know, that he, you know, had always thought I was beautiful and he couldn't believe the thought that, you know, kind of how I'd interpreted the stuff that he'd said. He was like "That's not how I ever meant it." And it was, it was a really good, it was only like an hour, but it did a lot of good really, I think, they understood where I was coming from a lot more and um, I understood their perspective a bit more.

And I think, um, the overdose had really shook (sic) us all up. I scared the life out of myself, to be honest with you. I, you know, it was such an impulsive thing to do that, erm. I don't think I ever wanted to die, I wanted everyone to realise how sad I was, you know, and how I just couldn't, couldn't deal with it anymore, as opposed to wanting to die. I think how close I came to dying freaked the life out of me and I, so I'd always say, I'd never try it and I never have, you know. It really did frighten the life out of me and them.

Erm, so I moved back to XXXX (place – another town), which is where I'm from, back with mum and dad, quit university. Erm, had to go to the GP, obviously, and that's where they referred me for CBT, which was at a, um… It was like a day centre, erm, it wasn't an eating disorders' day centre, it was just a normal (sic), they obviously do a lot of different therapies there. And that was in XXXX (place), near XXXX (place). Um, yeah, and that's, that's where, so I went straight there.

R9: Okay, okay. So at what point was it that actually sort of, did you get a formal diagnosis or how was that then actually done? 'Cause it sounds like, well you were describing sort of not really thinking that there was anything really that wrong with you or anything sort of maybe a bit amiss with what you were doing, but I was just kind of wondering about that (end inaudible due to overlapping with participant's speech).

P9: (Overlapping) Yeah, I don't think that I was ever aware that, one that it was a problem what I was doing or two that there had been a diagnosis attached, really. Um, when I found out afterwards that my GP, um, had. 'Cause I'd had a couple of, I only had one family therapy session at the XXXX (treatment centre), but I'd seen an individual kind of, there was like a nurse therapist and then there was a psychotherapist as well. And I guess that when they wrote to my GP, that it'd been generated. And I think... err, because I was such a low weight buli (sic), erm, they kind of, at one point it was like bulimiarexia or something… weird that he said. But in the end it was like a bulimia nervosa, err... kind of like a purging type, I guess really. But they'd, that was how I was referred to the XXXX (new treatment place).

R10: Okay, okay.

P10: So it must have been kind of formulated then, I guess. Erm, 'cause I certainly went to the centre with that diagnosis.

R11: Were you aware of it at the time?

P11: (overlapping) No.

R12: (overlapping) No, okay.

P12: No, I thi (sic). I remember um, going to the XXXX (new treatment place) for my first kind of talking to this lady. And you know, she kind of explained to me what it was. And I, I had no, no idea, kind of, what bulimia was or, I'd heard of anorexia, but er, and I remember just being "I'm not thin enough." You know, that's kind of. "I'm not thin enough to have an eating disorder, what's..." You know, and that's how I kind of thought about it. But I guess as you kind of learn more about it then, I, um. She gave me a book and I remember reading it and just thinking "God, this is me. You know, this is really... This is exactly what I've got. "

R13: Do you remember what the book was? Or what was it about?

P13: (overlapping) Yeah, um, it was "Getting better bite by bite." Have you seen it? It's the… No. It's erm, so it's, it's called "Getting better bit by bit", but it's got the E's, so getting better bite by bite. And she'd, she'd given me that. Um, to kind of like a workbook. Type of thing. So I think it was that and I, I thought "This says it's for bulimia. What's bulimia?"

R14: Right.

P14: And that's when she was kind of talking about it.

R15: Uh-huh. How were you feeling at the time, when you were still kind of... umm, maybe not fully aware of maybe what was actually going on, but you were engaging in these different kinds of behaviours or different things were going on. Then you were put into treatment for quite a specific thing, eating disorder. What, how did you experience that?

P15: I think, um... I remember thinking that the symptoms were right, but they didn't understand what was going on in my head. I think, um… I felt that it... They felt it was too simplistic. You know, like I've got this problem and they'll fix that and then I'll be okay. Whereas my life just felt like it was in an absolute chaos. Um, so I just remember being a bit frustrated and being a bit like, you know, "You guys don't really know what you're talking about." Um, my GP, my family, my, you know, everything really. I was just, I just felt very, very misunderstood and that people didn't understand why I was doing it. And I think for a long time I oversimplified, like for years I remember just saying to people "You're overthinking it, I just want to be thin." You know, just "I haven't got an eating disorder."

Like it, I acknowledged that I had all the, the behaviours. So like I, I acknowledged that. But to me it was all just to be thin. You know I didn't, I didn't think that I had issues or had anything to be fixed or I was just like "I just want to be thin, if I could be thin, then I'm happy." You know, it took a long time and a lot of people saying "But you are thin and you're not happy, so what's..." You know, but I just couldn't see myself as thin. You know, I just didn't see what they saw, really. So I just remember being very frustrated with people. You know "None of you really know what I'm talking about."

R16: Right, right. Sounds like quite a tricky situation to be in.

P16: Yeah. It was a really, it was a really bad time.

R17: Yeah.

P17: Really bad.

R18: So you started CBT in the... centre. Um, it sounds like it was a day service, kind of.

P18: Yes. Yeah, it was a day service. I went every week.

R19: Did anyone kind of talk to you about what the treatment was going to entail or anything about that?

P19: (overlapping) Yeah. Yeah, I remember she was a really lovely lady and I remember her kind of explai (sic), 'cause CBT was really new then. Um, and um, well I guess to us it, you know, I'm sure somebody had talked about it years before, but I remember her kind of really explaining to me about the cognitions and so "We're going to look at what you're thinking and what that leads you to do. And then, you know, kind of how to stop it, really. And how to think differently." And I remember her explaining that really well and how it kind of made sense.

But then, at that point I just wanted to stop making people angry with me and to stop people being sad. I didn't really think that I was hurting myself. So I kind of, I think when I started the therapy... I still thought I'm gonna (sic) stay thin, but I'm, I, but I need to stop making people shout at, a lot and get sad and cry and, you know, 'cause I hated it. You know, um, I was carrying a lot of guilt constantly and I guess I was trying to balance wanting to be thin with wanting to make everyone happy. So I think for me the therapy was just gonna (sic) be an answer for that.

R20: Right.

P20: I didn't think it was ever going to do anything for me. I just thought maybe this will shut everyone up and keep everyone happy.

R21: Right. Was the shouting and the screaming and crying about your behaviour?

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P21: Yeah. Yeah. I think, you know, I was still doing, um, still, um, my laxatives were very restricted, because mum just followed me everywhere. Um, so I was going back to being sick. Um, and I'd started doing exercise, um, and restricting my food and things again. And I also, you know, the day I ended up in A&E after taking all those laxatives again had scared me. So I think I was trying to stay clear of… you know those kind of things, um. And I'd also started taking speed at that time. Um, I remember like a friend of mine saying (laughter) to me "Speed's brilliant, 'cause you just don't want to eat. It's great, it gives you loads of energy. Um, you don't want to eat. And um, and you lose weight." And I was like "Brilliant. You know, this is great, you know it's illegal, whatever." So I started taking that. And it did really restrict my appetite to a huge extent, so. Yeah, I'd started doing that.

But obviously, I mean, I thought people didn't know I was doing speed, but obviously I was bonkers, you know. I was clearly high as a kite constantly, um, which obviously would mean that my parents would get angry with me. I was still with the guy that I'd been seeing for years by that point. He hated me doing it. Um, so everyone was just... you know, constantly shouting at me. And I think the most important thing for me was being thin, you know. I wanted to keep everyone happy, I wanted to, everyone to shut up, but really, the only thing that I wanted was to be thin.

R22: Uh-huh. People really didn't get it.

P22: No. They didn't. They just didn't understand why it was so important, I guess.

R23: Mm, okay. So was that before you went to the centre or was that sort of what was going on…

P23: (overlapping) All around the same time. It kind of really overlapped.

R24: (simultaneously) At the same time. Yeah. It's rarely sort of clear cut, is it. Life. (briefly laughing with the participant)

P24: (overlapping) No, no. Definitely not. And it's like so long ago, as well, I'm like. It all kind of blurs into one as well now.

R25: Yeah, yeah. So when you went to the centre, did um, you said that you met with the lady who was very helpful and explaining then (sic) sort of some of the principles of the therapy and so on. Did you um… Were you presented with a, with options of what type of therapy was there or was the CBT a kind of go-to?

P25: No. Yeah. That's the only thing they had there. I think, because the XXXX (treatment centre) was a specialist eating disorder, they had like a whole package, I guess and they, they gave you what they felt was best, but I think here it was an outpatient, that's what they had. And they said that it was a new thing that they'd been working with and I was just there, you know, so it didn't, it wasn't particularly a choice.

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R26: Uh-huh. Was this then the, the lady, was she then the person you saw for therapy there.

P26: Yes.

R27: Did you get any sort of say around that or you... was it somebody that you were just given an appointment and then you went there?

P27: (overlapping) Yeah, I was just given an appointment and…

R28: How did you feel about… that?

P28: I think I was glad that to a certain extent what I liked about CBT, as it was explained to me was that it wouldn't, it wouldn't require me to talk about... like my childhood or you know, she made it sound very practical. And that it deals kind of really with what you're doing right now and how to stop it, I guess. As opposed to... you know, looking back and kind of why I'd got here. I think, y-y-you know, she explained there would be certain amount of that, but not to the extent that the psychotherapy. And that had freaked me out. When they'd started talking about that kind of thing XXXX (place - town) that had, I was like "God", you know. Because still in my mind, there wasn't any issues. I just wanted to be thin. And so to me the thought of having to go over things that seemed completely irrelevant was quite hard.

R29: Okay.

P29: Because it really was just, it's as simple as I just want to be thin. So when they were saying "Well, we need to look at your relationship with your parent..." and I was just like "Why? I just want to be thin." Whereas CBT made more sense to me, because it was just "We're going to try and stop these behaviours." Does that make sense? You know that, um, that's how they explained it. It seemed far more practical.

R30: Uh-huh, uh-huh. Mmm.

P30: So I was pleased really that she wasn't gonna dig over... stuff. I mean she did in the end, but how it was sold to me, you know, was that it would be very much dealing with the here-and-now.

R31: Right, right. Do you think that had an impact on your decision to go ahead with it, or?

P31: Definitely. Yeah. I think um… I think I probably would've, err, been reluctant to, err… To return to something where I'd really had to talk about my issues. I think I would have stopped going or, you know, whereas I think the CBT, it didn't sound too demanding… so I liked, I liked that. And also I did just want to keep everyone happy, you know, and I was fully aware that if I didn't go then there would be hell to pay, really. And because I didn't drive, it was still a little way away from where I was, my mum would always take me. So you know, I couldn't not go. So I think it, you know… I don't know that I particularly always wanted to go, but I went.

R32: Uh-huh, uh-huh. So what was it actually that, that the therapy in itself, how, how was that?

P32: I found it really, I found it really useful and I think there's so much of it that I don't remember. But there were some things that really... stood out, I guess. Um... And I, I remember... there was this one exercise that she, she'd always give me homework, er, to do before the, the following week and um, and I was always really good at doing that, 'cause I find stuff interesting so, you know, I'd always do it. And there was this one where... well, there was a couple. First of all, I had to write a letter to my parents, um, and talk and kind of try and explain about why I was doing, you know, what I was doing. And um, and to try and think about how it made them feel, me doing what I was doing.

'Cause I guess I'd become really selfish, you know, I had very wrapped up in.. this is just, you're making me unhappy, because you, you wanna stop me from being thin, you know and I, I hadn't really thought about what, how it'd affected them. And then they had write a letter to me...

R33: (overlapping) Okay, so you actually, they actually got a letter…

P33: (overlapping) I wrote a letter and then they had to write a letter to me about how it'd affected them. And I just remember for the first time it really, really hit me, you know, when they talked about seeing me at the hospital on a drip and after my overdose and you know, I remember my dad kind of saying "It's like seeing you daughter being a drug addict, because", he said, "I feel like you're doing this to yourself and you're killing yourself and you don't realise that you're killing yourself." And he just said "You feel powerless to stop it, you just..." And I just remember thinking "What? You know. How can you see it as that, it's not even that bad." And I, but it really kind of, it was like a punch in the stomach, you know. "God, I'm actually hurting people." And I think up until that point I was just so wrapped up in myself and stopping them from being angry with me, er, whereas actually I didn't realise how sad I was making them, how worried they were and, you know. So that was really powerful.

And then another thing that she asked me to do was write a letter to myself in a year's time and where I want to be. And that… that was, that was really, it was, you know, it was a very simple thing, but it was very effective. You know, 'cause I, I remember thinking, 'cause she said to me, you know, "Is this where you want to be?" You know. "Is this your life? Is this..." And I was like "Of course not. I don't want this." And she was like "Well then, where, where d'you want to be in a year's time? You know, what, see that and then we can work on how to get you there, I guess." Um…

R34: Uh-huh. So what was it, 'cause you said that you were... Um... Didn't really think that there was a problem...

P34: (simultaneously) Yeah.

R35: There was just a big kind of hoo-ha around something that you thought was, you know, normal…

P35: (simultaneously) Quite normal. Yeah.

R36: Yeah. And when she asked you about um… "Is this how you want your life to be in a year's time?" You went "No, definitely not." What…

P36: (overlapping) Yeah. It was the external part.

R37: (simultaneously) Right.

P37: So it wasn't so much, I think as I wrote the letter, I think I wrote that I still want to be thin. So I still want to be as I am now, but by that point I'd started accepting that I was thin, so I think I was still around 7 ½ stone at that stage. Erm, so I kind of, I was like "Well, physically I'm okay so I wanna stay like this. I just want to s-stop people being angry." So to stop shouting at me. So I think it was very external, so I think it was kind of "Oh, you know, how am I going to stop people being angry with me."

R38: Okay.

P38: So I think that was kind of why I liked that, um. It wasn't so much that I was unhappy with myself, it was that I was just... I didn't want to be in that same situation in a year's time.

R39: Uh-huh, uh-huh. Okay. Was there, do you think there was anything else, 'cause I can't, remind me how long you were in therapy for?

P39: I think it was probably a good six months actually, I think. Yeah, I think it was a good six months.

R40: (overlapping) Was that every week?

P40: Yeah, every week, umm. I think from what I remember, she had quite a set plan, I remember there being like worksheets and things for about 12 weeks. And then there, but there was some time before we did those and then some time afterwards.

R41: Okay.

P41: So I think from what I remember there was kind of some kind of structure for 12 weeks. But then the rest of the time, she carried on seeing me for quite a while, I think.

R42: Okay. But there were no more worksheets or things like that?

P42: No. She'd, she'd sometimes set me things to, to do.

R43: Uh-huh. Do you remember what sorts of things she kind of asked you to do between the sessions, apart from the letters?

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P43: We did kind of like the ABC... um, charts a lot of the time so um... For example, things like when there was arguments with my parents, she'd ask me to kind of... "So what led up to the argument? What happened?" And then, you know, "What was the fallout?" really. To try and help me to identify, because for me, and it's a typical teenager thing, as well, I guess. You know and um, you know and I was just like "Well, they're just being arseholes." You know. "They're just, they, they're selfish. They're..." And she was like "Well, it's unlikely that that's the case. You know. Why don't you write down, every time that you have an argument, write down what, what led up to it." And at first I used to write down things like "Mum was in a mood. Then we'd have an argument." And, and she said "Look, that's not enough, you know. (laughter) Why was your mum in a mood?" And that. So I think she, she really helped me to kind of understand that normally something had happened before mum was in a mood, before we'd argued.

R44: Right.

P44: Um, so I think she did those for weeks, things like that. So arguments, um... And then, err, because I'd also, I'd really started bingeing as well by this point. Erm, I used to, so when I was um, really fed up, it was a real stress-reaction, erm. Really kind of just this insatiable hunger, just like, I could just eat everything. And um…

R45: Was that less in the picture to start with?

P45: Yeah, definitely. I think it was more just getting rid of stuff at first.

R46: Okay.

P46: That developed later on. Just wanting to literally eat my feelings. Just, just, you know, erm. By this point I, I was so worried about upsetting anyone. I didn't want to tell people when I was sad, I didn't want to tell people when I was angry. So I just found food… was a really, and people were happy to see me eat, you see, so you know, and nobody ever questioned, if I ate ten sandwiches, no one would ever go "That's bad." 'Cause they were just like "Oh my gosh, she's eating." You know. "Brilliant." Erm, so no one'd ever... say anything, err. And then I used to, so I'd eat loads and then I'd go to the shop and buy kind of more, I had very fixed erm, shopping lists and things that I liked bingeing on and erm, you know, it used to be a real escape clause for me. Kind of having these big binges.

And I think erm, I didn't see that as a problem either, because I just thought "Well, I'm making everyone happy 'cause I'm eating." And then, but talking to the lady, you know, she was kind of "Well, let's try and break down what's leading up to these... binges." 'Cause at first I didn't really see a pattern. I'd just say "Well, sometimes, you know, I just get really hungry." And then of course it's a crash afterwards, because I'd realise I'd just eaten like 10 000 calories. "Oh my god, how the hell am

I gonna get rid of them?" So I think that's when I started panicking… about it. Definitely. So we, we used to do the kind of ABC charts for them as well.

R47: Okay. So did that behaviour start sort of before the therapy started or was it somewhere…?

P47: (overlapping) Yeah. I think it um, it started. When I was in the nurses' home, I think I did it for a little, to a little extent, because I'd started getting hungry, sort of thing. Restricting my diet was to a certain extent. But I'd really restrict, restrict, restrict. And then just be star (sic), you know, just go mental and just eat everything. Erm… And then I think, but it got worse when I moved back home, I think… Because I, sometimes I think eating a little bit would start me off. I'd get a taste for it. Erm, and I, I, to a certain extent I still kind of err, think like that. So for example, if I miss breakfast, I won't be hungry at lunch. Just. And I always eat breakfast, but erm, for example, I won't then be hungry. Whereas if I eat breakfast, by lunch I'll be hungry. It's that kind of, once you've started eating, it triggers it off. So I think at home, because I'd... tried to keep everyone happy by eating, erm, it started the bingeing off a lot more.

R48: Uh-huh. You were able to tell that to the, or talk about the behaviours with the lady that you saw?

P48: Yeah. I think I, er, erm, it was only when she questioned me really that I realised I'd done it.

R49: Okay.

P49: Erm, because I do think, I hadn't seen that as a problem either, apart from the fact that I panicked afterwards. Erm, but no, but I just thought "Well, I'm eating, that's what everyone wants me to do. What does it matter if it's hundreds of sandwiches or..." You know, so I didn't really, but when she kind of said "Well…" You know, erm… I remember her just asking if I ever get lots, if I ever get starving and have to eat loads and I was like "Yeah, yeah, I do that sometimes." And then she started talking to me about it and I was like "Oh, right, this is part of it as well." I didn't, you know, I didn't realise… at first... that I was doing that as well.

R50: Uh-huh. So you had framed it in your mind that actually you are doing something that everyone wanted you to do.

P50: Absolutely. Yeah, yes, so that the fact that I was doing it to an excess didn't really… figure. I just thought I'm making them happy, I'm eating, you know.

R51: So apart from the, sort of you said that there were number of weeks when it was quite structured in terms of the worksheets and so on, what, what was kind of, you said there were bits before that and bits after that that were not necessarily focused on that type of work, so what was going on... in those…?

P51: (overlapping) So in the first couple of weeks it was more just, you know, how have we got to this point and why are you here. Erm, what's going on. And safety planning really, because I think, erm, at that point, although I'd kind of... err... said that I wouldn't take an overdose again, I think I was always very clear in my mind that I wouldn't do that again, erm. That never wavered. But to a certain ext (sic), I was extremely depressed, I was really, really depressed. Erm, and I think they were very concerned that that would develop into me trying to… take an overdose again or something like that. Um, so I think at first it was more about put plans into place for "If you feel like this, what are we gonna (sic) do?" You know. And I was adamant from the beginning "Look, I'm not gonna do that again. That freaked me out. I'm not, I'm not gonna. (sic)" But I guess people wanna (sic) make sure that you're safe.

And, and just trying to get me to realise that it was worth work (sic), like I, I was so kind of hopeless at that point. I'd just given up uni, you know, erm. Things were bad with my boyfriend, things were bad with my family, I was just so depressed, um, that I think it was just setting that into place at first. Just generally talking about things… I think.

And then after the 12 weeks, it was again um, it was a, we would revisit things. So.. certain exercises, um and then we used to work a lot on food diary, so we used to do that every week, we'd always work on... so what I'd eaten for that week, um, and how many laxatives I'd taken and all this kind of stuff. And we used to try and look at ways, I think at some point, my memory is a bit hazy, but I think there was like a dietician as well, that was at the centre, who'd kind of talked to me about um, like the physical side of, of bulimia and how things that I'd thought in my head, they weren't right. So you know, things like being sick, you know, it doesn't actually, you don't get rid of it all, you know, so you're making yourself, and she really talked to me about healthy choices that I can make and. So that was really useful actually, I remember, I remember that and she was in the session sometimes, so. I think she was a dietician. She probably was, it was something like that.

Err, so yeah, we did all kinds of things really. And then towards the end I wanted to, I really wanted to go back to uni, but I didn't want to go back to XXXX (town where studied previously) for kind of obvious reasons really. So they kind of talked to me a lot about… what it was that I wanted to do and why I wanted to do it. And at that time I didn't, I kind of, I just always wanted to be a mental health nurse. I didn't see the "Why do I want to do that?" I'd never kind of, you know, weighed it up. Um and then I thought "Well, I'm mad, so there's no way I can go and work with mad people." And that's how I kind of remember saying it and they were like "That's just not the case. You know. You've been through, you're going through this and that's not going to change. But it doesn't mean that you can't help other people." So I think they, they were really positive. Definitely.

R52: Mmm. So you know that the other person was a dietician. Do you know who the therapist was, or what, what was their sort of…?

P52: I knew she was a psychologist. That's, yeah, I knew that. And I remember her saying that she was newly qualified so yeah, that's the only thing I… (laughing) And I, I remember she wasn't the first one that I saw, she wasn't the first one that I saw. There was another one, who err, who assessed me first. And um, I couldn't talk to her because she was a really big woman, she was a really big woman. And I remember going back to my GP and just saying like "I don't think I can talk to her", because I felt like I was insulting her by, because I, I saw myself as fat, but I could see that she was much bigger than me and I felt really rude saying "I'm fat" knowing that she was, does that, you know like, I know it sounds silly, you know, because she was, I, I'm sure she was absolutely fine. But for me I just felt incredibly rude and that I couldn't work with this person.

R53: Mmm. Was that in the centre as well?

P53: No, yeah, yeah. She was at the centre as well. So I'd been assessed by her and then I'd gone back to my GP and just said "I really can't work with that person. I'm sorry." And they were, they were, you know, they were fine. I never saw her again, so. I hope (laughing) I didn't, you know, really upset her. But I just couldn't do it. I just thought "That's a really weird thing to do. I can't sit here." But I just felt like I'd be abusing her.

R54: Okay. So in some ways you had that there was an actual physical difference…

P54: (interjecting) Definitely.

R55: … even though…

P55: In my mind I was still big, but I knew that she was bigger.

R56: Right.

P56: And I, I just couldn't, I just couldn't do it. She was probably about my size actually. Like now. And I, but I just couldn't, couldn't do it. Just couldn't. It was really weird. And she was really lovely, but… just couldn't. And the way I, the girl that I ended up doing all the work with was quite young. And she was slim. And I think it just, it was fine in my head. So…

R57: Okay. You were quite aware of their sort of physical characteristics?

P57: Oh, very. Very, very critical really of, of people, kind of how I saw, um people, I saw, um I really admired thin people. You know. And I kind of, I didn't really respect people who were bigger or. Yeah, very critical actually. Um, which is stra (sic), especially people, because I was never like fit, fit like sporty. So I'd always really admire people who were. And I hated having boobs and I hated, you know, I really wanted to be very lean.

Err, I think one of my best friends at the time, she was always very sporty. So I guess I kind of wouldn't have minded being her. And it was very natural to her, she ate a lot, but she'd burn it all off.

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So, um, and I could never get that into my head (laughter) really. She'd be like "Just come running" and I'd be like "No, I'm not running, don't be stupid." (P and R laugh briefly) So she never kind of understood where I was coming from really. So… yeah. We did all sorts.

R58: Mmm. How did you find it in the, when there was more focus on the food diary and how many laxatives you'd taken, so the kind of purging behaviours.

P58: Yeah.

R59: How was that process for you?

P59: I liked it, because it was practical. Um, it was very clear what I had to do. And I quite liked, I liked that. I like structure. So I liked that I had err, and it kind of fed into my, almost like OCD ways about food. Because having to write everything down was quite good for me. It was a record, so I could remember what I was doing and that kind of stuff. But I always lied. You know, I, err I would say, no I wouldn't say I'd always lied, but I would probably overestimate how much I ate and underestimate the laxatives.

R60: Okay.

P60: And then I'd see how their reactions were. So, say if I'd taken twenty laxatives, I'd write that I'd taken ten. And then kind of see what the reaction was. I was, so if they said "That's, that's really bad." Or, not that they ever said that. But they'd say kind of "That's too much" or erm… then I'd think "Oh", whereas if they went "Oh that's okay", I'd think "Oh, I can take more then." You know. It sounds a bit strange, but I'd kind of read people's reactions on how they'd reacted to what I'd said… to gage what was expected, I guess. And I liked that about them. That they, they never said to me "Stop. Don't take laxatives. Don't stop being sick (sic). Erm, eat this, this and this." They never did that. They kind of accepted that, until we'd kind of got through the process, that really it was like a comfort blanket that I needed to do it.

I couldn't just stop doing it. I think if they'd said to me that at the beginning "Right, you've got to stop." Then I don't know how that would've… worked for me. Because I wasn't ready... I think. Because I would've just been like. You know I always compare it to Alcoholics Anonymous or something and how really they need to stop for that. And I always think that's quite… I don't know… difficult… to stop and then look at the problems. Does that make sense? You know, whereas I think you almost got to deal with the problems and then, you almost change yourself… as opposed to… just stopping.

R61: Uh-huh. What do you think, hypothetically, if, if that, that's what would have happened. How would have that been for you? Or what…

P61: I just don't think I could've done it. I just don't think. I think I would've just stopped going. Erm.

R62: Uh-huh. Why do you think it was important to kind of be able to carry on doing what you… were doing?

P62: (overlapping) Because… I think err… I don't know actually. I think I just wasn't. I was so scared of getting big. And I think I, I didn't understand enough about diet and um… how the body works and things… to just, I thought that if, if I stopped taking laxatives, if I'd started eating normally then I would just get fat. So I think I had to go through the process of learning why it was. For example, by then I'd stopped losing weight and I couldn't understand why, because I was still doing all the things that I was doing. And I guess like, you know, they explained to me why. You know, and I, as I started to understand the body better, then I accepted it more… Whereas if they'd said "Right, you've got to stop", that would've terri (sic), it would have terrified me, because I would have just thought "I'm just going to get fat then." And actually as I reduced the laxatives and everything, nothing changed. I didn't put on weight, I didn't, you know, because I was getting healthier.

R63: Uh-huh. What do you think was going on with your sort of… I don't know if body image would be the right word, but. Because you were describing earlier sort of maybe being quite unaware of how you actually were physically.

P63: (overlapping) Very.

R64: And then, during that process what was going on with that at the time? Because I'm just wondering when you were telling me that actually, if they'd told me that I couldn't have gone ahead with it, but however, as it happened gradually…

P64: (overlapping) Yeah. I think um, we were doing the exercises as well about kind of erm, you know like drawing yourself as you think you look and then as other people, as other people look at you and things like that and erm. I think like now with phones and photos and stuff it would be so different, erm, because I, I couldn't, I remember kind of, there was a piece of paper on the wall and I had to draw kind of my outline like as I saw it. And then they would draw around me and how thin I was.

R65: Right.

P65: So I kind of drew what I thought I looked like and then, but then they, and me just thinking "What? That's not me." You know and really not being able to see… that how thin I was. And um, I remember buying job, a job outfit, interview outfit and it was a size six sk (sic), size six skirt and it'd be lose. And um, and my mum just saying "You do realise you can't shop in adult shops." There was (sic) only a few shops then that sold size sixes. Like Top Shop didn't do them, for example. I think sizes have got much smaller now, haven't they. But then you couldn't get size sixes. And mum just

saying "We're gonna (sic) have to go to the children (sic)" and me just being like "What? That's ridiculous." You know, I just really didn't get it, because I, I just didn't see what, you know, I couldn't equate those two things together.

Erm, and even now I um, I have no idea how look. Like I, I can't ever, I don't see what other people see. It's ever so, I don't trust my image of myself. Does that make sense? You know like someone will show me a picture of me and I'll be like "Really?" You know. It's, it's ever such a strange thing. I don't think that's ever gone away, kind of the, my self- image. Definitely hasn't changed.

R66: Uh-huh. Mmm, okay. Do you think anything happened to it during the therapy or, or? 'Cause you said that it's kind of still there to some extent, that kind of… maybe perception of how you are… But…

P66: Yeah. I think what changed with therapy was that they educated me about kind of how the body works and what I was doing to myself. And I think they helped me see the behaviours and how erm… there were other options. And that they were destructive. I don't think umm… it… kind of… it didn't change myself concept. I think it stopped me doing things and it did stop me. You know like by the end of it I really had stopped taking laxatives. Err, you know I, I think and I accepted that. But I probably never saw myself as any different. Do you, you know. So it's weird. Like I, I think it was very successful, but never dealt with the internal side of it.

R67: Right, okay. So some of the things that you were doing, like the external behaviour in a way.

P67: Yeah, that. It dealt with that, definitely. You know, I think practically.

R68: Yeah. How do you think it did that? Was it just the education that was probably enough for you?

P68: (overlapping) I think a lot of it was educa (sic), a lot of it was education and a lot of it was those powerful moments of seeing it of other people's empathy, I guess. Kind of learning about how it affected other people. I don't think it was ever about how it affected me. Erm, I'd never thought that was that important. Erm, I was just like "Well, I just want to be thin, you know, and that's it." But when I understood more about how it affected other people… that helped me. Erm, just, just, I think I just felt such tremendous amount of guilt that it, it was like "I can't do this to other people." And I think it was those moments that was (sic) very powerful in stopping me.

I don't think it was ever because I learnt to love myself. Or because, um, you know, I thought better of myself then. It didn't. I think I still feel to a certain extent those same ways, but I wouldn't do it to other people anymore. Does that make sense, I, I know it's a really strange… So I always say that it was successful for me, it definitely was. It stopped me doing the things that I did. But probably not for the reasons that you'd expect. (laughter) You know that you might expect, I guess.

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R69: Okay. What, what do you think you might expect? What's the kind of… The reasons that you outlined were sort of very much about other people's welfare…

P69: (overlapping) Yeah.

R70: … But it sounds like then there's a flip side to that. What…

P70: (overlapping) Yeah. I think, you know, that um… I think… For me to say that something like that can be a hundred per cent successful, not that anything is, but you know, much more successful, is like based on kind of internal feelings and like I had very external motivation for changing. Um… Internal motivation. I always still erm… It was kind of like it was because I valued other people more than I valued myself, I guess. Erm… Whereas I think for it to be successful, it would be the whole kind of, err, you know "I'm worth more. I'm, I deserve to be happy, I deserve to be um… healthy." That kind of thing. To be that would be a far more successful…

R71: What do you mean by successful in that context?

P71: Like genuinely not thinking like a bulimic anymore.

R72: Right.

P72: D'you, d'you know? I think I, I believe that I still fee (sic), think like a bulimic, but I won't act on it.

R73: Uh-huh. What do you mean by that? If you had to kind of explain it to a lay person. What's thinking like a bulimic?

P73: (overlapping) Yeah. I think, um, I value thinness much more than I value most things. And I think, um, over the years like I've put on a, like I'm literally, I'm probably almost double what I was. Um, and a lot of that has been to do with um, not wanting to be seen as someone with an eating disorder. Or you know, erm, I have always disclosed it, you know, in health interviews and that kind of stuff. And people are always incredibly surprised and I like that. You know, I don't ever want people to, to think that, you know that I'm still poorly or anything, so um. But I still, I'm still obsessed with calories, I'm still obsessed with food. I love food you know and, and which has allowed me to kind of to, to be healthier, I guess. Um… but you know, if it didn't impact on anything, then I would probably straight away go back and you know.

I also think one of the reasons why I've put on so much weight is just like self-protection thing, like err… I'm always scared to lose weight, because I'm scared to get obsessed again. You know like I, I've known, I've been on hundreds of diets over the years, properly done Slimming World, Weight Watchers, that kind of stuff. But the problem is I get fully obsessed and I, I get um I get competitive, I get rea (sic) and I, I know it's just under surface. You know, it's like it's just like scratching the

surface and it's… you know for example, I joined the Slimming World club. And the day that I would get weighed, I wouldn't eat anything. I wouldn't even drink water. And err, because I was terrified of the scales. Absolutely terrified. And in the end I was like "I can't, I just can't do this."

So it's almost like a self-protection thing. Like I know what I'm capable of… and so I just don't think about it. Because to go down that road would be opening a can of worms. I know how I can lose weight really quickly. It's like, you know, it's in my head, you know, I'll just go and buy laxatives and I just do this and I know that I can do it, but I know that that's just such a slippery slope. It's like you're constantly. And I do always compare eating disorders with like alcoholism or drug addiction or something, because it does feel like to me every day is, is not, I don't think about it every day, it's nothing like that. But I know that you could easily slip back into it.

R74: Uh-huh. So it sounds like you kind of have to keep yourself in check in a way, without sort of labouring over it.

P74: (overlapping) Yeah, definitely.

R75: But there's a kind of checking point…

P75: (overlapping) It's there. You know it's like I know I think I, I need to just not think about that… Um, but yeah, I think it. I have a much healthier outlook, but it's err definitely sti (sic), it's there. But it, I just don't think about it, I guess.

R76: Uh-huh, uh-huh. Just to go kind of back to the… what you said about the food diaries and stuff like that and you said that actually you were kind of… fiddling around a bit…

P76: Yeah. Oh yeah.

R77: With the numbers (short laughter). Um, and I was, you said you were kind of checking in with… how they were.

P77: (overlapping) Their reaction. Yeah.

R78: Yeah. And what, what were their reactions? Or how, what was that like? Did you stick with your method or did that start changing at some point?

P78: (overlapping) No. I think I stuck with it really, because um again it's about me… kind of wanting people's approval and wanting to make people happy and I think I would really read whether they'd approve what I'd done. You could read people's rea (sic), you know you can read kind of… err, they'd go "Oh you shouldn't have, you know, that was too many. Ten, maybe you should've taken eight. And next week try that." And I'd pick up on those little things really…

R79: (overlapping) And if they said that kind of thing, what… would be your reaction?

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P79: (overlapping) And then next week I would. I wouldn't necessarily change, but I would write down that I'd done that.

R80: Okay, uh-huh.

P80: So that I would get the "Oh that's much better, well done." You know and I'd think "Oh right, that's what they want me to say." So I think the food diaries and that, they um, that was kind of how I did, and it's funny 'cause I, I've got a fitness app on my phone, where you count calories and I lie to that. And I'm like "Why am I lying to it, no one knows?" And I'll be like "Well, I only had this amount of cheese." It's like, it's just stupid, but I still, you know you still do it. Definitely. I think it's, it's that little bit of deceit. You're not, not willing to be… fully honest. I think it's a very secretive… thing.

R81: Uh-huh. What did you, did you ever have any ideas of what might have happened, if you were to be honest, or?

P81: No, I'm sure that they'd, you know, just would've been absolutely accepting of it and would've worked with the honesty. You know, I think that's um…

R82: Did you feel that at the time? That that would have…

P82: (overlapping) No, because I, I think I wanted, I so just wanted to make everyone happy, you know, and I think like everyone was unhappy with me. So, to a certain extent, just to get a bit of approval, a bit of praise, a bit of um, just acceptance, I guess, was quite a nice feeling. So I think for them to say "You've actually done quite well", when my mum would be, you know, saying "You haven't eaten enough" or "You've done this or you've done that." My mum was still very critical. If I can make one person happy, then it, it felt quite powerful. So, um.

But no, at the time I didn't really consider what being honest… would have done. You know. Because I was lying to everyone and I, I do think with eating disorder you lie to everyone around you. Again, with addiction, you, you do, because you never tell anyone really how much you've taken or, because you're just scared of shocking them or you know um… And I, I think now, because I've worked in mental health services, I know that they would have been just like, they've always seen worse. You know like, they would've just been like "Well, that's fine, we'll work with that." But at the time… I didn't have a clue. So I think I just didn't want to get their disapproval really, I didn't want to be told of or, you know, and that's kind of how I thought, and they never did anything to make me think that. It was just completely my perception.

R83: Mmm. It's quite sort of tight monitoring in terms of what's um… acceptable or…

P83: Definitely.

R84: … Sort of um, despite feeling that you had a problem necessarily, or I don't know how it was at that point when you were doing those diaries, but… um, then kind of having to keep those in check as well, what was going down on paper.

P84: (overlapping) Yeah, yeah.

R85: How was that? Was it easy or?

P85: No, I think, I think um… It was just a, it was a really weird time, 'cause I was just lying to everyone. I didn't really feel like I had anywhere, where I could be fully honest or um, I, I was much more honest with the lady than, I wish I could her name, than with her than with anybody. Certainly about my feelings and about something that was going on at home and, and that. She was very uncritical. Very, um, just non-judgemental, I guess. But even then I still wouldn't tell her… all of it.

You know, so… err. It just felt really lonely really, I think. It felt very lonely, because everyone knew a little bit, but no one knew the, you know, and I think um… everyone just, that people just couldn't understand why I couldn't just stop… You know, people just really didn't get it. It was just like "For god's sake, you're thin, just stop. You know. Why are you getting yourself like this?" Umm. So yeah, it was just very lonely, really.

R86: Was that ever sort of, 'cause you said something about um, sort of for it would be hundred per cent successful, if you wanted to use those terms, but there was sort of, it would have dealt with more of the internal stuff that was going on for you…

P86: (overlapping) Yeah.

R87: … Rather than the behaviour in itself.

P87: Yeah.

R88: And something about you said sort of self-worth, or… I think you used some other words for that. But was that ever touched on in anyway, sort of was it going beyond that…? (inaudible as the participant starts talking)

P88: (overlapping) Not really. You know, they did very basic kind of body image type. You know, what would you say to your friend, if they looked like you, you know. And I was always very good at the, you know, the, I could see how it applied to other people, I just couldn't see how it applied to me. Um, so they did touch on bits of it. Um… But then, I think, like I, what I was saying to you about what I liked about CBT was that it dealt with the here and now. I think although I probably would've benefited from more of a… internal kind of, like psychotherapy type thing, I don't think I could've dealt with it. I think I would've run away from that, I think it would have been too much. So I think CBT was the right… you know, approach at that time, I guess. I don't know that I could've dealt with

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anything more. Even now it makes me feel uncomfortable. You know, and I, it's, it's ever so weird, you know, you just kind of… you know "Oh, I don't know if I could have gone into that." Whereas CBT did enough… I think.

R89: Uh-huh. Mmm. So that was sort of… (clearing throat) You said after the twelve week period and so on, you were doing more of the food diaries and things like that.

P89: Yeah.

R90: Was there anything else that was sort of leading up towards the end of therapy or anything that you remember from that period at all?

P90: We talked um… They were very clear about kind of, we had a very clear end date.

R91: Right.

P91: And kind of how I would deal with things after that end date. They were really good at that.

R92: When was that set? Or…

P92: I think it was probably about a month or so before and they said "Right, we've got four sessions left, four weeks left, um. How are we gonna (sic), how are we gonna (sic) use those? What do you think we need to work on? What do you want to focus on? Because this is our last time. And how are you, you know, what are you gonna (sic) do, when you." 'Cause I guess it was a safe space for me to go every week. Umm, and talk about things and you know, it, it was a nice area, I guess. So I was scared coming up to the end, because I was like "Well, what am I gonna (sic) do now?" You know. Um…

But we had a, like a, at that point I was working in a kind of like a… youth centre and a looking after school club kind of thing. And there was a youth worker there, who I'd, who'd worked at our school when I was there. And he was ever so good and I think I'd kind of started speaking to him about things and so I'd kind of identified that there was someone who, if I was reaching crisis point, that there would be someone that I could talk to.

R93: Okay.

P93: And I think we did like develop a kind of like a (sic) ABC, you know, if this happens and this is where I know it leads, what, how am I gonna (sic) divert. So we had, we would make plans for, you know. And it, it, we talked a lot about the kind of the suicide thing and how it couldn't get to that point again. Erm… And I guess I was always adamant that that wouldn't happen, but (laughing) know, knowing now, and I was right. I knew that it wouldn't and it hasn't. But um… but from their point of view, it's very much, you have to safety plan. So we worked a lot on that and what I would be doing in that situation and that kind of stuff. So…

R94: Uh-huh. And was the youth… um, service staff member, were they aware of what you'd been going through and?

P94: (overlapping) Yeah, yeah. He knew, he knew.

R95: How, how did he find out about it?

P95: I told him.

R96: Okay.

P96: Yeah. I told him. And I think he'd noticed obviously that I'd lost so much weight and err, he was someone who was always there through school. He was a great guy, and um, I always find him very easy to talk to, very uncritical of me. You know, just whatever. Erm, you could tell him anything. You know, that's a, that's a good youth worker, isn't it? They don't, they don't judge you, I think. So he was always kind of like a safe person for me to talk to. And was never bothered by anything that I said to him. Erm, he'd always listen to all our boyfriend dramas and all this kind of stuff. (R and P laugh briefly) He'd be like "Oh, for god's sake, what's wrong with you?" And you know he was always, he was always great, so it was someone who, um, I knew that yeah, I'd be okay talking to him.

R97: Uh-huh, uh-huh. And you said that they were quite clear in the therapy, as well, regards to sort of after you finish and what the date is and what the plan might be after that…

P97: (overlapping) Yeah, very.

R98: … and so on.

P98: Yeah, which I think is great. I think if it, if it was just like "Alright, bye. It's ending next week." I think it doesn't allow you to get used to it. Whereas they, they obviously had a very strict deadline, I guess.

R99: Uh-huh. And how was it for you when it did end?

P99: Um… I remember being quite sad… Um, but feeling… o-kay with it. I remember thinking that "Now I'm alright, I'm gonna (sic), you know, I'll be okay now." I think I, I felt confident… that I would be okay. I was ready to apply for uni again and then… I think I, yeah, I felt okay. I felt shaky. And they were quite clear that I couldn't just phone up and see them again, you know, it wouldn't. I would have to go back through my GP and um… err… so I was okay. I was nervous, but I was okay. I think my family were very concerned…

R100: Okay.

P100: That I'd fall back again.

R101: Okay. How did they… express that… concern?

R101: (overlapping) They, they'd just be like you know like "What will you do, if?" But again it was quite good, because it would have wri (sic), written safety plans, so. And I'd give them to my parents and just say "Look, this is what I'll do in this situation." And so, I think that helped them.

R102: Uh-huh, uh-huh. So what do you think… overall, how do you think the therapy or the therapy process, how has it impacted on your life or on you?

P102: I think it was very powerful. I think it happened, for me it happened at the right time. It happened at the point after crisis, I guess. I was at my lowest point. Erm, it was the right therapist, it was the right approach. I think it was very, very successful. Like I said, I've had a few blips over the years and I, I think I've… err, at times when I've had to take laxatives, for example. It's always very tempting to take a few more. But I've been quite open with people and said that. I've always had good GPs and I've just always been like "I'd rather not take a laxative, if that's okay, because of this, this and this." And they're always very good. Um, so I think it, it was the right thing for me at the right time. I think it was very powerful… Certainly some of it. I don't remember it all. But some of the things really stuck in my mind, like I said about the letters and the… um… you know the… um, looking at kind of how, like the ABC charts for arguments. Things like that were very powerful.

R103: Uh-huh. Is there anything that you still sort of, 'cause you said that you've had a few blips over the years. Was there anything that you were making use of at the time? That you could possibly link to what you went through in therapy or was there something else?

P103: (overlapping) Yeah, definitely. I think I, I'm very… err, like you know, I work like I said, I trained as a mental health nurse… eventually. I qualified, you know, and I've always worked in forensics, so… um and one of my strengths, I think, is that awareness that things don't tend to just happen. So, like how I used to say like "My mum's just grumpy. That's why we had an argument." I guess it taught me that things don't happen in isolation, you know. And that people's moods, you know they, something's normally going on. And I guess I've always used that a lot.

And I, I use, I use a lot of those approaches in my work, because it was very powerful for me. And because of my experience of lying, for example, in the food diaries, when I ask people to do, I really emphasise that I'm not gonna jud (sic), you know I'd rather you be honest and we could work with things, but I need to know, you know. And I, I see it from their point of view, why you would lie. You know, other people don't get it all the time, you know, whereas I get it. I get why you'd, you know I've never worked with eating disorder. I've avoided it like the plague. I don't think that I could deal with it. I think that the competitive side of me, I think being around it too much… would be hard for me. So I've always worked particularly with men and in very different situations, but I think there are

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similar, you know, you can use those approaches anywhere, so I think that's always been useful. Definitely taken so much of it away.

R104: Uh-huh. If you were to go back, back to that or back over it in a way and kind of replay it, do you think that there would be any bits that you would… change or anything that you, in hindsight anything that you think was not that helpful or at the time didn't feel particularly helpful or…

P104: I think I should've been more honest. Definitely. But that's about me. I think that the process itself was, was great. I don't remember it ever being anything that I was unhappy with. I remember not enjoying it, but I, I did feel very, it felt very safe. Um, the structure felt very safe for me. Um, but it, with hindsight I think perhaps I could have got more out of it, if I had been more honest and less worried about being judged. But that's where I was at that time, I guess.

R105: Uh-huh. Okay. Do you think that there's anything that sort of… hasn't been talked about or you think that is relevant to what, what we've been talking about or…

P105: No, no.

R106: Anything that you wanted to add, or?

P106: No, no, I think it's… No, that's been cool.

R107: Okay.

P107: Yeah.

R108: Did you have any questions or anything that you wanted to check out?

P108: No, I don't think so.

R109: No? Okay.

P109: No, that all sounds cool.

R110: Cool. Well, is it alright to finish here?

P110: Yeah. Of course, absolutely. Yeah.

R111: Yeah, brilliant. (Interview ends at 1:14:53)

521 Err, I think one of my best friends at the time, she was always very sporty. So I guess I kind of

desire to be like a sporty friend

522 wouldn't have minded being her. And it was very natural to her, she ate a lot, but she'd burn

weight control was easy for the friend

523 it all off. So, um, and I could never get that into my head (laughter) really. She'd be like "Just

P couldn't understand this

524 come running" and I'd be like "No, I'm not running, don't be stupid." (P and R laugh briefly)

Friend didn't understand

525 So she never kind of understood where I was coming from really. So... yeah. We did all sorts.

why P didn't exercise (if she wanted to lose weight)

526 R58: Mmm. How did you find it in the, when there was more focus on the food diary and

527 how many laxatives you'd taken, so the kind of purging behaviours.

therapy focus on purging?

528 P58: Yeah.

529 R59: How was that process for you?

530 P59: I liked it, because it was practical. Um, it was very clear what I had to do. And I quite

clear expectations, meet others' expectations?

practical, liked it clear, structure

531 liked, I liked that. I like structure. So I liked that I had err, and it kind of fed into my, almost

Obsessiveness remains

feel into P's OCD. rel ship with food

532 like OCD ways about food. Because having to write everything down was quite good for me.

So in some ways the therapy reinforces some traits...

Written records

Same

admiring difference, rejecting sameness

easy to meet others' expectations in therapy - satisfying others

therapy reinforces rigidity regarding food

like P1

43

533 It was a record, so I could remember what I was doing and that kind of stuff. But I always

534 lied. You know, I, err I would say, no I wouldn't say I'd always lied, but I would probably

535 overestimate how much I ate and underestimate the laxatives.

536 R60: Okay.

537 P60: And then I'd see how their reactions were. So, say if I'd taken twenty laxatives, I'd write

538 that I'd taken ten. And then kind of see what the reaction was. I was, so if they said "That's,

539 that's really bad." Or, not that they ever said that. But they'd say kind of "That's too much"

540 or erm... then I'd think "Oh", whereas if they went "Oh that's okay", I'd think "Oh, I can take

541 more then." You know. It sounds a bit strange, but I'd kind of read people's reactions on

542 how they'd reacted to what I'd said... to gage what was expected, I guess. And I liked that

543 about them. That they, they never said to me "Stop. Don't take laxatives. Don't stop being

544 sick [sic]. Erm, eat this, this and this." They never did-that. They kind of accepted that, until

Handwritten marginal annotations:

a record of what was going on

P lied on the records

overestimate food, underestimate purge

P would monitor professional's reactions

Write down 1/2 of P

balancing behaviour (through) based on feedback from others

read others' reactions to what she gave on P

to be left in peace? To accepted into what she gave on P

Trying to understand the expectations

P wasn't told what to do (helpful for P)

that they were easy to read? easy to deceive?

they didn't ask me to change

44

slip-up in the interviews indicating a reluctance to stop?

deceit (to hide the truth about ED)

Complying on the surface to appear other...

struggle to give up the is beg of ED

171

Safety?

allowing P to have a comfort blanket (purge)

545   we'd kind of got through the process, that really it was like a comfort blanket that I needed

546   to do it.

547   I couldn't just stop doing it. I think if they'd said to me that at the beginning "Right, you've

Couldn't just stop (er) need to be ready to stop (er)

548   got to stop." Then I don't know how that would've... worked for me. Because I wasn't

549   ready.... I think. Because I would've just been like. You know I always compare it to Alcoholics

Compare ED changing to AA

ED as an addiction (identity of an addict?)

550   Anonymous or something and how really they need to stop for that. And I always think

Required to stop first then look at the problems

551   that's quite.... I don't know... difficult... to stop and then look at the problems. Does that

552   make sense? You know, whereas I think you almost got to deal with the problems and then,

P thinks stopping is a process (that happens when problems are being dealt with)

change as a result of changing yourself (identity)

553   you almost change yourself... as opposed to... just stopping.

Shift in identity, change of behaviour?

554   R61: Uh-huh. What do you think, hypothetically, if, if that, that's what would have

555   happened. How would have that been for you? Or what...

P not able to engage with therapy if had been told to stop

556   P61: I just don't think I could've done it. I just don't think. I think I would've just stopped

Pressure to change = drop out of therapy

557   going. Erm.

172

558 R62: Uh-huh. Why do you think it was important to kind of be able to carry on doing what

559 you... were doing?

560 P62: (overlapping) Because... I think err... I don't know actually. I think I just wasn't. I was so

561 scared of getting big. And I think I, I didn't understand enough about diet and um... how the

562 body works and things... to just, I thought that if, if I stopped taking laxatives, if I'd started

563 eating normally then I would just get fat. So I think I had to go through the process of

564 learning why it was. For example, by then I'd stopped losing weight and I couldn't

565 understand why, because I was still doing all the things that I was doing. And I guess like,

566 you know, they explained to me why. You know, and I, as I started to understand the body

567 better, then I accepted it more... Whereas if they'd said "Right, you've got to stop", that

568 would've terri (sic), it would have terrified me, because I would have just thought "I'm just

569 going to get fat then." And actually as I reduced the laxatives and everything, nothing

570 changed. I didn't put on weight, I didn't, you know, because I was getting healthier.

Handwritten annotations:

not sure why it was important to carry on with P

lack of knowledge
values

no scared to get to a lack of knowledge re diet

beliefs about consequences of stopping laxatives

therapy: learning how body works

didn't understand why stopped losing weight

starting to accept body more when knowledge increases
(insight increased acceptance)

just stopping would have been terrifying, as scared of the consequences

learning through changing behaviour (laxatives decrease)
becoming healthier

taking a risk
did not
challenge values

change attributed
to increase in
knowledge

values (thinness)
remain unchallenged

571 R63: Uh-huh. What do you think was going on with your sort of... I don't know if body image

572 would be the right word, but. Because you were describing earlier sort of maybe being quite

573 unaware of how you actually were physically.

574 P63: (overlapping) Very.

575 R64: And then, during that process what was going on with that at the time? Because I'm

576 just wondering when you were telling me that actually, if they'd told me that I couldn't have

577 gone ahead with it, but however, as it happened gradually...

578 P64: (overlapping) Yeah. I think um, we were doing the exercises as well about kind of erm,

579 you know like drawing yourself as you think you look and then as other people, as other

580 people look at you and things like that and erm. I think like now with phones and photos and

581 stuff it would be so different/erm, because I, I couldn't, I remember kind of, there was a

582 piece of paper on the wall and I had to draw kind of my outline like as I saw it. And then they

583 would draw around me and how thin I was.

584   R65: Right.

585   P65: So I kind of drew what I thought I looked like and then, but then they, and me just

586   thinking "What? That's not me." You know and really not being able to see... that how thin I

587   was. And um, I remember buying job, a job outfit, interview outfit and it was a size six sk

588   (sic), size six skirt and it'd be lose. And um, and my mum just saying "You do realise you can't

589   shop in adult shops." There was (sic) only a few shops then that sold size sixes. Like Top

590   Shop didn't do them, for example. I think sizes have got much smaller now, haven't they.

591   But then you couldn't get size sixes. And mum just saying "We're gonna (sic) have to go to

592   the children (sic)" and me just being like "What? That's ridiculous." You know, I just really

593   didn't get it, because I, I just didn't see what, you know I couldn't equate those two things

594   together.

595   Erm, and even now I um, I have no idea how look. Like I, I can't ever, I don't see what others

596   people see. It's ever so, I don't trust my image of myself. Does that make sense? You know

175

48

Handwritten annotations:

- discrepancy between actual self and beliefs about self — couldn't see how thin she was

- Being in Denial of own Physical size 578-587

- adulthood

- Shopping in adult — children's clothes, a job interview outfit with mum — not an adult yet

- 'Can't shop in adult shops' too small to be an adult

- (struggle to) move from childhood into Adulthood

- mum tells P: need to buy children's clothes — P thought that was ridiculous

- gap between actual and imagined size (couldn't put the two together)

- still doesn't know how she looks to others

- Still Can't trust Self / own judgement — don't trust own 'self-image'

Change has to happen
'in Sarah's terms →
staying in control

seeing pictures of self
is surprising

It's strange (to be like that?
that it's never changed?)

'definitely' no change in how
perceives self

597 | like someone will show me a picture of me and I'll be like "Really?" You know. It's, it's ever

598 | such a strange thing. I don't think that's ever gone away, kind of the, my self-image.

identity remains unchanged

599 | Definitely hasn't changed.

600 | R66: Uh-huh. Mmm, okay. Do you think anything happened to it during the therapy or, or?

601 | 'Cause you said that it's kind of still there to some extent, that kind of... maybe perception of

602 | how you are... But...

603 | P66: Yeah. I think what changed with therapy was that they educated me about kind of how

+ therapy was educational
(biology of body)

surface seems changed, but the core remains unchanged

604 | the body works and what I was doing to myself. And I think they helped me see the

+ helped to see alternatives
to destructive behaviours

605 | behaviours and how erm... there were other options. And that they were destructive. I don't

– didn't change self-
concept

Who am I? Identity?

606 | think umm... it... kind of... it didn't change myself concept. I think it stopped me doing things

607 | and it did stop me. You know like by the end of it I really had stopped taking laxatives. Err,

+ stopped laxative use

608 | you know I, I think and I accepted that. But I probably never saw myself as any different. Do

but body image/core
'self-concept remained!

610 internal side of it.

611 R67: Right, okay. So some of the things that you were doing, like the external behaviour in a

612 way.

613 P67: Yeah, that. It dealt with that, definitely. You know, I think practically.

614 R68: Yeah. How do you think it did that? Was it just the education that was probably enough

615 for you?

616 P68: (overlapping) I think a lot of it was educa (sic), a lot of it was education and a lot of it

617 was those powerful moments of seeing it of other people's empathy, I guess. Kind of

618 (conviction with other) learning about how it affected other people, I don't think it was ever about how it affected

619 me. Erm, I'd never thought that was that important. Erm, I was just like "Well, I just want to

620 be thin, you know, and that's it." But when I understood more about how it affected other

Handwritten annotations:

(no good on the surface, but didn't get to the core?)

successful in practical terms (behaviour)

education and powerful moment contributed to the outcome

(insight; empathy; changed view point)

insight into how it affected other rather than self

external focus in therapy. Maintains a sense of safety (not about me)

others are more important than me?

is this safer than focus on the self? keeping it external?

50

Handwritten annotations (margin, top):

guilt stopped P from continuing with the behaviours

insightful (quite) moments contributed to P stopping behaviours

Outcome didn't happen because of:
- learning to love oneself
- value self more
(you learn like she did before, but knowing what she knows about the impact on others → doesn't carry out the behaviours)

motivation behind the change 'strange', surprising

Handwritten annotations (margin, left):

621 — prioritising others' perceived needs in therapy

624 — valuing self - no difference

625 — [unclear]

627 — the self remains hidden in therapy untouched

---

621 people... that helped me. Erm, just, just, I think I just felt such tremendous amount of guilt

622 that it, it was like "I can't do this to other people." And I think it was those moments that

623 was (sic) very powerful in stopping me.

624 I don't think it was ever because I learnt to love myself. Or because, um, you know, I thought

625 better of myself then. It didn't. I think I still feel to a certain extent those same ways, but I

626 wouldn't do it to other people anymore. Does that make sense, I, I know it's a really

627 strange... So I always say that it was successful for me, it definitely was. It stopped me doing

628 the things that I did. But probably not for the reasons that you'd expect. (laughter) You

629 know that you might expect, I guess.

630 R69: Okay. What, what do you think you might expect? What's the kind of... The reasons

631 that you outlined were sort of very much about other people's welfare...

632 P69: (overlapping) Yeah.

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633 R70: ... But it sounds like then there's a flip side to that. What...

634 P70: (overlapping) Yeah. I think, you know, that um... I think... For me to say that something

635 like that can be a hundred per cent successful, not that anything is, but you know, much

636 more successful, is like based on kind of internal feelings and like I had very external

637 motivation for changing. Um... Internal motivation. I always still erm... It was kind of like it

638 was because I valued other people more than I valued myself, I guess. Erm... Whereas I think

639 for it to be successful, it would be the whole kind of, err, you know "I'm worth more. I'm, I

640 deserve to be happy, I deserve to be um... healthy." That kind of thing. To be that would be

641 a far more successful...

642 R71: What do you mean by successful in that context?

643 P71: Like genuinely not thinking like a bulimic anymore.

644 R72: Right.

Handwritten annotations (left margin):

Fundamental change relates to change in self-perception

deep down: bulimic identity

Handwritten annotations (right margin):

100% success would mean internal (more fundamental?) change

P: external motivation for change (as opposed to internal motivation)

valued others more than she valued herself

successful outcome would mean valuing self more

'that would be a far more successful' (outcome) in comparison to P's therapy outcome

success = 'genuinely' not thinking like a bulimic

(+ so the bulimic thoughts are closer to the core, behaviour can change even if thinking doesn't change) 52

645 bulimic identity remains

separation between thoughts and actions

P72: D'you, d'you know? I think I, I believe that I still fee (sic), think like a bulimic, but I won't

646 (A)

act on it.

so what/who is a bulimic? does it come through thoughts or behaviour?

still think like a bulimic

647 R73: Uh-huh. What do you mean by that? If you had to kind of explain it to a lay person.

648 What's thinking like a bulimic?

649 P73: (overlapping) Yeah. I think, um, I value thinness much more than I value most things.

thinness very important

650 And I think, um, over the years like I've put on a, like I'm literally, I'm probably almost

? has nearly doubled her body weight

651 double what I was. Um, and a lot of that has been to do with um, not wanting to be seen as

652 someone with an eating disorder. Or you know, erm, I have always disclosed it, you know, in

hiding the bulimic identity behind a healthy exterior

motivation for weight gain - what others think don't want to be seen as someone with ed

653 health interviews and that kind of stuff. And people are always incredibly surprised and I like

disclose history of ED others v. surprised P likes this surprise don't want anyone to think she's 'still poorly'

654 that. You know, I don't ever want people to, to think that, you know that I'm still poorly or

managing others' perceptions of the self by hiding the interior (real self)

655 anything, so um. But I still, I'm still obsessed with calories, I'm still obsessed with food. I love

obsessed with calories and food

656 food you know and, and which has allowed me to kind of to, to be healthier, I guess. Um...

love food + helped to become healthier

d x still bulimic, not recovered! so the bulimic part is hidden

STAYING ON THE SURFACE –Master theme 1?

Staying on the surface feels preferable 286-289; *External focus in therapy maintains a sense of safety (it's not about me) 616-619; Practicality of CBT makes change seem easy 284-286; CBT requires little effort 305-308; Only behaviours were seen as a problem in CBT 295-299; Both Sarah and therapy were unable to move beyond the superficial 765-768; Frustrating to look deeper, when there is nothing to find there 290-293; Change attributed to increase in knowledge (rationality) 560-567; Therapy lead by the therapist and pre-set structure 372-379; Issues simplified into logical sequences 224-228; Committing to CBT just to appease others308-311, Intimidated by 'deeper' therapy, too exposing 301-303; Compliancy on the surface to appease others 537-542; Easy to meet others' expectations in therapy 530-531; Being unable to handle a more beneficial, deeper therapy 762-765; Partnership in monitoring behaviours 467-470; Therapy reinforces rigidity about food 531-532.*

< > Concrete interventions made a long-lasting impact 846-848 (OR NOT?)

The core remains unchanged

The grip of bulimia is just under the surface 659-664; *Surface seems changed, but the core remains the same 603-610; 613; Surface change to get approval 698-702; The self remains hidden/untouched in therapy 624-629; Identity remains unchanged 596-599; Rationality has a limited impact on the core 757-760; Deep down: bulimic identity remains unchanged 642-645; ED as an addiction 329-331; 547-551; 721-723; Struggle to give up the safety of ED 542-546; Values (thinness) remain unchanged 560-561; 567-570; Still can't trust own judgement of self 595-596; Self as an unreliable judge 727-729. Feeling responsible for the limitations of therapy 874-879*

Change as a result of changing yourself (identity) 550-553; *Fundamental change relates to change in self-perception 634-64; Helpful treatment recognises family dynamics 135-140; Internal conflict about the level of 'success' of therapy 838-845.*

Allowing others in

Violent realisation regarding the impact of own illness on others 335-339; *Turning point: understanding own eating related experiences as problematic 186-188.*

Conflict between own identity ('mad') and others' perceptions 481-487; *The body seen differently by Sarah and others 212-215; Having to take on someone else's view point made an impression 315-322; Therapist challenging Sarah's thinking processes enabled insight*

387-393; Others' challenging Sarah's beliefs behind behaviours 472-477; Making sense of own experience through others' words 440-444.

Rejecting similarity, admiring difference

Weight makes a therapist unacceptable 490-494; *Therapist approved by Sarah 224-225; 227-230; Needing a therapist that she could admire 511-514; Rejecting similarity 516-520; 521-525; Avoiding similarity at work (now – safety?) 864-869. Needing others to do the unacceptable (reject the therapist) 494-499*

CHASING HAPPINESS – Master theme 2?

Thinness equals happiness

Full commitment to being thin even at cost of own health 82-87; *Thinness as a measure of worth (worth is conditional) 35-39; Conditional love: thinness equals being loveable 19-23; Desire to be thin overrides everything 97-99; Thinness associated with femininity (family values) 7-10; Becoming thin is euphoric (becoming the ideal version of self) 65-68; Freedom to commit to the drive of becoming thin (worthy) 56-64; Desperate to be thin 255-258.*

External focus

Desperate to make others happy 110-114; *Priority to make others happy 447-448; Balancing between own needs/wants and those of others 429-431; Confusion – difficult to please others due to mixed messages 39-41; Unable to assert self due to wanting to appear a certain way 501-505; Others seen as a barrier to happiness 323-325; Using therapy insights to help others (now) 852-858; Prioritising others' perceived needs in therapy 618-623; Attributing responsibility for problems at home to others 383-387*

POWERLESSNESS AND VULNERABILITY – Master theme 3?

Loss of control

Binges representing escape and avoidance 408-410; *Loss of control after restriction 421-424; Binge seen as an uncontrollable reaction to overwhelming emotions 396-398; Powerlessness – who is in charge with EDs? 331-335; Fear of losing control with food still impacts on Sarah 424-430; The dilemma of eating: pleasing others or losing control 411-418; Feeling like there's nothing to live for 463-466*

OD an escape when feeling powerless/cornered 150-153; *OD as a potential way to escape unbearable feelings 457-459.*

Ending up powerless unless stay in control all the time 668-675; *Losing the power to continue pursuing thinness freely 118-120; Loss of control results in an uncontrollable panic (danger) 437-440; Feeling out of control is very scary 153-155; Starving self to cope with emotions/have some control 23-25.*

Struggle to move from childhood into adulthood 587-594

Caught in the middle of family/relationship conflicts 107-111

No choice – therapy promoting a particular approach (CBT) 272-276

Isolation

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